Board of Directors
Approved Minutes of the Meeting of the Board of Directors of County Durham and Darlington NHS Foundation Trust held on Wednesday 30 September 2020 from 09:00hrs
Rooms 5, 6 & 7 Prospect House Durham
Part One (Open)

Present:

Prof Paul Keane OBE	Chairman
Mr Michael Bretherick	Non-Executive Director
Mr Steve Crosland	Non-Executive Director
Ms Jenny Flynn MBE	Non-Executive Director
Mr Paul Forster-Jones	Non-Executive Director
Mr Simon Gerry	Non-Executive Director
Ms Sue Jacques	Chief Executive
Mr David Brown	Executive Director of Finance
Mr Jeremy Cundall	Executive Medical Director
Ms Carole Langrick	Executive Director of Operations
Mr Noel Scanlon	Executive Director of Nursing

In Attendance:

Ms Morven Smith	Director of Workforce & Organisation Development
Mr Warren Edge	Senior Associate Director of Assurance and Compliance
Ms Alison McCree	Managing Director – CDD Services
Mr Peter Dixon	Corporate Affairs Lead (Minute Taker)
Ms Kathryn Burn	Deputy Director of Nursing (Observer)

No members of the public were in attendance.

57/21	**Welcome and apologies**	**Actions**
	The Chairman welcomed Board members and others present. The Chairman clarified that the meeting was undertaken in accordance with Covid-19 social distancing guidelines, including those relating to the North East of England which had come into came into effect at midnight. There had been no apologies received for the meeting and the Chairman welcomed Ms Burn as an observer.	
58/21	**Declarations of Interests**	**Actions**
	Any Board Member who was aware of a conflict of interest relating to any item on the agenda was required to disclose it at this stage or when the conflict arose during consideration of a particular item. Mr Forster-Jones, Mr Crosland and Ms McCree declared their interests as Directors of Synchronicity Care Ltd (SCL).	
59/21	**Minutes & Matters Arising from the Previous Meeting held on Wednesday 26 August 2020**	**Actions**
	Accuracy The minutes were **agreed** as an accurate record of the meeting subject to the following amendments: *Item 34/21 Chief Executive's Report*, *Page 4, second bullet point*: To read: Regional Chief Executives had signed up to the publication of the joint promise to protect staff from BAME backgrounds, to be issued by the North East and Cumbria ICS. *Item 34/21 Chief Executive's Report*, *Page 6, second paragraph:* To read: The Trust had begun its own testing of the forecast costs, which included significant expenditure for PPE, Covid-19, reconfiguration of ED and implementation of SDEC. *Item 35/21Covid-19 trends, Incident Management and Performance*, *Page 7, eighth bullet point:* To read: The Trust had produced an Agile Working Policy, through partnership working with Staff Side Colleagues, led by Sue Williams from Workforce Compliance. Alongside this, Mr Edge and his team had produced the Working Safely Policy. The former policy enabled services and departments to work in a different way, giving staff the option to be able to work from home or alternative sites, service dependent and in line with the Trust's People Matter strategy. *Item 36/21 Patient Safety and Quality*, *Page 10, first paragraph:* To read: Mr Bretherick presented the IQAC Preface to the Board which provided an overview of the meeting which had been held on 25 August 2020. Matters Arising from the Minutes *Item 34/21Chief Executive's Report, Page 4, first bullet point:* Ms Flynn enquired whether the 'Talk before you Walk' scheme had begun to have a positive effect on the Trust Ms Jacques clarified that the scheme had only launched in the North of the Region and as such was not active in the footprint of the Trust at that time.	

	Item 35/21Covid-19 trends, Incident Management and Performance, *Page 7, fourth bullet point:* The Chairman asked for assurance that there were no Oxygen supply issues at DMH given that the work planned to increase capacity was not expected to be completed until December and the current rise in Covid-19 cases. Ms Jacques confirmed that present use of the oxygen supply at DMH was well within capacity. Oxygen consumption was being monitored as the number of cases was rising. The work, which involved the installation of a separate vaporiser, had originally been requested in the Spring and the Trust had been put on a waiting list. Once fitted, the vaporiser would enable the Trust to expand the oxygen capacity at DMH. The work was expected to begin imminently with a completion date earlier than December which had been given previously as the best estimate. The Trust would endeavour to complete the work by the end of October. <u>Action Log</u> Those actions 'greyed out' were accepted as complete: Action 1 (175/20), Action 2 (238/20(a)) and Action 5 (243/20). Updates were noted for the following actions: *Action 4 (242/20) Review and determine the evidence that could be provided to illustrate the way patients in ED were prioritised by the Trust:* The Chairman noted that there was a briefing paper on the prioritisation process included in the meeting pack and asked Mr Forster-Jones who had raised the question, if he felt that this was sufficient evidence on the matter. Mr Forster-Jones confirmed that the paper provided was comprehensive and provided assurance on how patients were prioritised. **Action Complete** *Action 6 (36/21), Reinstate Duty of Candour Reporting in the Patient Safety Reports to Board:* The Chairman asked Mr Scanlon for confirmation that this aspect of the report had been reinstated. Mr Scanlon confirmed that it had and would be discussed during his presentation of the report. **Action Complete**	
60/21	**Chief Executive's Report**	**Actions**
	<u>Chief Executive Officer's Update</u> Ms Jacques presented the report which sought to provide an update to the Board on national, Cumbria and the North East ICS, southern and central ICP and sub-ICP developments as well as other matters relevant for the Board, which were not substantively covered in the standard reports, and the likely implications associated with each. Ms Jacques discussed the contents of the report and elaborated on the following points: <u>National matters</u> • Phase 3 Planning guidance had been issued by NHS England and Improvement which had three areas of focus: i. Accelerating the return of near normal levels of non Covid-19 health services. Ms Jacques explained that, because of the requirement for social distancing within the Trust's hospitals and other infection control requirements, the target levels of activity in the guidance were at this time, not achievable under the current Trust plans. ii. Preparing for winter pressures in addition to vigilance for further probable Covid-19 spikes. Ms Jacques highlighted that it was currently believed that the Trust was seeing the beginning of a second spike. She advised that winter planning was ongoing and a peer review had taken place on the plans. There were outstanding	

