South West Yorkshire Partnership NHS Foundation Trust

Trust Board (performance and monitoring) (private session)
Tuesday 31 March 2020 at 9.30am
Virtual meeting, via Skype for Business

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal**	2	To receive
2.	**9.32**	**Declarations of interest**	Chair	**Paper**	2	To receive
3.	**9.34**	**Minutes and matters arising from previous Trust Board meeting held 28 January 2020 (public meeting only)**	Chair	**Paper**	6	To approve
4.	**9.40**	**Chair and Chief Executive's remarks**	Chair	**Paper**	15	To receive
			Chief Executive	**Paper**		
5.	**9.55**	**Interim governance arrangements**	Chair	**Paper**	10	To approve
6.	**10.05**	**Performance reports**				
	10.05	*6.1 Arrangements in place for the management of Covid-19 (private session only due to confidentiality)*	Director of HR, OD & Estates	**Paper**	30	To receive
	10.35	*Break*				
	10.45	6.2 Integrated performance report month 10 2019/20	Director of Finance & Resources and Director of Nursing & Quality	**Paper**	30	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.15	6.3 Serious incident report Quarter 3 2019/20	Director of Nursing & Quality	**Paper**	5	To receive
7.	**11.20**	**Business developments**				
	11.20	*7.1 South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (private session only, commercial in confidence)*	Director of HR, OD & Estates and Director of Strategy	**Paper**	10	To receive
	11.30	7.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy and Director of Provider Development	**Paper**	10	To receive
	11.40	7.3 Receipt of Partnership Board minutes	Chair	**Paper**	2	To receive
8.	**11.42**	**Strategy updates**				
	11.42	8.1 Trust Constitution	Director of Finance & Resources	**Paper**	2	To receive
	11.44	8.2 Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)	Director of Finance & Resources	**Paper**	2	To approve
	11.46	8.3 Standards of business conduct policy	Director of Finance & Resources / Director of HR, OD & Estates	**Paper**	2	To approve
	11.48	8.4 Involving People strategy	Director of Strategy	**Paper**	2	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.	**11.50**	**Governance matters**				
	11.50	9.1 Eliminating mixed sex accommodation (EMSA) declaration	Director of Nursing & Quality	**Paper**	2	To receive
	11.52	9.2 Data Security and Protection toolkit	Director of Finance & Resources	**Paper**	2	To receive
	11.54	9.3 Assurance from Nominations Committee 6 March 2020	Chair	**Paper**	2	To receive
10.	**11.56**	**Assurance and receipt of minutes from Trust Board Committees** - Clinical Governance & Clinical Safety Committee 11 February 2020 - Equality & Inclusion Committee 3 March 2020 - Finance, Investment and Performance Committee 23 January 2020, 27 February 2020 and 24 March 2020 - Mental Health Act Committee 10 March 2020 - West Yorkshire Mental Health Services Collaborative Committees in Common 21 January 2020 - Workforce& Remuneration Committee 11 February 2020	Chairs of committees	**Paper**	4	To receive
11.	**12.00**	**Use of Trust Seal**	Chair	**Paper**	2	To receive
12.	**12.02**	**Trust Board work programme**	Chair	**Paper**	3	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
13.	**12.05**	**Date of next meeting** The next Trust Board meeting will be held on Tuesday 28 April 2020	Chair	**Verbal**	0	To note
	12.05	*Close*				

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Trust Board 31 March 2020
Confidential agenda item 2

Title:	**Trust Board declaration of interests, including fit and proper persons declaration**
Paper prepared by:	Corporate Governance team on behalf of the Chief Executive
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Any background papers/ previously considered by:	Previous annual declaration of interest papers to the Trust Board. Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality last reviewed and approved by Trust Board in March 2019.
Executive summary:	**Declaration of interests** The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor / NHS Improvement require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution. **Non-Executive Director declaration of independence** Monitor's Code of Governance and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its

	annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect. **Fit and proper person requirement** There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for Directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements. The Company Secretary is responsible for administering the process on behalf of the Chief Executive of the Trust. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website. In February 2017, NHS England released new guidance on Managing Conflicts of Interest in the NHS including a model policy which took effect from 1 June 2017. The Standards of Business Conduct Policy (conflict of interest policy) for staff was updated to align with the model policy and approved by Trust Board in October 2017. A revised version of the Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality was last reviewed and approved in March 2018, with minor amendments to align it to the staff policy. **Risk appetite** The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Recommendation:	**Trust Board is asked to CONSIDER the attached summary, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020

Register of interests of the directors (Trust Board)
From 1 April 2020 to 31 March 2021

All members of Trust Board have signed a declaration against the fit and proper person requirement. All Non-Executive Directors have signed the declaration of independence as required by Monitor's Code of Governance, which requires the Trust to identify in its annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement.

The following declarations of interest have been made by the Trust Board:

Name	Declaration
Chair	
MONAGHAN, Angela Chair	Spouse – Strategic Director at Bradford Metropolitan District Council. Spouse – Non-Executive Director of the National Association for Neighbourhood Management. Spouse – Director of the Bradford Culture Company.
Non-Executive Directors	
CAMPBELL, Laurence Non-Executive Director	No interests declared.
DYSON, Charlotte Deputy Chair / Senior Independent Director	Independent Marketing Consultant, Beyondmc (including consultancy for Royal College of Surgeons of Edinburgh). Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional). Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Bradford Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee. Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE.
JONES, Chris Non-Executive Director	Director, Chris Jones Consultancy Ltd.
MAHMOOD, Erfana Non-Executive Director	No interests declared.
QUAIL, Kate Non-Executive Director	Owner / Director of The Lunniagh Partnership Ltd, Health and Care Consultancy, including carrying out Care and Treatment Reviews (CTRs) *(will not be carrying these out for any SWYPFT service users)*

Name	Declaration
YOUNG, Sam Non-Executive Director	Owner / Director, ISAY Consulting Limited. Interim Transformation Director, Irwell Valley Homes
Chief Executive	
WEBSTER, Rob Chief Executive	Chair, Stakeholder Advisory Board for Rapid Service Evaluation Team, Nuffield Trust Visiting Professor, Leeds Beckett University. Honorary Fellow, Queen's Nursing Institute. Honorary Fellow, Royal College of General Practitioners. Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System). Member of the NHS Assembly Member of the National People Board Son – Mencap Ambassador
Executive Directors	
BREEDON, Tim Director of Nursing and Quality / Deputy Chief Executive	Son – works in the Trust's Occupational Health Service as a Registered Nurse.
BROOKS, Mark Director of Finance and Resources	Trustee for Emmaus (Hull & East Riding) Homeless Charity
DAVIS, Alan Director Human Resources, Organisational Development and Estates	Spouse - Employed by Blackpool Teaching Hospitals NHS FT as the Managing Director for NHS North West Leadership Academy.
THIYAGESH, Dr Subha Medical Director	Spouse – Trustee, Hollybank Trust Hospital Consultant, CHFT
Other Directors (non-voting)	
HARRIS, Carol Director of Operations	Spouse – Engineering Company has contracts with NHS providers including Mid Yorkshire Hospitals NHS Trust.
RAYNER, Sean Director of Provider Development	No interests declared.
YASMEEN, Salma Director of Strategy	Board member, PRISM charity in Bradford.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 28 January 2020
Small conference room, Wellbeing & Learning Centre, Fieldhead, Wakefield

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Chris Jones (CJ)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Tim Breedon (TB)	Director of Nursing and Quality / Deputy Chief Executive
	Mark Brooks (MB)	Director of Finance and Resources
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Subha Thiyagesh (ST)	Medical Director
Apologies:	Members	
	Laurence Campbell (LC)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
In attendance:	Carol Harris (CH)	Director of Operations
	Sean Rayner (SR)	Director of Provider Development
	Aimee Willett	Corporate Governance Manager (author)
	Salma Yasmeen (SY)	Director of Strategy
Observers:	John Laville	Public elected governor – Kirklees
	Jeremy Smith	Public elected governor – Kirklees

TB/20/01 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies as above were noted. At the commencement of the meeting there were two members of the public present, which included two publicly-elected governors from the Members' Council. AM reminded the members of the public that there would be an opportunity at the end of the meeting for questions and comments from members of the public. Questions asked and responses would be included in the meeting minutes going forward, and a form was available for completion if members of the public preferred to raise their questions in that way and to enable a response to be provided outside of the meeting.