	actions to be completed from the peer review and an update would be brought to the next Board meeting iii. Incorporating lessons learned from the first Covid-19 wave including support to staff and actions on inequality. Ms Jacques confirmed that the Trust was working with staff to ensure that there were no inequalities in the approach to Covid-19, either for staff or regarding how care was delivered to patients. • The planning guidance referred to revised financial arrangements to be introduced from October 2020. Ms Jacques explained that the details of these arrangements had not yet been received. However further to meeting with Finance, she was confident that the anticipated financial resources would enable the Trust to deliver on the ambition, as agreed, for the rest of the year and provide the resource to do so. • The timetable for Phase 3 planning submissions had been amended. A delay in the financial allocations being released and the requirement for the ICP to allocate aspects of the funding as per local agreements, had caused the timescales to slip. An update presentation would be delivered to the Board during the private and confidential session on 30 September 2020.The National ICP return would now be 5 October with a mid-October date for the planning return. An Extraordinary Board Meeting would be put in place to sign the plans off. <u>North East and Cumbria Integrated Care System (ICS)</u> • There had been no ICS meeting since the last Trust Board, but there had been a virtual event in order to develop the governance of the group and to begin the process of appointing an independent chair. The group agreed to put forward candidates from the lay board members. The Chair from South Tyneside and Sunderland NHS Foundation Trust, the GP Chair from South Tyneside CCG and the Chair of the Local Authority Health and Wellbeing board had all been nominated as candidates. <u>The "Local Authority 7"</u> • The seven North East councils in this group (County Durham, Sunderland, South Tyneside, Gateshead, Newcastle, North Tyneside and Northumberland) had agreed, with the central government, the implementation of additional local restrictions in light of the increase in in the number of Covid-19 infections. The Trust provides services in the areas covered by these local restrictions but also outside of them, with DMH based outside of the area covered by these local authorities. In order to ensure the safety of patients and staff, the Trust has made the decision to apply the same restrictions to DMH as its sites in County Durham. <u>Collaborative work between CDDFT, South Tees and North Tees / Southern ICP</u> • The ICP had developed and agreed a management compact. • A final draft of the ICP governance arrangements was expected in autumn for the Board to review. • The Clinical strategy workshop update had been deferred to enable more time for each work stream to develop its vision and plans. • The ICP had overseen the progress of ICP plans to be submitted on 5 October. <u>Central ICP</u> • The ICP had met periodically during the Covid-19 pandemic and had focused on recovery planning. Due to this there has been no advancement	**SJ (Oct-20)**

in the clinical work stream. The Chairman added that he would be attending a virtual meeting of the Chairs from the ICP area on 8 October 2020.

Secretary state of visit

- The visit of the Right Honourable Matt Hancock MP to three of the Trusts sites on [14 September 2020 was his first visit outside of London since the pandemic began and was indeed the Trust's first Secretary of State visit for some time and the first ever to the Trust's Shotley Bridge site. The Secretary of State was impressed by the Trust's work, particularly to stand up services to deal with Covid-19, especially in the ED at DMH. Ms Jacques noted that it was helpful to have had this visit and it had given staff the opportunity to share their experiences with him, as well as for Ms Jacques to have a private discussion about the Trust.

Ms Jacques invited questions from the Board.

The Chairman noted that there had been additional funding allocated to aid Trusts with recruitment and asked for clarification as to how this would be allocated. Mr Scanlon explained that there had been around £29 million assigned to support regional hubs and local initiatives to help with recruitment and the development of nurses and health care assistants. . There was a bidding process in place to obtain funding but Mr Scanlon was confident that the Trust would be able to obtain a sizeable sum from the process.

The Chairman thanked Ms Jacques for her update and the Board **noted** the contents of the report.

CQC Update

Ms Jacques presented the report which had been prepared to update the Board on the latest position with respect to CQC Insights and to provide assurance that the Trust understood, or was undertaking investigations to understand, the reasons for any adverse indicators, and was both taking appropriate action and considering those indicators as part of its overall evaluation of its principal quality objectives in assurance reports and the Board Assurance Framework.

Ms Jacques discussed the contents of the report and elaborated on the following points:

- Ms Jacques that some of the data sources used in CQC's Insights tool were older than those that the Trust was currently working with. As such she advised that the CQC Insights data should be used as a guide only to prompt the Trust to review areas of good practice or those areas where practice was not indicated to be as strong as others.
- The last report to the Board on CQC Insights was in January 2020 and there had been a mixture of both improvements and deterioration, however Ms Jacques noted that some deterioration was as a result of Covid-19 and this would be the same in most organisations.
- Whilst there had been positive and negative movement on some specific indicators, the overall distribution of indicators showed no significant difference between January 2020 and July 2020. The September 2020 report was now available but had been received too late to be presented to Board.
- Ms Jacques assured the Board that, of the indicators which had been deteriorating since the report from January 2020, the Board was already

	aware of the work ongoing and improvements being made especially in relation to MRSA. • Ms Jacques highlighted to the Board that there were 17 indicators which had been identified as Better or Much Better. Ms Jacques invited questions from the Board Mr Gerry enquired as to how indicators were identified as being worse or better. Mr Edge clarified that that the term worse or much worse referred to the Trust's relative performance against other organisations rather than against its own historical position. Mr Edge also explained that due to the data used for the Insight report being older, there was a lag in what the report shows. As such the Insight report can often show a deterioration which has already been previously identified by the Board Assurance Framework. Mr Gerry noted that the Trust's performance in relation to the Quality of Appraisals, Quality of Care, Safety Culture and Staff Engagement indicators had been measured using the 2018 NHS Staff Survey data. Ms Jacques explained that this highlighted how the Insights report was based on out of date data. Based on the 2019 survey the Trust had already seen improvement in relation to these indicators; however, as the report was based on old data this was not reflected. Ms Jacques assured the Board that the reports were used by the CQC to prompt discussion in the CQC relationship meetings, not to draw conclusions on performance or risk. In addition Ms Jacques explained that the Trust was in the process of developing its own quality monitoring system which would bring in clinical quality indicators and provide the ability to drill down to the service and specialty level of data, to further understand what was impacting on performance. As the system becomes available in the Autumn the board would then have access to more up to date and relevant data for consideration and assurance alongside the CQC Insight reports. Ms Flynn asked how much emphasis the new CQC inspection regime would place on the Insight reports. Ms Jacques responded that at this time this was not clear. The CQC had advised that the inspection regime was to be reviewed but was conducting a consultation, with a possible view to move away from the number of comprehensive inspections. Mr Edge added that he and Emma Carter, Head of Assurance and Compliance, had attended a national webinar on this matter. It appeared that the CQC were keen to move towards a more risk based inspection, utilising more comprehensive data sources, provided by an individual Trust or organisation to hone in on the risks that the organisation was facing, and inspect accordingly, as opposed to a broad inspection of the full organisation. The limitations of the Insight reports had been raised during the early phase of the consultation and the CQC indicated that they were working to refine and improve this tool. Mr Edge would provide a further update at a future Board when more information was available. Mr Bretherick noted the worsening of the mortality indicators; 'Deaths in Low-Risk Diagnosis Groups and In-hospital mortality: Acute bronchitis. He acknowledged that IQAC had previously received assurance about the ongoing work to address the issues but asked if there was a timescale for completion Ms Jacques explained that the Trust had commissioned an extra piece of work, requesting a detailed case review of all deaths where there had been a less than 10% chance of mortality and any issues which were identified would be escalated appropriately. Mr Cundall added that there were around a 100 cases to be reviewed and this was currently expected to be before Christmas.	**WE (Dec-20)**

	The Chairman noted that, against the indicator titled 'being left alone' the report stated that the Band 7's were 'driving midwives presence in the rooms'. The Chairman asked for assurance that patients in labour were not being left in the room alone. Mr Scanlon responded that the department was well staffed and feedback on birth experiences was universally positive. Mr Scanlon elaborated that the work ongoing here was in relation to providing continuity of care. There was a dedicated team working to improve the experience of at risk women in labour. This included those from economically deprived areas, difficult families and those from a BAME background. The programme was currently in the early stages. The Chairman thanks Ms Jacques for her report and the Board **noted** the contents. <u>Board Assurance Framework (BAF)</u> Mr Edge presented the report which had been prepared to provide the Board with; an analysis of the movement in risk scores, (based on the underlying level of assurance), over the last quarter and the resulting Red, Amber, Green (RAG) ratings for the strategic risks which the Board manages through the BAF. The report also sought to provide a 'helicopter view' of the level of assurance available for each of the Trust's 16 principal business objectives including any gaps in controls of assurance and associate action plans, and a summary of key risks (those above the tolerances set by the Board) together with their mitigating actions. Mr Edge discussed the content of the report, elaborating on the following points: • The scores and outcomes had been discussed individually and as a collective in the Executive Director meeting. Mr Edge clarified that there would be an additional paper in the Private and Confidential Board meeting to provide further information on the Executive Directors discussion, unable to be included in the Open meeting due to the inclusion of commercially sensitive content. Mr Edge assured the Board that the review and discussion undertaken by the Executive Directors had used the Trust's risk assessment matrix and had been reflective of good practice. • The Integrated Quality and Assurance Committee had also reviewed the objectives within its remit. It had endorsed the current risk ratings and trajectories, as being consistent with the underlying assurance reporting scrutinised by that committee. • Mr Edge provided assurance to the Board that risk scores were reviewed with a holistic approach, with full consideration of the risk rather than defaulting to the highest scored operational risk. • Of the 18 objectives that the BAF was tracking, 10 were on target with eight not yet at their target scores. • Since the report had been written there had been an increase in Covid-19 admissions and it was suspected that this could be the beginning of a spike. As such Mr Edge advised the Board that the Executive Directors meeting would monitor how this could impact the BAF; for example certain objectives may have an increase in scores alongside mitigating actions being impacted. • There was one red rated risk, relating to the building of restart capacity and performance, which reflected the significant challenges involved in reducing waiting lists for elective services, managing the growth in long-waiters and achievement of 18 week waiting referral to the treatment waiting times. • There were five high-amber rated risks which required further mitigation. These risks related to IS strategy, Financial Sustainability, Protecting Patients from Nosocomial Infection, Effective Covid-19 and Workforce capacity.	