TB/20/02 Declarations of interest (agenda item 2)

The following declarations were considered by Trust Board for Laurence Campbell (LC), Non-Executive Director and Rob Webster (RW), Chief Executive:

Name	Declaration
Non-Executive Director	
CAMPBELL, Laurence	Term at Kirklees Citizens Advice and Law Centre ended 31 December 2019.
Chief Executive	
WEBSTER, Rob	Declared an interest in the item on the private session agenda relating to the dual role of the Chief Executive.

There were no other comments or remarks made on the Declarations, therefore, **it was RESOLVED to formally NOTE the Declarations of Interest made above**.

TB/20/03 Minutes of and matters arising 26 November 2019 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 26 November 2019 as a true and accurate record.

The following matters arising were discussed.

- TB/19/111a Integrated performance report month 7 2019/20 – detailed paper to the next Workforce and Remuneration Committee (WRC) – Alan Davis (AGD) agreed to do deep dive into turnover.
- TB/19/99a Integrated performance report – Tim Breedon (TB) complaints Q4 proposals regarding measuring success rate will be included in the report to April Board. Remove from action log.
- TB/19/99a Integrated performance report – supervision will be reviewed by committees. Papers to the Clinical Governance & Clinical Safety Committee (CGCS) in February, with an overview at WRC. Remove from action log.
- TB/19/99a Integrated performance report – Salma Yasmeen (SYa) updated that financial sustainability will be reflected in the next year's priorities from March 2020, with an overview at the Finance, Investment and Performance Committee (FIP). Remove from action log.
- TB/19/101b – review of charities section in in SFIs, included in Corporate Trustee papers. Remove from action log.
- TB/19/101b – breaches reportable to the Audit Committee – Mark Brooks (MB) outlined that a proposal was discussed by the Executive Management Team (EMT) and will be discussed at the Audit Committee (AC) in April. Remove from action log.
- TB/19/103 – MB advised that we are still awaiting the guidance, a verbal update is on the agenda in line with the work plan. Remove from action log.

TB/20/04 Service User Story (agenda item 4)

The Trust Board heard a service user story in relation to early intervention in psychosis. CH introduced the service user and their story, and outlined that the story shows how the Trust supports service users from recovery into employment.

The service user accessed the early intervention service in 2014 due to struggling with hearing a voice and suicidal thoughts. They also made multiple attempts on their life over the span of a couple of years. The service user shared that they had previously been admitted to inpatient wards and had been sectioned under the Mental Health Act. The crisis team had also been involved however it was felt that their situation had got to the point where nothing was moving forward and they felt that something had to change.

At this point, the service user became involved with psychology and open dialogue. They provided an explanation of open dialogue for those who were unaware of this therapy. The professionals speak to the voice and the voice hearer acts as interpreter. As a consequence of this therapy, it became apparent that the service user has heard a voice from the age of 14, and it was suggested that trauma at some point, possibly related to heart problems in 2014, that changed the voice to a nasty voice.

The service user explained that the voice sounds like their partner's voice as an influential person in their life, but that previously as a child, the voice has been someone else's.

Throughout the therapy, the service user's partner was involved which helped them to make peace with a lot of things from the past and led to recovery.

The service user shared that they stopped taking antipsychotics 2017 and antidepressants last year, which was more of a challenge. The service user expressed that it is possible to recover but only when you try to get past the trauma. The service user has written an article on their experience to share with the Board. SY queried if the service user had considered publishing the article and if there was anything the Trust could do to support this. The service user confirmed that they are considering this, however are unsure if they would like to publish it anonymously.

AM asked the Board if there were any further questions relating to this story.

RW asked if the service user is still involved with open dialogue. The service user advised that they are encouraging other people to get involved in open dialogue with those close to them as well as with the professionals, and that they provide honest reflections on their experience. Before the therapy, they didn't have a proper relationship with their partner and the therapy improved this, and brought back honesty and emotions back into their relationship.

The service user shared that they were able to get back into work at the end of 2017 as a peer mentor after attending college and completing a course. Also, since September 2019 they have been working as a support worker which has helped to boost confidence, and get something from working with and supporting others. CH commented that it is humbling thinking what the service user has come through and the success made on their journey, and well done on their success.

CD queried if there was anything from their journey that they would like to be different. The service user advised that they would have liked open dialogue to be offered straightaway. RW noted that there had been a review of open dialogue work that he had been involved with, which reinforced the support for carers and how this is reviewed and expanded.

It was RESOLVED to NOTE the Service User Story.

TB/20/05 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- There is a Members' Council meeting taking place this week.
- There will be issues discussed in the private session of the Trust Board. These are items that have met the test of being discussed in private before they come into the public agenda, typically for reasons of commercial confidentiality.
- Today the Board will discuss the following items in private:
  - Risks that are commercially confidential.
  - Those aspects of financial performance considered to be commercial in confidence.
  - Operational plan 2020/21.
  - Headlines from the staff survey that are embargoed until mid-February.
  - Consideration of the Chief Executive's dual role.
  - Board development plans.
  - Serious incidents under investigation.
  - Commercially confidential business developments in West Yorkshire and South Yorkshire including the Integrated Care Systems (ICSs).

Chief Executive's report

RW commented that "The Brief" communication to staff was included in the papers and provided an update on the local and national context as well as what was happening across the organisation. He highlighted the following:

- Planning guidance has been delayed by the general election. The next financial year will be year one of the 5 year plans developed by ICSs. National consolidation required for the guidance in relation to what commitments were made in manifesto and what needs to go into the guidance. The Secretary of State is continuing to promote four things – importance of prevention, the workforce, capital infrastructure and health tech.
- Exit from EU. A lot of planning was underway in preparation for no-deal, however transitional arrangements means safe transition on 31 January, and contingency planning is now stood down. We are keeping this in view as a risk. The Trust needs to consider consequences of trade deals in the future. We continue to receive advice on the impact of the EU exit.
- Good work continues to be done regarding equality, inclusion and diversity. West Yorkshire & Harrogate - ICS has made a commitment in the 5-year plan on diverse leadership. The BAME network was part of session to define what this means in practice, a paper will be discussed at a West Yorkshire & Harrogate ICS system leadership executive regarding details to deliver. Reciprocal mentoring has been launched in the Trust.

It was RESOLVED to NOTE the Chair's remarks and Chief Executive's report.

TB/20/06 Risk and assurance (agenda item 6)

TB/20/06a Board Assurance Framework (BAF) (agenda item 6.1)

MB introduced the updated Board Assurance Framework (BAF). MB reminded the Board that as part of the ongoing cyclical review a full review had taken place at the Executive Management Team (EMT) meeting and updates have been made accordingly.

MB noted where changes of scoring had been considered appropriate, and that some have a level of subjectivity based on information available. Over the course of the past year there has been increased contract alignment in terms of service provision which has helped matters. A number of actions have been completed to support changes in RAG rating. Risk score has deteriorated for strategic risk 2.3 to amber due to the level of increased demand and acuity of service users.

MB outlined that the Board need to consider how the BAF needs to change for next year. This will be discussed at the February strategy session, with full board engagement regarding any such changes for next year.

Action: Mark Brooks

Chris Jones (CJ) commented on the change of 2.3 to amber and queried if there is less confidence in controls, or if this is an emerging issue – he suggested it would be helpful to revisit controls to make the process more effective. TB advised of increased acuity, particularly in inpatient wards and workforce issues on some wards in terms of recruitment and retention. The amber rating represents reduced capacity to deliver, this is the most significant reason the change was made.

TB reported that staffing pressures are reported on regularly, progress has been made with out of area placements but this is not yet at the stage it can be considered as sustained. Significant pressures relating to staffing and changing population are particularly notable along with capacity to deliver in acute and forensic inpatient services. This links to workforce planning and the ability to deal with increased demand. CJ advised that 2.3 relates to 4.1

and felt that this was inconsistent and could also be considered as amber due to the level of staff vacancies. Charlotte Dyson (CD) agreed with this view.

AGD highlighted that in the integrated performance report safer staffing has always been good. The Trust has proactively increased staffing levels on acute and forensic areas. Associate roles have also been introduced. There is a national supply problem and work is ongoing to look at how we can increase supply. Consideration is being given to other markets, and if there are new roles that we can bring in to replace traditional roles. SY added that there is work ongoing in hotspot areas. Erfana Mahmood (EM) suggested that the "new world" impact has been delayed in comparison to acute trusts and that this is not going to be quick turnaround.

RW commented that "double jeopardy" should be avoided, where one adverse development causes several scores to change. He also suggested that the Board needs to look at the risk scores strategically. For example, on developing a great place to work, our staffing culture is good with support from Occupational Health and weekly meetings to make sure services are safe. It was noted that missing from report were gaps in control and new actions in place to address this risk, gaps in assurance and control need to be reviewed.

Action: Alan Davis / Tim Breedon

RW suggested that a strategic response to safety risks would include considering a change to smaller wards to help deal with acuity. CD queried how we are measuring acuity and what work is taking place to determine the benefits of moving to smaller ward sizes. TB outlined that staff are assessing needs of people on the wards on a regular basis. Some of this is evident at risk panels and levels of acuity, 1:1 staffing, safe care report will give more data to understand better.

RW outlined good conversations taking place regarding safer staffing, there is a clear view regarding mental health inpatient areas, however further work is needed to understand learning disability and community services. RW queried if we have a measure of acuity across all services? TB noted that we do in some places and by proxy in others, and noted that this could be improved.

AM suggested that the BAF does not reflect the Board agenda as well as it could and suggested we reflect priority programmes. This will be included as part of the review at the strategic Board. Comments from the internal audit will also be considered again following review at the October Trust Board.

AGD noted that the staffing risk is reviewed at the Workforce & Remuneration Committee (WRC). There is a global workforce risk. Committees will not routinely discuss the BAF however will discuss specific issues. TB added that the acute improvement plans need to be reflected in the BAF.

Subha Thiyagesh (ST) added for 4.1 further discussion is required to determine how further assurance can be provided. There are different workforce activities happening across different areas. RW added short term actions are happening now to boost support for staff and workforce, the workforce plan will be implemented over the next 12 months.

It was RESOLVED to NOTE the updated Board Assurance Framework and ongoing target, and to REVIEW the BAF and links to priority programmes in more detail in February strategic Board session.

TB/20/06b Corporate / organisational risk register (ORR) (agenda item 6.2)

MB introduced the organisational risk register by explaining that over the course of the last quarter the risk register has been reviewed at EMT and Board committees have reviewed risks allocated to them.

MB outlined a number of movements with risks and their scoring since the last report. In respect of the financial risk relating to national funding the current level of investment in mental health means the likelihood of financial challenge due to national funding arrangements has reduced. Similarly the fact that the Trust has a cash balance in excess of £30m means the likelihood of cash depletion in the short term is much reduced. MB also noted that over the past twelve months there has been a significant reduction in NHS services we provide going out to tender. Finally he noted that out of area bed placements (OOA) bed have significantly improved year on year.

Risk ID 1216 has now been merged with 852 – agreed to close.

The Board discussed the Committees in Common and links with the ORR. It was agreed that this will be considered further once the Committees in Common risk management framework had evolved.

Risk ID 1362 relating to a no deal Brexit – agreed to close, however noted that this risk needs to be reflected in BAF.

A number of risks have now been aligned to the Finance Investment & Performance (FIP) committee and will be discussed at the next FIP meeting and presented in the Q4 report to board.

Risk ID 1157 discussed at the Equality & Inclusion Committee (EIC) previously aligned to both EIC and WRC, however discussed at the last EIC and agreed to be aligned to this committee only. This will be reflected in future reports.

RW raised the cyber security risk and it was noted that this is still 'red'. MB suggested that this will always be a high level risk due to the constant threat of cyber security and the increasing sophistication of cyber-crime, however it was noted that a lot of work has been carried out on the IT infrastructure and the rolling out windows 10 is underway. A detailed report on this is presented to the Audit Committee (AC) twice per year, next report due in April. The Audit Committee will feedback to the Trust Board on the contents of this report.

Action: Mark Brooks

Risk ID 522 - the change in risk score was noted and this risk is now within the risk appetite, this will be reflected in a different way next report.

The Board discussed the downward trend in risk over the past year and if this felt right. MB advised that this does feel right for the areas of risk that have reduced. The Trust financial position has improved and finance has been a big driver of the risk register. In addition the level of tendering of services has reduced and there has been good improvement in the use of out of area bed placements. RW noted that the improved CQC rating has also had an impact, the mental health alliance is stronger, and Integrated Care System (ISC) plans are established.

It was RESOLVED to NOTE the updated Organisational Risk Register, supporting current risk levels, and AGREE to the recommendations on risk closure.

TB/20/07 Business developments (agenda item 7)

TB/20/07a Planning guidance (agenda item 7.1)

MB noted that there were some changes since the report was written in relation to the development of the operating plan and planning guidance. MB outlined that the detailed guidance was not expected to change the fundamental assumptions used in the generation of the 5 year plan significantly. The Trust continues developing the plan based on these assumptions. MB noted that the first submission is now expected to be 28 February, and that the plan will be discussed at the FIP Committee and strategic board before this date. It was noted that the capital regime is unlikely to be available until the end of Q1. MB noted that the final submission of the Trust's plan is likely to be in April.

It was RESOLVED to NOTE the report and that the plan will be discussed in detail at the February strategic board and FIP committee.

TB/20/07b South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 7.2)

SYa noted that there has been significant work over the past few months with partners to develop, mobilise and implement the integrated care specification for community services in Barnsley. Discussions are ongoing through the programme board regarding the final model and what this will look like. As this will be a priority programme, it will be monitored and reported on in the integrated performance report (IPR). It was noted that this will also need to be reflected in the Board work programme.

Action: Salma Yasmeen

MB noted that the FIP committee will consider parameters for appropriate resource to meet a new service specification and that time will be factored in at Board to discuss this, governance and strategy as options become clearer.