	• Ms Jacques expanded on the Sustainability item in the report. She explained to the Board that the Sustainability Group had been reconstituted, having been suspended during the first wave of Covid-19. The Sustainability Group had undertaken a Sustainable Development Self-Assessment using a tool from the Sustainable Development Unit. This work would enable the Group to present to the board proposals for principal objectives such as ambitions for carbon neutrality as well as other short term objectives. The work was expected to conclude in October 2020 and the Sustainability objective on the BAF would be updated after this date rather than pre-empting the results. Questions on the report were invited from the Board. Mr Bretherick queried whether the commentary for Objective 1: Minimise avoidable patient deaths (non-Covid) needed amending to reflect the SHMI indicator. Mr Edge confirmed that it would as it should be updated to make clear that the SHMI indicator was just within the upper limit. The Chairman noted that it was good to see progress on Operational Risk 2338, poor management of inpatient paediatric eating disorders due to CDDFT Paediatric Dieticians not being clinically skilled in this area of dietetics. As per NICE guidance care should be delivered from multidisciplinary team with the expert skills in this field including mental health. But the Chairman enquired whether the risk would need to remain open given that there were pressures on Child and Adolescent Mental Health Services, regionally and nationally, that may yet impact on the quality of mental health support available to work with the Trusts Dietetics teams. Mr Edge confirmed that the risk would reduce, but would be kept open and monitored for some time until it was clear that new support arrangements were embedded The Chairman asked whether there were any implications for patients for Operational Risk 2116; the risk to the operation of the laboratory Assisted Conception Unit department at BAH due to the small number of staff in the service and the potential for service interruption due to sickness absence. Mr Edge clarified that the service was being sustained, but the risk to sustainability could result in short term disruption to patients during periods of sick leaves. This risk was not specific to CDDFT and was noted to be a challenge in the region. Mr Edge assured the Board that the service sought to prioritise the needs of patients over reporting requirements, to minimise the build-up of backlogs when necessary. The Chairman noted Operational Risk 2060, the risk of paediatric cases backing up in the paediatric Accident and Emergency area due to insufficient staffing and asked whether the Trust had been successful in recruitment for the paediatric A&E area. Mr Scanlon confirmed that paediatric staffing was the strongest it had been for some time and that work would be undertaken to maintain the staffing levels, as while this was an encouraging place to be at, there was still a risk to the service. Ms Jacques added that physical changes to the configuration of the A&E Department at DMH, which were due to begin prior to Christmas, would be a good opportunity to bring the paediatric staff together and allow for reflection. Ms Flynn noted that there was no mention of the use of Healthwatch or the voluntary sector in the Covid-19 main objectives in the report, particularly the objective relating to stakeholder engagement and support. She sought assurance as to how the Trust was focusing on the experience of the patient; seeking feedback and ensuring that they have a good experience. Mr Scanlon explained that during Covid-19 the usual activities of Healthwatch for dialogue with patients were, to	**SJ (Nov-20)** **WE (Dec-20)**

	some extent, compromised as there were restrictions in place preventing site visits due to the Trust's visiting restrictions; however, there had been remote monitoring. In addition Mr Scanlon explained that the Covid-19 Perfect Ward tool monitored both the staff and patient experience during this time. Attention had been given to how patients would experience their admissions and iPads which had been donated via Charities had helped to keep patients in touch with families and to reduce isolation. Ms Flynn then asked if the Trust was still able to capture patient stories or testimonies to give a flavour to the figures collected through reporting. Mr Scanlon answered that compliments and feedback were being received and when written feedback was volunteered by patients, carers or families the Trust did ask if it was possible to use it. Ms Jacques added that the Patient Engagement Strategy elicited ways for both the Board and IQAC to pull together surveys, stories and the Friends and Family test to provide a better picture. Mr Gerry enquired as to the progress of specific developments to the estate at UHND to prepare for a second Covid-19 spike, which had been at risk of delay due to negotiations with the PFI provider. Ms Langrick responded that thanks to the hard work of Ms McCree and her team the issues had been resolved and work would start immediately after the enabling works were completed. It was expected that everything would be complete by the end of December to the beginning of January at the earliest. Mr Bretherick noted that the Board development programme had been paused and asked if this could impact on the CQC's assessment of whether the Trust was well -led. Mr Edge confirmed that this work had not been restarted and, with Ms Smith's help he would bring an update to the next meeting. The Chairman thanked Mr Edge for his paper and the Board **noted** the report.	**WE/MS (Nov-20)**
61/21	**Covid-19 Trends, Incident Management and Performance**	**Actions**
	<u>Executive Directors Report on Covid-19 management, performance, finance and reset programme</u> Ms Jacques presented the report to the Board which had been prepared to enable the Board to be fully sighted upon, and to scrutinise, all aspects of the Trust's response to the Covid-19 outbreak, including performance against constitutional targets during the period. Ms Jacques discussed the following points in relation to the report: • Since the report there had been an increase in the number of Covid-19 patients. At the time of writing the report there had been eight Covid-19 positive patients; however, there were now 31 confirmed Covid-19 positive patients with a further 72 patients who were waiting for the result of the Covid-19 test. Ms Jacques assured the Board that this significant increase was in line with neighbouring Trusts. • Command and Control arrangements were in place with Gold Command continuing to meet twice weekly and the Executive Team meeting three times a week. In addition, Ms Jacques explained that she spoke with the Chairman seven days a week and would be stepping up meeting with the Non-Executive Lead for resilience to weekly rather than every two weeks.	

	• There had been an increase in activity at the regional Strategic level with the Strategic Recovery Group (SRG) paused and the Strategic Coordinating Group (SCG) re-started. The membership of the groups were extremely similar and as such they had a good understanding of the issues and oversight of the regional approach. In addition, the Local A&E Delivery Board (LADB) had increased the frequency of its meetings. The LADB included CCG's, Local Authorities and other partners in health. The role of the LADB was to ensure a safe response to patients' most urgent care needs, regardless of whether it was mental health, acute, primary or community care. The LADB and SCG reinforced the collective responsibility of all system partners to optimise care and responses to Covid-19. • The Trust had now fully rolled out the Perfect Ward Covid-19 module which covered 8 domains relating to Covid-19: hand hygiene: PPE compliance: staff awareness; signage; patient safety and handling of actual and suspected cases. Ms Jacques reported that the audits from August 2020 demonstrated an overall compliance score of 99% with all areas in the acute hospitals scoring 95% or better. • The Trust had identified an incident of possible hospital transmission of Covid-19 on a ward. A Root Cause Analysis (RCA) had been conducted and had found that the patients had been nursed by different teams at different ends of the ward. While there was no access to a test to determine the strain of Covid-19 and therefore identify where the patient had contracted it, the RCA had determined that it was unlikely the patients had come into contact with each other and therefore unlikely that one had passed Covid-19 to the other. Ms Jacques confirmed that there had been issues and learning identified as part of the RCA in relation to the re-testing process. As an outcome, the process of when to test and re-test new admissions had been reinforced to staff. Ms Jacques assured the Board that Mr Scanlon had a team reviewing any possible or actual cases of hospital spread to ensure that rapid learning was identified and implemented to minimise the risk of nosocomial transmission. Ms Jacques also confirmed that further to her report, there had been a small number of further outbreaks in a hospital setting. • The Trust continued to emphasise staff safety and ensure that Track and Trace requirements were reinforced. At the time of the report Ms Jacques confirmed that the numbers of staff shielding or self-isolating had reduced however the number of staff with Covid-19 had increased. Work was ongoing by Mr Scanlon and Mr Cundall to reiterate to staff the need for using correct PPE, hand hygiene and social distancing. Ms Jacques confirmed that there continued to be no shortages of PPE. • The increase in Covid-19 cases meant that the Trust was optimising the use of side rooms whilst ensuring that elective capacity was protected as much as possible, in order to ensure the safety of all patients. Ms Jacques clarified that the Trust had taken significant learning from the first wave to understand how it could continue to operate. Some impact on the Trust's ability to fully restore elective services was anticipated, however, as the rest plans had been formulated without a second wave. • To date, the Trust had tested 2,899 staff for Covid-19 as well as undertaking over 5,000 tests for partner organisations and 1,486 tests in support of care homes. Ms Jacques confirmed to the Board that the Trust was expecting delivery of four further testing machines. It was anticipated that these machines would enable the Trust to improve the turnaround time and capacity for testing significantly. The Trust was bidding for more machines, as, at that time, for every 300 tests conducted, around 150 of were sent to	

external laboratories to process which resulted in longer turn-around times which impacted on decision-making and patient flow. The Trust hoped to secure a high speed analyser, or the 90 minute test when available, to improve testing capability further.

- The Trust had rolled out an Agile Working Policy which had included significant arrangements to enable appropriate staff to work from home with stringent rules set. At the time of the report the Trust had 700 staff working from home. It was not possible for all staff to work in this way; however, as there were many staff who would not be able to fulfil their role without the contact and equipment available on site. Where possible and safe, the Trust continued to facilitate the arrangement.
- The Trust continued to have additional objectives on the BAF relating to Covid-19 and a discrete Covid-19 risk log which was reviewed weekly.
- There had been an increase in Covid-19 in care homes with both staff and patients testing positive. The Trust was providing support with tests for those who were symptomatic. In addition, and only in extreme circumstances, the Trust would assist with staffing; however, the Trust was working with the Local Authorities to help them find an alternative and more substantive solution.
- The Trust continued to perform solidly against national, constitutional targets when compared with neighbouring and similar Trusts.
- There had been a financial arrangement in place for the first six months of the year but this would be changing for the second half. The new arrangements had not been published at the time of the report but based on an estimation by the Trust of what the arrangement could be, it was anticipated that the Trust would be looking to run to break even over the year.
- There was work ongoing to review the operational reset program as the original plans had not accounted for a second spike of Covid-19 cases. A full update had been previously provided to the Board at an extraordinary private and confidential meeting on 21 September 2020.

Ms Jacques invited questions from the Board in relation to the report.

Ms Flynn enquired if the Trust had Covid-19 positive patients in the acute setting only or if they were also in other areas or sites. Ms Jacques confirmed that there were Covid-19 patients across a number of Trust sites, including some community sites. The Trust ensured that the patients were managed appropriately using IPC guidance to minimise the risk of spread, with mitigations based on each individual patient. However Covid-19 patients were more concentrated in the acute sites.

Mr Crosland sought assurance that the Trust was able to meet the demand for tests for care homes. Ms Jacques confirmed that the Trust was meeting the demand for tests and had additional capacity available. Ms Jacques also clarified that there were around 90 care homes in the CDDFT footprint, of which there were only two known to have difficulty with staffing, as most had more capacity due to lower numbers of patients being referred.

The Board thanked Ms Jacques for her report and **noted** the contents.