CD noted that there are a lot of programmes happening that depend on partners. How will we know if another part of the partnership is not delivering and how do we have oversight of this. SYa noted that this is part of the role of the integrated care delivery group, of which the Trust is a member, which reviews programmes, deliverables and risks, and decides if anything needs to be escalated. A shared dashboard is also being considered. TB noted that a priority programmes summary is presented to the CGCS committee and considered if this could be included.

AM noted some developments in the SYB system, and asked if the Board is clear on the strategic aims, what are the co-dependencies and how we are assured. The Board discussed if the Trust is involved in the right way and it was suggested that this could link into the Trust's annual review of governance.

KQ queried if there will be a shared equivalent of the BAF for the ICS work. RW noted that in West Yorkshire and Harrogate, each programme has a risk register and each place through joint arrangement has risk arrangements in place.

RW noted that A&E performance in Barnsley tended to be amongst the best in the country, but has been under a lot of pressure recently. Mental health services that support A&E and community services are also under pressure, and numbers of delayed transfers of care has also slipped.

AM queried what is the impact and timescale of individual placement work, and how will it help to deliver our objectives in Barnsley. SYa noted that there is high level support for service users into employment and an individualised programme. CH was unsure how it will improve our overall performance, but it will improve experience for SUs.

It was RESOLVED to NOTE the updates on South Yorkshire and the South Yorkshire & Bassetlaw Integrated Care System and to consider the governance and assurance arrangements as part of the Trust's annual governance review.

TB/20/07c West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 7.3)

SYa noted that a light touch review of the Memorandum of Understanding (MOU) has been completed with the recommendation to Board to support the changes. SR noted that since the report was written, Leeds Community Health NHS Trust will write to NHS England regarding the tier 4 Child and Adolescent Mental Health Services (CAMHS) business case asking for it to be put back by six months to April 2021. AM noted that this was supported by the Committees in Common.

RW noted that some organisations will need to be involved in more than one place based planning system.

AM added that the schematic of governance needs to be consistent and include learning disability and autism, which has not been updated. SYa to feedback.

Action: Salma Yasmeen

It was RESOLVED to NOTE the updates on West Yorkshire and the West Yorkshire & Harrogate Health & Care Partnership and to APPROVE amends to the Memorandum of Understanding.

TB/20/07d Receipt of Partnership Board minutes (agenda item 7.4)

It was RESOLVED to NOTE the minutes from partnership boards.

TB/20/08 Performance reports (agenda item 8)

TB/20/08a Integrated performance report (IPR) month 9 2019/20 (agenda item 8.1)

TB opened this item by noting:

- Under 18 admissions – 1 admission in December, He stressed this was the least worst option.
- Out of area position continues to be challenging –progress has been made but significant pressures remain in the system. CH noted that this is as expected, system is delicate.
- Safer staffing – the report has been updated to reflect updated and agreed safer staffing. Report to Clinical Governance & Clinical Safety Committee showing 106-7% fill rate, need to look at and take back to CGCS to understand difference.
- E-appraisal will help to record appraisal completion rated. Issues regarding recording continue to be explored / monitored. CH noted that recording of supervision needs to take place especially during periods of high acuity. Looking at opportune and group supervision options.
- Medicine omissions – targeted approach with some areas doing well, some data issues also being investigated. ST continues further discussions with matrons.
- Complaints position, positive to see turnaround relating to planned completion times. Looking at how record and report against complaints. Complexity and level of input required to achieve outcome needs to be taken into consideration.
- Increase in falls in December – need to look at quarterly data, positive work ongoing in relation to restraint.
- Metrics holding up well, can't underestimate impact of demand on acuity. Early warning signs through risk panel and EMT.

AM noted staff turnover – threshold red, should still be red as at 12%. MB confirmed this was an error in the report. To be amended.

Action: Mark Brooks

EM noted that there will be a deep dive into supervision, and the recording of this, in Q4 that will report to CGCS committee. CD noted that it is not just about recording of, but about the quality. TB advised there is a new way of reporting that will allow us to audit in a different way, see that risks were being logged and comments made but not always made in the right way. Need to separate issue with risk assessments training and supporting to understand benefits and SystmOne tool issue.

EM noted that falls have increased – Kirklees and Wakefield quarter on quarter reduction but has increased in month. CH advised that after looking at the data, this relates to particular individuals and matrons have checked care plans to ensure they are followed.

Section 17 leave – AM noted the deterioration in recording of section 17 leave on the form. CH advised that forensics are auditing the highlighted concern of completion of this section on the system. Auditing forms need to be completed weekly with support from Mental Health Act team. There is more work to do but it is felt the position is improving. CD outlined a discussion regarding expectations of section 17 leave that took place at CGCS committee and how to balance resource and service users' needs. Some service users have expressed concerns about taking leave, because, if beds are needed, they may be used by another service user whilst they are on leave. The impact that this has on service user experience was noted and CH advised that risk assessments are completed on an individual basis. Staff discuss any concerns that service users may have about taking leave with them at the time and provide reassurance. RW noted that the form that is not always being completed on the system is the one that relates to staff having these conversations with service users and expressed the importance of ensuring this is completed in all cases.

National metrics – MB outlined that despite all the pressures in the system the Trust is achieving the vast majority of targets against nationally set metrics. The good work taking place to achieve this was noted.

Locality – CH noted the following:

- General community services – the development of integrated neighbourhood teams is continuing at pace. Staffing challenges are not just in health services.
- Single Point of Access for Barnsley has been confirmed and will be housed at Kendray from April onwards.
- Barnsley mental health action plans and improvement, starting mobilisation for all-age liaison psychiatry post – recruitment underway.
- Calderdale & Kirklees developing towards provision of all-age liaison service.
- Personality disorder pathway alternative to inpatient treatment.
- Support from commissioners to strengthen offer.
- Forensics & LD – forensics serious incident over Christmas involving member of staff, investigation underway and review of security. Workforce measures put in place, 30 day plan being worked on and reviewed weekly. Reviewed in detail at CGCS committee.
- Forensic CAMHS performance notice: awaiting written confirmation from Leeds Community services that this is being removed following their expected letter from NHSE.
- Wakefield – inpatient facing challenges in relation to delivering Electroconvulsive Therapy (ECT) due to a shortage of staff with the right skills. Mitigating actions in place to travel to other areas and at times need has not been met.

CJ queried the impact of availability of Local Authority social workers in mental health services. CH advised that at meetings with the Local Authorities it was noted that this does impact on such matters as discharge as social workers are not available. In Calderdale, they are looking at different ways of attracting staff. CH noted that the Trust employs social workers into mental health practitioner posts to target specific service user needs.

Priority programmes – SY noted the following:

- FIRM, the new clinical risk assessment tool in SystmOne, will 'go live' in Q1 2020/21. Improvement groups in place to demo. Lots of work ongoing in the background to support data quality issues.
- CAMHS workstream is now 'green' as the trajectory has improved, there is a clear plan in Barnsley and Wakefield and robust processes are in place.

Finance / contract – MB noted the following:

- Month 9 was strong with a surplus recorded, however he noted there could be some change in January due to expenditure on laptops required for the roll out of Windows 10.

CJ acknowledged that it has taken a lot of work to get to this position.

CD queried if the agency spend would impact on the Trust's rating. CJ advised that a self-assessment tool will be completed at the next FIP meeting which is unlikely to trigger any further financial concern. MB added that there has been a reduction in the number of agency medics but that this has been offset by nursing increases. Typical monthly agency cost is circa £600k, some of which relates to the short term nature of work such as waiting list initiatives. If the Trust exceeds its cap by more than 50% its risk rating will reduce. Based on current spend and projections whilst spend is well above the cap it is unlikely to exceed by 50%. The positive work on recruitment of substantive medics was noted.

RW noted the statistical process control (SPC) chart on agency spend. March data was on point, and this has reduced over the past couple of months. It was felt that there should be some confidence regarding not going over the cap, and that the Board needs to consider the approach to take for next year.

Workforce – AGD noted the following:

- Next WRC will discuss workforce issues in forensic services.
- Appraisal completion – slightly below target – e-appraisal has a potential downside of becoming a once per year tick box exercise. Discussions needed regarding links between supervision and appraisal.
- Turnover – agreed the WRC will focus on this, and complete a comparison against other areas.
- Fire training – green across board, inpatient areas set higher target as this is the area with the highest level of risk.

RW noted the SPC charts for turnover and sickness absence, and that this is not getting worse but we need to think about how to improve, linked to the deep dive at WRC.

It was RESOLVED to NOTE the Integrated Performance Report.

TB/20/09 Strategies and policies (agenda item 9)

TB/20/09a Estates strategy progress update (agenda item 9.1)

AGD outlined to the Board that the Health and Safety Executive (HSE) are visiting the Trust over the next two weeks. No notifications or concerns have been raised thus far.

CD suggested that discussions regarding inpatients and bed base are the right ones to have. AGD noted that following an evaluation of the estates strategy, the Trust has done what was previously agreed, however it was noted to review if it worked out and achieved the goal. What is the learning and how do we feed back into the strategy.

Action: Alan Davis

RW noted the clear link to the sustainability strategy and that further discussion is required around the green agenda and estates strategy. AGD noted that the previous strategy was developed when there was significantly more money to invest. RW expressed the importance of safety for staff and service users in all environments and the green agenda being more prominent. MB added that the strategy needs to be clear regarding capital to ensure it is accessible. This may be clearer once the new capital regime is announced.

Timetable: AGD stated that the strategy should be ready for Q1. Conversations required regarding how to review the strategy going forward. It was noted that further detail and engagement is required from Board before it is submitted for approval. The strategy will be discussed in March by EMT, and a draft brought back to the Board in April with a commitment to sign off the final version in September.

Action: Alan Davis

It was RESOLVED to NOTE the update and AGREE to a review of the timetable.

TB/20/10 Governance matters (agenda item 10)

TB/20/10a Assessment against NHS Constitution (agenda item 10.1)

MB noted that the Trust is no longer required to submit this paper to regulators, however it is a good exercise to remind Board members of the requirements of the constitution and how the Trust is assured it is meeting them.

It was RESOLVED to APPROVE the paper and to NOTE that this submission is no longer a requirement.

TB/20/10b Review of the Trust Constitution (agenda item 10.2)

AM provided a verbal update on the Constitution review. A session with governors took place in December and the Board discussed changes and updates at the December strategic session. Suggested amendments and areas for further investigation will be discussed at the forthcoming Members' Council meeting.

It was RESOLVED to NOTE the update.

TB/20/10c Assurance from Nominations Committee 9 January 2020

It was RESOLVED to RECEIVE the assurance from the Nominations Committee.

TB/20/11 Assurance and receipt of minutes from Trust Board Committees (agenda item 11)

Audit Committee – CJ provided an overview. Good update on SystmOne with a useful format of data. Phishing test carried out, 'scam' emails sent to staff to see how people

respond, some did respond to the IT helpdesk within a matter of minutes which gave confidence in the system.

Equality & Inclusion Committee – AM noted that the September meeting minutes were approved and are now available. To be circulated / added to board papers.

Action: Aimee Willett

AM provided an overview from the December meeting. Updates received on Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) updates, Equality Impact Assessments (EIAs) and Equality Delivery System (EDS2) performance. Refined performance dashboard now available but acknowledged that there is still further work to do. Feedback received from BAME and LGBT+ staff networks and representatives now attend routinely. Equality strategy and Communication, Engagement and Involvement strategy are being developed and will be discussed at Members' Council. Noted that the pay-gap audit interim report has cross-committee interest with WRC.

Finance, Investment & Performance Committee – CJ provided an overview. Mental health benchmarking report was useful with indicators coming back to FIP later in the year. At the January meeting, the first area of performance the committee focused on was waiting times for learning disability services and received assurance that performance is now on track. Data quality and availability of staff will continue to be monitored through the IPR at Board. Contract negotiation parameters for 2020/21 agreed. RW noted that the majority of CQUINs were delivered and acknowledged the work that has gone into this. MB added that the team are working on benchmarking and increasingly populating one of the tools on intranet, SWIFT, which looks at benchmarking data for different services. All Board members can use this tool to look at available data. MB to circulate information on how to access SWIFT.

Action: Mark Brooks

West Yorkshire Mental Health, Learning Disability & Autism Collaborative Committees in Common – the Board noted the summary from the latest committee meeting. RW outlined risks in new care models will be discussed and agreed at the committee and the Board will receive assurance from this. Annual review process, similar to that used for the Trust board committees, to be adopted. It was noted that the chair of the meeting will change from AM to Cathy Elliott, Chair of Bradford District Care Trust, later this year.

It was RESOLVED to NOTE the assurance from committees and RECEIVE the minutes.

TB/20/12 Trust Board work programme (agenda item 12)

The Board noted the changes to the work programme and that the 2020/21 programme will be discussed at the February strategic board session, with agenda items linked to priorities.

Trust Board RESOLVED to NOTE the changes to the work programme.

TB/20/13 Date of next meeting (agenda item 13)

The next Trust Board meeting held in public will be held on Tuesday 31 March 2020, Room 5/6, Laura Mitchell Health and Wellbeing Centre, Great Albion St, Halifax HX1 1YR.

TB/20/14 Questions from the public (agenda item 14)

TB/20/14a – *workforce retention – how well do we do with completion of exit interviews and how do we collate information, pick up trends and put in action plans?*

AGD noted that return rates are not high for exit interviews and that this is voluntary but the process is being reviewed. When staff leave the organisation they are sent a questionnaire. Data from those returns is collated and discussed at WRC. CH added that if someone is thinking of leaving, this is discussed at appraisal and managers have a conversation regarding why someone wants to leave.

TB/20/14b – *it has been raised following some PLACE inspection visits that some wards do not have ensuite facilities.*

AGD noted that the Trust has an ambition to develop all wards to be ensuite, however this is not possible in all buildings and capital would be required for further development.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 28 JANUARY 2020 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 28 January 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/06a	MB outlined that the Board need to consider how the BAF needs to change for next year. This will be discussed at the February strategy session, with full board engagement regarding any such changes for next year.	MB	February 2020	Discussed at the February strategic board.
TB/20/06a	(BAF, 2.3 and 4.1) It was noted that missing from report were gaps in control and new actions in place to address this risk, gaps in assurance and control need to be reviewed.	AGD / TB	April 2020	To be updated as part of the quarterly review process.
TB/20/06b	A detailed report on this [cyber-crime] is presented to the Audit Committee (AC) twice per year, next report due in April. The Audit Committee will feedback to the Trust Board on the contents of this report.	MB	April 2020	
TB/20/07b	SYa noted that there has been significant work over the past few months with partners to develop, mobilise and implement the integrated care specification for community services in Barnsley. Discussions are ongoing through the programme board regarding the final model and what this will look like. As this will be a priority programme, it will be monitored and reported on in the integrated performance report (IPR). It was noted that this will also need to be reflected in the	SYa	April 2020	