<u>Integrated Performance Report</u>

Ms Langrick presented the report to the board which had been written for the purpose of summarising performance against national standards and Trust touch-

	stones, and national requirements for the re-start of the full range of services whilst continuing to manage and recover from Covid-19. Ms Langrick explained that the Executive Directors would each discuss the information from their own remit. Ms Langrick discussed the performance section of the report, elaborating on the following matters: • The Trust's waiting list position had begun to increase again and this was linked to the increase in outpatient activity which meant that more patients were being added to waiting lists. However Ms Langrick emphasised that the Trust had not reached pre-Covid-19 levels. Outpatient and elective activity was slowly improving, month on month, since it was restarted in July 2020. There were, however, many patients who were constantly moving into the 'over 18 week' position due to the previous suspension of services and limitations on capacity as a result of infection control requirements and the unwinding of actions taken to manage the first wave of Covid-19 admissions. Ms Langrick explained that it would be likely that the Trust's performance on this target would be below the national targets for some time while those patients moved through the system. • There had been a change in the A&E performance for the better during the pandemic due to a reduction in attendances to the departments alongside dual A&E pathway to improve patient flow. Since the end of wave one the Trust's A&E performance had worsened. This was believed to be a combination of: the increase in the Trust's elective activity which meant that there were fewer beds available in the acute sites, an increase in A&E attendances, A&E departments having returned to a single pathway and the additional staff who had been redeployed to A&E having been repatriated. In addition a further factor of Covid-19 testing had increased the time patients spent in A&E while results of the tests were awaited. Once the Trust gained access to the additional testing machines and high speed analyser, this risk could be mitigated. • Diagnostic procedures had been stood down during the first wave, with the exception of urgent or emergency referrals. Further to being stood back up, Ms Langrick confirmed that there was no backlog in radiology however there was a backlog in endoscopy. Ms Langrick assured the Board that initiatives were now in place to increase endoscopy activity and a gradual improvement had begun to be seen. In addition there had been further initiatives approved in the week prior to the Board meeting which would be implemented from the end of October 2020 to improve performance further. Ms Langrick emphasised that the Trust was monitoring the performance of the department closely as it had an important role in cancer diagnosis and pathways. • Ms Langrick reiterated that during wave one of the Covid-19 pandemic the urgent and cancer services were maintained and as such, while the Trust was not meeting the standards for cancer, it had maintained a relatively strong performance. Ms Langrick explained that the link between cancer performance and the endoscopy service, meant that the Trust expected performance to improve as the endoscopy service increased its activity. The expected improvement was set against a potential second wave and, as such, Ms Langrick clarified that there could be a further impact on the Trust's ability to implement plans to meet national targets set out in the Phase 3 planning guidance from NHS England and Improvement. Ms Langrick invited questions on her section of the report	

	The Chairman sought to understand if ambulance handover delays were still a problem in A&E. Ms Langrick confirmed that delays were much reduced from the previous winter, but might still arise mostly due to the way in which the departments needed to operate, including the need for IPC and social distancing in addition to a limit on the number of individuals in the waiting areas. This combination of factors, Ms Langrick explained, did increase the pressure and meant that handovers might, in a minority of cases, be delayed until it was safe to do so. Ms Langrick clarified however that this was dependant on the clinical condition of the patient, with those needing to be seen straight away being prioritised for such attention. Ms Flynn sought further assurance on the increasing of capacity in endoscopy and outpatients. Mr Cundall clarified that both Endoscopy and Outpatients were monitoring their activity and capacity regularly and adapted as necessary to improve activity levels. The Chairman sought to understand how the telephone clinic appointments were working, as he had received anecdotal evidence that patients were being given four hour time slots rather than a specific time as they would in the case of a face to face appointment. Mr Cundall responded that this was the first he had heard of such a practice. Mr Cundall explained that, in his own clinics, he had a list of patients, each with a specific time for their telephone appointment. He would look into the matter with the team responsible for appointments. Ms Flynn sought to understand the expected impact of the second wave of the pandemic and asked whether the Trust would be looking to stand services down again. Mr Cundall responded that the Trust was optimistic in its plans to maintain outpatient, diagnostic and elective activity while managing the urgent and emergency services. He elaborated that the Trust hoped to be able to approach the wave like they would with any other winter. The intention was, therefore, not to stand down outpatient or elective services unless absolutely necessary due to the levels of Covid-19 pressure. The difference between the second wave and the first was that the Trust had a greater understanding of how to manage the flow of patients. Mr Scanlon added that the Trust was receiving pandemic modelling information from Public Health as a second wave had always been a case of when rather than if. As such the Trust had escalation plans in place which would be maintained and elective activity would only be stood down if there was no alternative. Mr Cundall added that it was hoped that this would be in the New Year rather than prior to Christmas. Mr Scanlon presented the next section of the report on patient safety and nurse staffing, elaborating on the following points: • Overall the report demonstrated that the Trust nurse staffing had been sustained effectively with most difficulties experienced in Sedgefield Hospital and wards six, 10 and 15 in UHND. The report contained accounts from the ward sisters to provide context to the data, which allowed for a greater understanding. • Mr Scanlon explained that there had been a fluctuation of staffing over the previous few months due to around 500 staff having been redeployed, though most of these had now been repatriated. • Mr Scanlon explained that the data in the report was distorted due to second and third year nursing students appearing in band three and four HCA pay lines despite being a neutral cost to the Trust. This meant that interpreting the data was more complex in some areas.	**JC (Nov-20)**

- Vacancy levels appeared significant in the report, but Mr Scanlon explained that they were planned against an actual second spike which inflated the requirements. In addition Mr Scanlon explained that some of the figures were misleading. This was due to the third year nursing students being counted twice. This resulted in overstaffing under the HCA category and the same students then counted on the pending RN list, inflating vacancies.
- There were 75 jobs offered to student nurses in the week prior to the Board meeting with 56 acceptances. However there would be a number of delayed starts due to requirements on practice hours or other outstanding checks. Mr Scanlon advised the Board that it was pleasing that a number of the new nurses had come from universities outside of the local area.
- The staffing picture was expected to stabilise, however the number of vacancies would be likely to increase, given the timing of each in-take compared to usual levels of attrition. In addition the ability to redeploy staff in a second wave would be depleted by the desire to maintain elective services. Mr Scanlon advised that the Trust would need to be nimble in how it approached redeployment.