Min reference	Action	Lead	Timescale	Progress
	Board work programme.			
TB/20/07c	WYHHCP MOU schematic of governance needs to be consistent and include learning disability and autism. SYa to feedback.	SYa	January 2020	
TB/20/08a	AM noted staff turnover – threshold red, should still be red as at 12%. MB confirmed this was an error in the report. To be amended.	MB	January 2020	
TB/20/09a	AGD noted that following an evaluation of the estates strategy, the Trust has done what was previously agreed, however it was noted to review if it worked out and achieved the goal. What is the learning and how do we feed back into the strategy.	AGD	September 2020	
TB/20/09a	Timetable: AGD stated that the strategy should be ready for Q1. Conversations required regarding how to review the strategy going forward. It was noted that further detail and engagement is required from Board before it is submitted for approval. The strategy will be discussed in March by EMT, and a draft brought back to the Board in April with a commitment to sign off the final version in September.	AGD	September 2020	
TB/20/11	Equality & Inclusion Committee – AM noted that the September meeting minutes were approved and are now available. To be circulated/added to board papers.	AW	January 2020	Added to the Board papers.
TB/20/11	MB to circulate information on how to access SWIFT.	MB	January 2020	

Actions from 26 November 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/111a	RW queried if turnover had changed through the year. AGD to review outside of Board and	AGD	November 2019	Detailed paper to the next Workforce and Remuneration Committee (WRC) –

Min reference	Action	Lead	Timescale	Progress
	confirm.			Alan Davis (AGD) agreed to do deep dive what actual turnover is.
TB/19/111c	RW noted that the report considers safer staffing on inpatient wards but does not cover community services… RW queried how to get to a point where we report safer staffing for the organisation. TB advised that there is a pilot project with community teams, but it is too early to make recommendations. Timescales for introduction will be reported into the next CG&CS committee.	TB	February 2020	
TB/19/1114a	SYa updated on the process for the strategy refresh which will also include a strong focus on inclusion and stronger relationship with equality. The team formed in mid-October and has commenced on the work. SYa proposed to bring back the strategy for approval in March 2020.	SY	March 2020	

Actions from 29 October 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/97a	CD also noted that bullying has been picked up as a theme to tackle and that this is not really represented in the report. MB noted this issue should also be assessed for the Board Assurance Framework (BAF) and risk register.	AD	April 2020	This will be considered in the next versions of the Board Assurance Framework and risk register the Board receives.
TB/19/97c	Reflecting on the discussions relating to the Board Assurance Framework and Operational Risk Register RW suggested there could be another strategic risk for consideration in relation to external threats where people are aiming to do harm. Examples being cyber and the agenda around Prevent. This will be reviewed during the next update of the BAF for 2020/21.	MB	April 2020	This will be considered in readiness for the next versions of the Board Assurance Framework and risk register the Board receives.
TB/19/99a	EM stated that she had spent some time with the complaints team and recognised how complex some are to complete and bring to a conclusion. She	TB	January 2020	Target under review – Proposal to EMT in Q4

Min reference	Action	Lead	Timescale	Progress
	wondered if the target completion date was always achievable and whether we should again review.			
TB/19/99a	In relation to supervision AM asked if any of the committees should focus on this issue? TB stated it has been reviewed at CGCS in the past, but not recently. It was agreed both the CGCS and Workforce & Remuneration Committee (WRC) have a role to play	CD / SY	December 2019	Papers to the Clinical Governance & Clinical Safety Committee (CGCS) in February, with an overview at WRC. Remove from action log.
TB/19/99a	CJ asked where the financial sustainability work fits within the priority programmes. SYa explained that thought is currently being given to how this is reflected.	SYa	January 2020	Salma Yasmeen (SYa) updated that financial sustainability will be reflected in the next year's priorities from March 2020, with an overview at the Finance, Investment and Performance Committee (FIP). Remove from action log.
TB/19/101b	AM asked for the charities section of the SFIs to be reviewed at the Charitable Funds Committee. It was noted that if further changes are needed following this, they will be brought back to a future board meeting.	SYa	January 2020	Included in January Corporate Trustee papers. Remove from action log.
TB/19/101b	LC also highlighted that at the Audit Committee one of the considerations was which breaches are reportable to the Committee. It was felt that this is the included in the remit of the Director of Finance. RW suggested some principles are identified and agreed.	MB	January 2020	Mark Brooks (MB) outlined that a proposal was discussed by the Executive Management Team (EMT) and will be discussed at the Audit Committee (AC) in April. Remove from action log.
TB/19/103	RW asked if the timings for the operating plan reports were correct. MB stated they are indicative based on past experience. Once national guidance is received the work programme for this year will be updated if required	EJ	January 2020	MB advised that we are still awaiting the guidance, a verbal update is on the agenda in line with the work plan. Remove from action log.
Actions from 24 September 2019				
TB/19/83a Integrated performance report Month 5 2019/20	SYo asked when reporting would commence for psychology waiting times. MB commented that there had been some long term sickness absence issues	EMT	April 2020	Initial reporting on Mental Health Act indicators commenced in the September report. Given the impact of long-term

Min reference	Action	Lead	Timescale	Progress
	within the performance team which may delay the reporting until Quarter 4. LC asked if the data in relation to Mental Health Act areas would also be delayed. SThi commented that this was planned to commence in October/November. SYo asked, with regard to indicators where data was not yet available, if there was any other information that could be provided for assurance. CH commented that currently the waiting times were recorded manually and used for the report into the Clinical Governance & Clinical Safety Committee. RW suggested that a recommendation be provided on when reporting would commence and any other data that could provide assurance.			sickness and additional sizeable priorities that have emerged in the year it is unlikely that much development work can take place meaning it is unlikely any new indicators will be reported on this year
	AM asked when reporting would commence on the number of records with an up to date risk assessment. TB commented that this is expected to commence in Quarter 3. MB commented that it appears there has been an increase in data quality issues since the introduction of SystmOne as staff are recording information in different ways and it was taking time to ensure the reporting is accurate. Performance and finance reviews took place with each BDU on 23 September 2019. It is important to ensure that the core data is accurate on the indicators the Trust has to provide to commissioners to then be able to take forward into other areas. CH commented that work is ongoing in terms of monitoring risk assessments and starting to build the reports. RW requested that SY raise this with the clinical records system programme board.	SY	April 2020	
TB/19/83b Serious incident report Quarter 1 2019/20	SYo commented that some incidents suggest that they are still linked to the Trust's smoking policy. TB commented that these may be to do with the introduction of vaping and how that was impacting some areas. CH added that vaping had been introduced in inpatient areas in single bedrooms or some areas of the courtyard, however this had not	CH/SThi	March 2020	Update to CG&CS February 2020 and Board March 2020.

Min reference	Action	Lead	Timescale	Progress
	solved all problems. In the last couple of Mental Health Act Care Quality Commission (CQC) inspections it had not been raised as an issue, whereas it had previously. A review of the implementation of the change to the policy was due to take place and would be reported back.			

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Trust Board 31 March 2020
Confidential agenda item 4

Title:	**Chair's report**
Paper prepared by:	Chair
Purpose:	To provide an overview of the Board meeting structure and key items for discussion.
Mission / values / objectives:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers / previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting.
Executive summary:	The Trust has made changes to normal Board arrangements for this meeting in response to the national restrictions relating to Covid-19 and to ensure our resources are focussed on addressing the major incident that has been declared. Consequently, the Board meeting is taking place by teleconference in private, and some regular agenda items are being revised, deferred or stopped in line with national guidance and / or decisions taken through our emergency response and resilience (EPRR) control structures. In making these changes we have sought to balance the need for speed and management focus, to address the Covid-19 emergency, with safeguards to ensure proper oversight and accountability. The items under discussion on the private board agenda today are: ➢ Chair and Chief Executive remarks ➢ Interim governance arrangements ➢ Arrangements in place for the management of Covid-19 ➢ Integrated performance monthly report ➢ Serious incidents quarterly report ➢ Business developments across the South Yorkshire & Bassetlaw Integrated Care System and the West Yorkshire & Harrogate Health & Care Partnership ➢ Receipt of Partnership Board minutes ➢ Trust Constitution review update ➢ Involving People strategy update ➢ Eliminating mixed sex accommodation (EMSA) declaration ➢ Data security and protection toolkit ➢ Approval of the following policies: - Policy for the development, approval and dissemination of policy and procedural document (Policy on Policies) - Standards or business conduct

	➢ Assurance from committees ➢ Use of the Trust Seal ➢ Trust Board work programme Some of these items, whilst not being essential for the response to Covid-19, are being taken because they were already prepared prior to a major incident being declared. This will help reduce the burden of deferred activity when we return to normal business. It is anticipated that they will be received by the Board with minimal discussion to shorten the meeting. Whilst we are not able to hold a meeting in public at this time, it is our intention to enable video conferencing for future meetings, if possible. We will produce a public minute of the full meeting as soon as possible after the meeting, along with any papers that can be shared in public.
Recommendation:	**Trust Board is asked to NOTE the Chair's report.**
Private session:	N/A.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020
Confidential agenda item 5

Title:	**Interim governance arrangements**
Paper prepared by:	Corporate Governance Manager
Purpose:	The purpose of this paper is to agree the interim governance arrangements and principles of the Board during the Covid-19 pandemic.
Mission / values:	To ensure that the Trust meets its governance requirements, and to allow the Trust to fulfil with mission and values during the pandemic.
Any background papers / previously considered by:	Local and national guidance relating to Covid-19. Regular internal updates.
Executive summary:	In line with national guidance, the Trust needs to adopt interim arrangements to allow business to continue during and after the Covid-19 pandemic. To protect members of the public and staff, in line with point 4.17 of the Standing Orders of the Trust Board the Chair has agreed to exclude members of the public and the press from this Board meeting for special reasons pertaining to health and safety following guidance in relation to social distancing. It is noted that the Trust does not currently have the technology to support members of the public and the press from joining a public Board meeting remotely; however options for this will be explored for future meetings. **Key principles for the Board** For the next 3-6 months, the focus of all Trust activity and governance will be on dealing with Covid-19. This means that immediate steps will be taken to minimise the burden of bureaucracy and ensure proportionate governance. During this period, Board and board committee business should be confined to: ➢ Delivery of the national Covid-19 plan, as outlined by NHS England and NHS Improvement in their joint letter of 17 March 2020 and any subsequent guidance. ➢ Business continuity. ➢ Any other business the Trust believes to be essential. It is proposed that all Board meetings will take place virtually whilst social distancing guidance remains in force, under the current terms of reference and quorum. Appropriate technology will be provided to enable this to happen. Any changes to this, or requirement to suspend

	the Standing Orders of the Board, will be agreed in line with the Trust Constitution, as outlined in point 6.2 of the Standing Orders of the Trust Board: *"**Emergency Powers and urgent decisions*** *The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 3.14) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification."* It is noted that, during this period, papers for the Board meetings will be reduced in number and length, may not always be available in line with the time standards in the Constitution, and that verbal updates may often be required to supplement papers due to the rapidly changing nature of the Covid-19 pandemic. An agenda for Board meetings will continue to be published to the agreed timescales. The current work plan (2019/20 and 2020/21) will be suspended for the next 6 months. **Areas of focus for Committees of the Board** ➢ Staff wellbeing and staffing changes. ➢ Delivery of clinical services. ➢ Reporting and management. The chair and lead director for each committee has discussed the priority items within the committee work plans, based on the principles set out above, and has agreed how the often the committees will meet and the functionality of committees over the next three to six months. The Board is asked to approve any recommended changes to the terms of reference resulting from the revised work plans for each committee, which will be outlined verbally at the Board.
Recommendation:	**Trust Board is asked to AGREE the interim governance arrangements and Board principles as outlined above.**
Private session:	Not applicable.

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Trust Board 31 March 2020
Confidential agenda item 6.2

Title:	**Integrated Performance Report**
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for February 2020.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	➢ IPR is reviewed at Trust Board each month ➢ IPR is reviewed regularly at the Finance Investment & Performance Committee (FIP) ➢ IPR is reviewed at Executive Management Team (EMT) meeting on a monthly basis
Executive summary:	The IPR for February has been prepared in line with how it has been prepared historically with all information that is available provided. For future meetings whilst the Covid-19 pandemic is being managed It is proposed that performance reports for the next few months will focus on: ➢ Covid-19 ➢ Other areas of performance we need to keep in focus and under control ➢ Locality reports will focus on business continuity ➢ Priority programmes report will focus on those programmes supporting the work on Covid-19 **Quality** ➢ No admissions of children to MH acute wards is positive ➢ Incident reporting within normal range – increases in moderate / severe harm to be reviewed ➢ Positive result for complaints reporting ➢ Increase in meds omissions subject to review **NHSI Indicators** ➢ No young people were admitted to an adult ward in February. The first month this has been achieved since September 2019 ➢ Inappropriate out of area bed usage increased to 170 days in February and the forecast for the year has moved to amber ➢ All other nationally reported targets are currently being achieved **Locality** ➢ Teams are operating business continuity plans in light of the Covid-19 pandemic ➢ Areas for smoking within ward courtyards have been agreed as a temporary measure to support safe management of wards

- The comms team is focussed on managing the comms message associated with the Covid-19 pandemic

Priority Programmes

- Priorities recommended by the mental health alliance in Wakefield for 2020/21 have been agreed cy the CCG
- Work continues on the development of integrated neighbourhood care in Barnsley as well as the implementation of early supported discharge within stroke services
- Current focus on extended hours patient flow to support out of area bed reduction
- All priority programmes being assessed to determine what work needs to take place on them in the coming weeks and months such that focus is placed on managing core service provision
-

Finance

- Pre Provider Sustainability Funding (PSF) deficit in month 11 of £49k. Cumulative position is a surplus of £0.1m which is £0.6m favourable to plan.
- Cumulative income is £0.6m lower than plan due to the agreement to return £0.5m funding for forensic outreach liaison services to commissioners and the recognition of a number of risks relating to CQUIN coupled with requirements for spending on waiting list initiatives and areas of new investment. These have been partly offset by income from Calderdale CCG in recognition of out of area bed and safer staffing cost pressures.
- Out of area bed costs were £230k in month, which represents the highest monthly costs since April 2019 and the fifth consecutive month there has been an increase in these costs. Cumulatively these costs now total £1,565k which is 56% lower than the spend incurred over the same period last year.
- Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend of £6.8m is already £1.5m above the full year cap of £5.3m, 40% above the year-to-date cap and 17% higher than the same period last year. Approximately £0.6m of the costs incurred relate to waiting list and other non-recurrent initiatives
- Net savings on pay amounted to £0.5m in-month and £6.0m year-to-date.
- CIP delivery of £8.5m is £1.1m lower than plan. Total non-recurrent CIP for the year is projected to be £5.1m (48%).
- Cash balance of £37.9m at the end of February
- Capital expenditure of £3.2m is £2.0m lower than plan, partly as a result of delays whilst the final capital plan was agreed. There is confidence the full year plan of £6.0m will be achieved.
- The financial risk rating remains at 2
- The full year forecast has improved from a deficit of £0.2m to a

	surplus of £0.1m **Workforce** ➢ All mandatory raining targets achieved at the end of February including information governance ➢ Sickness absence improved to 4.6% in February, from 5.0% in January and compares to 5.2% last year ➢ Staff turnover reduced from 12.1% to 11.3% month on month ➢ There will clearly be a significant impact from the Covid outbreak on our workforce metrics in the coming months
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

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Integrated Performance Report
Strategic Overview

February 2020

With **all of us** in mind.