Mr Scanlon invited questions from the Board on his section of the report

Mr Bretherick noted that one ward in the report had reported 13 vacancies and sought assurance on the immediate recruitment the Trust was undertaking. Mr Scanlon confirmed that, in addition to the graduates he had mentioned in his presentation, there were also 20 Indian nurses on the shop floor who were due to undertake their practice exams in October which would, if passed, enable them to work as RNs. In addition, a further 20 Indian recruits were expected to be brought over in October who would be able to begin work after a quarantine period and Mr Scanlon confirmed that he would be submitting a request to the next Gold Command meeting, to recruit a further 20 in November. Mr Scanlon assured the Board that the Trust had another 40 on contract in India and would be able to draw on these if required and there were a further 65 pending graduates due to be interviewed within a week, ready for a January commencement. Ms Smith added that there was also work ongoing in relation to local recruitment to raise the profile of the Trust and its sites to attract more staff. BAH was a particular focus for this work as it was expected to become the Trust's central location for elderly medicine and it was believed that this may attract more applicants. Mr Scanlon emphasised that the Trust's current staffing was safe but that there was an ongoing balancing act to manage urgent frontline recruitment, redeployment and Covid-19 requirements.

Mr Forster-Jones asked if it would be possible for the Non-Executive Directors to be briefed on the profile of the patients in wave two in comparison to those in wave one, to enable them to understand the levels of care required and the implications of this. Mr Cundall explained that this would not be possible at that time as it was too early in the wave to be able to understand the patient profile; there had not been enough wave two patients to date. Ms Jacques assured Mr Forster-Jones that the Trust was monitoring the number of patients and the requirements. If the number of Covid-19 patients increased further, it would be expected that the Gold Command meetings would return to a daily frequency to enable the Trust to manage and optimise the activity levels. Ms Jacques also provided assurance that the Trust was monitoring the requirements of patients and sought to ensure that patients were not disadvantaged and that there were no inequalities between those following a Covid-19 pathway and those not. Mr Cundall advised that a full patient

	profile would be unlikely prior to November, and advised Mr Forster-Jones to request this at the next open board. Mr Forster-Jones enquired whether there had been any benefit reaped by the Trust from learning outside of the organisation, such as that from the Primary Care sector. Ms Jacques confirmed that through the Strategic Command Group, Local Resilience Forum and LADB the Trust had close contact with external colleagues, including the Mental Health Sector. This had resulted in improved cooperation with colleague organisations as well as the development of a multi-agency approach to the Covid-19 response. In addition, the GPs working within the Trust's localities had been invaluable during the first wave as they worked in the community hospitals supporting the Trust. Collaborative working at neighbourhood level was strong during the first wave and this had continued since. Mr Crosland noted that, in the previous Board meeting, the importance of supporting staff and alleviating the impact of fatigue should be addressed. Mr Crosland sought assurance that this work had been undertaken. Ms Jacques confirmed that this was important to the Board and had been discussed in the Executive Directors meeting. It had been noted that it would be a long winter for staff considering the restrictions in their personal lives based on local and national guidance as well as the winter and Covid-19 pressures which would impact their work life. As a result the Executive team were keen to maintain morale and to try and spread happiness through the staff. Following a suggestion from Mr Cundall, Ms Jacques had written on the closed staff Facebook page to request suggestions from staff as to how things could be made better at work. The Executive team would then review suggestions and action as appropriate. Ms Smith presented the next section of the report titled 'Best Employer' discussing the following points from the report: • The data presented in the report relating to sickness was fluid. This was due to a combination of staff requiring to isolate due to 'Track and Trace' as well as staff returning from shielding. Overall the sickness level reflected the additional levels of Covid-19 and, at 4.81%, against a target of <4%, should not be considered unreasonable. • The appraisal performance level was low at 69% against a 95% target however appraisals had been suspended for three months, resulting in a backlog. Ms Smith explained that she would hope to see an improvement in appraisal performance; however, a second wave would present significant challenges for this. • Essential training was mostly being delivered through e-learning rather than physical sessions and considering the pressure Covid-19 had placed on staff, a performance of 90.98% against a 95% target was good. Ms Smith invited questions on her section of the report Mr Forster-Jones enquired why appraisals had not been suspended again, as the Trust believed that it was starting to see the beginning of a second wave. To not to so was likely to exacerbate the low level of performance. Mr Cundall responded that appraisals needed to be undertaken to support staff even more than to support performance, allowing for a discussion of work in a neutral environment. In addition from a clinical perspective, some appraisals could be linked with revalidation and as such could not be suspended. The 2019/20 staff survey had highlighted that staff felt it was the quality of the discussion which was important, and this resonated now even more than last year. Ms Smith added that this was a major factor of the NHS	**PFJ/JC (Nov-200**

	People Plan, allowing the health and wellbeing of staff as well as Covid-19 risk assessments and agile working discussions to be linked into the process. Ms Smith agreed that the compliance level was less important than the discussion that staff were able to have with their manager, ensuring that it was not simply a box ticking exercise and providing a more rounded experience. Mr Brown presented the Finance section of the report, elaborating on the following points: • At the end of August the report showed that a total of £4.096 million was required as a top up to the current block funding in order to report a balanced income and expenditure position. This would be claimed retrospectively by the Trust but this was reflective of the Trust's position year to date. • The Trust's cash flow position continued to be positive with £50.5 million in the bank. This was as a result of commissioners paying the Trust one month in advance to ensure that the Trust was able to pay all suppliers promptly to assist with the Covid-19 response. • The Trust had spent £6 million in capital to date. • The Trust expected to receive two additional awards from NHSE/I. the first was a £627k payment to enable the replacement of two CT scanners due to their age. Secondly the Trust was to receive £1.2m for the endoscopy programme which would enable enhancements to the building at BAH and the purchase of additional scopes. Mr Brown invited questions from the Board on the Finance section of the report Ms Flynn enquired if the £1.2 million would also cover the ultrasound machine that the Charitable Funds Committee had been asked to review and approve. Mr Brown confirmed that it did not. The Executive team were thanked for their report and the Board **noted** the contents of the report and **endorsed** the actions being taken.	
62/21	**Patient Safety and Quality**	**Actions**
	<u>IQAC Preface</u> Mr Bretherick presented the preface to the Board which had been prepared to provide an overview of the meeting which had been held on 22 September. Mr Bretherick advised that the contents had already been discussed during the other items in the meeting and, as a result, he had nothing further to add at that time. There were no questions for Mr Bretherick and the Board **noted** the contents of the preface. <u>Patient Safety and Experience</u> Mr Scanlon presented the Patient Safety and Experience Report to the Board, which had been prepared for the purpose of updating the Board on the position of the Trust with regard to HCAI and serious incidents. Mr Scanlon discussed the report and highlighted the following points: • At the time the report was prepared there had been zero Trust apportioned cases of MRSA Bacteraemia; however, there had been one case since the report.	

- The sharp decline in Covid-19 cases had begun to reverse as the number of cases rose, though the Trust was reviewing each new case on a daily basis, to monitor the impact.
- The Trust was working towards being more self-sufficient with PPE however respirator hoods, ordered for staff struggling to fit test with any of the respirator masks supplied, had not yet arrived due to an issue with the NHS supply chain.
- The number of cases of Clostridium Difficile remained erratic but in excess of the planned trajectory. The Trust had believed that the consumption of antibiotics in the community had been increasing, and contributing to the trend in cases; however, further analysis had identified that it was, in fact, declining.
- Side room capacity remain an area of concern for the Trust as such rooms were required for Covid-19 patient management; however, winter pressures from Norovirus and Influenza would add further demand.
- There had been four falls resulting in harm.
- The potential wrong site surgery Never Event, referred to in a previous report had been 'de-logged' as the full review had determined that it was not a wrong site surgery and that there had been a difference of opinion in how to operate. Learning had been taken from the event with annotation of medical photographs remaining key. Mr Cundall added that this decision had been made due to the evidence supplied through photographs and discussion with the nurse who had undertaken the biopsy. Mr Cundall confirmed he had chaired the panel reviewing the case and was confident in the judgement made.
- There was a case of testicular torsion which had been reported as the patient should have been examined. As a result of this incident, Mr Scanlon had requested a thematic analysis of the three testicular torsion cases which had occurred in the last four years to determine further learning for the Trust.
- Compliance with the Duty of Candour requirements stood at 98% and Mr Scanlon assured the Board that this process was monitored every two weeks at the Patient Safety Forum.
- The Trust had a slightly higher rate of complaints than comparative organisations in the area.
- The Friends and Family Test had been reinstated however the National Patient Survey programme had been stayed.

There were no questions in relation to the report.

The Board **noted** the contents of the report.

<u>Medical Management</u>

Mr Cundall presented the report to the Board which had been prepared to provide an update in relation to the implementation of the newly formed Clinical Ethics Committee and the progress with the Medical Examiner Service.

Mr Cundall discussed the contents of the report and expanded on the following points:

- The Director of Research had returned to his clinical role and the Trust was in the process of recruiting to the position. Regretfully the advert had closed and no applications had been received. As such an interim Director had been appointed until spring and Mr Cundall had identified a candidate to whom he would provide training in anticipation of re-advertisement of the vacancy next year.

	• The Trust was the 46th highest recruiter for research trials in the country and was third in the region. • There had been a delay in the recruitment of Medical Examiners due to Covid-19; however, the Trust was now in a position to advertise five vacancies. Mr Cundall invited questions from the Board Ms Flynn enquired as to how the previously recruited Medical Examiners had settled into the roles. Mr Cundall responded that regretfully one of the Medical Examiners was on long term compassionate leave. As such the original plan of having a Medical Examiner trialling the process with respect to one ward had not been able to be implemented. The original model was being centrally funded and further funding could become available if the Trust could show that it was required; this would not be possible until the Medical Examiner posts were filled. The Board thanked Mr Cundall for his report and **noted** the contents. <u>Guardian of Safe Working Report</u> Mr Cundall presented the report which had prepared in order to provide an update to the Board on the safety of junior doctor rotas. Mr Cundall discussed the report and elaborated on the following points: • The Trust had taken learning from the work of the Guardian of Safe working with respect to how it should manage the movement and redeployment of junior doctors in response to the second wave of Covid-19 cases. • The Trust was taking further steps to engage with junior doctors and understand how they felt about their role and working in the Trust. There were weekly meetings being held on each site of the Trust as well as a monthly junior doctor forum hosted by Mr Cundall and his deputies. Mr Cundall invited any questions from the Board: Mr Gerry noted that 10% of the ongoing issues had not been closed and sought an understanding as to why this was. Mr Cundall clarified that in order to close an issue, the junior doctor needed to meet with their trainer to discuss the outcome and agree to close. Due to the movement of the junior doctors, the logistics of meeting meant that this was often delayed. The Board thanked Mr Cundall for his report and **noted** the contents.	
63/21	**Other Board Business**	
	<u>Any Other Business</u> No items were raised.	
64/21	**Announcement of Next Public Meeting(s)**	
	The next public meeting of the Trust Board would be on 25th November 2020. This was expected to be held virtually.	

65/21	**Motion to Exclude Press/Public**	
	The Chairman moved the following motion. That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interests.	
66/21	**Meeting Closed at 10:55**	

Chair – Prof Paul Keane OBE ……..

Date: ……... 2020