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Table of Contents

Introduction

Please find the Trust's Integrated Performance Report (IPR) for February 2020. An owner is identified for each key metric and the report aligns metrics with Trust objectives and CQC domains. This ensures there is appropriate accountability for the delivery of all our performance metrics and helps identify how achievement of our objectives is being measured. This single report plots a clear line between our objectives, priorities and activities. The intention is to provide a report that showcases the breadth of the organisation and its achievements, meets the requirements of our regulators and provides an early indication of any potential hotspots and how these can be mitigated. An executive summary of performance against key measures is included in the report which identifies how well the Trust is performing in achieving its objectives. During April 19, the Trust undertook work to review and refresh the summary dashboard for 2019/20 to ensure it remains fit for purpose and aligns to the Trust's updated objectives for 2019/20.

Given the outbreak of Covid 19 this month's IPR includes information that is readily avalable such that staff can focus on essential service provision. A separate section of the Quality report has been added to cover Covid reporting. This is likely to become clearer and expand in the coming days and weeks. It is expected there will be further development of the oversight framework for 2020/21 onwards to include measures identified in the long term plan. It is proposed that performance reports for the next few months will focus on:

- Covid
- Other areas of performance we need to keep in focus and under control
- Locality reports will focus on business continuity
- Priority programmes report will focus on those programmes supporting the work on Covid

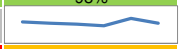
The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions and will contribute towards streamlining the number of different reports that the board receives.

The Trust's four strategic objectives are:
- Improving health
- Improving care
- Improving resources
- Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
- Strategic summary
- Quality
- National metrics (NHS Improvement, Mental Health Five Year Forward View, NHS Standard Contract National Quality Standards)
- Locality
- Priority programmes
- Finance
- Contracts
- Workforce

Performance reports are available as electronic documents on the Trust's intranet and allow the reader to look at performance from different perspectives and at different levels within the organisation. Our integrated performance strategic overview report is publicly available on the internet.

This dashboard is a summary of key metrics identified and agreed by the Trust Board to measure performance against Trust objectives. They are deliberately focussed on those metrics viewed as key priorities and have been reviewed and refreshed for 2019/20. Some metrics require development and it is anticipated that these will be ready over the course of the year.

KPI	Target	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Year End Forecast
Single Oversight Framework metric	2	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green
Improve people's health and reduce inequalities	**Target**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Year End Forecast**
% service users followed up within 7 days of discharge	95%	100/102 =98.0%	114/115 =99.0%	111/116 =95.6%	94/96 =97.92	89/87 =95.4%	81/85 =95.2%	1
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]	90%	88.0%	*93.0%*			Due Apr 20		1
Out of area beds [2]	19/20 - Q1 576, Q2 494, Q3 411, Q4 329	21	4	55	49	139	170	3
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA	Community 75% Inpatient 90%	86.2%	88.0%	88.4%	87.7%	87.7%	87.0%	1
Community Inpatient [9]		92.5%	93.0%	97.8%	94.8%	94.8%	92.5%	1
IAPT - proportion of people completing treatment who move to recovery [5]	50%	54.6%	52.4%	53.4%	55.9%	*55.4%*	*51.1%*	1
Number of suicides (per 100,000) population [6]	tbc	0.93		0.77		Due Apr 20		N/A
Delayed Transfers of Care	3.50%	2.7%	1.6%	1.0%	1.6%	0.7%	1.8%	4
Improve the quality and experience of care	**Target**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Year End Forecast**
Friends and Family Test - Mental Health	85%	86%	83%	88%	88%	85%	90%	85%
Friends and Family Test - Community	98%	98%	99%	93%	98%	97%	97%	98%
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) [4]	trend monitor	29	25	22	17	41	25	
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	10	8	6	16	15	12	
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic [7]	trend monitor	13.1%		11.2%		Due Apr 20		N/A
Total number of Children and Younger People under 18 in adult inpatient wards	*TBC*	0	1	1	1	1	0	
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [3]	trend monitor	39.1%	41.4%	38.9%	39.8%	45.6%	44.3%	
Psychology waiting times [12]	tbc	Reporting to commence in 19/20 - likely Q4						
Access within one hour of referral to liaison psychiatry services and children and young peoples' equivalent in A&E departments [13]		Reporting to commence in 19/20 - March 20						
Improve the use of resources	**Target**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Year End Position**
Surplus/(Deficit)	In line with Plan	£207k	£201k	£260k	£384k	£348k	(£49k)	£60k
Agency spend	In line with Plan	£628k	£674k	£572k	£594k	£558k	£581k	£7.5m
CIP delivery	£1074k	£4.2m	£5.2m	£6m	£6.8m	£7.6m	£8.5m	£10.7m
Staffing costs compared to plan [10]	tbc	(£624k)	(£566)	(£518k)	(£992k)	(£681k)	(£534k)	tbc
Completion of milestones assumed in the optimisation of SystmOne for mental health [11]	on plan						** see note below.	
Financial risk in forecast	0	£1.1m	£1.2m	£0.8m	-	-	-	-
Making SWYPFT a great place to work	**Target**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Year End Position**
Sickness absence	4.5%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Staff Turnover	10%	11.8%	11.1%	11.8%	12.3%	12.1%	11.3%	11.4%
Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	80%	88%	N/A	N/A	N/A	N/A	N/A	
Staff FFT survey - % staff recommending the Trust as a place to work	65%	72%	N/A	N/A	N/A	N/A	N/A	
Actual level of vacancies	tbc	12.8%	11.8%	11.5%	11.5%	12.6%	12.2%	12%
% leavers providing feedback	tbc	18.4%		20.0%		Due Apr 20		

NHSI Ratings Key:
1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures Figures in italics are provisional and may be subject to change.

Notes:

1 - Please note: this is a proxy definition as a measure of clients receiving timely assessment / service delivery by having one face-to-face contact. It is per referral. This KPI counts first contact with service post referral. Under performance is generally due to waiting list issues. Q1 data has been impacted by some data quality issues as a result of transition to SystmOne and continuing challenges in recruiting specialist practitioners timely due shortage of LD specialists/applicants, this is a national issue - currently impacting on psychologists in Wakefield & Barnsley and LD nurses / speech & language therapists across all localities.

2 - Out of area beds - From April 18, in line with the national indicator this identifies the number of inappropriate out of area bed days during the reporting month - the national definition for out of area bed is: is a patient that is admitted to a unit that does not form part of the usual local network of services. This is for inappropriate admission to adult acute and psychiatric intensive care unit mental health services only.

3 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Data refreshed back to April 19 each month. Excludes ASD waits. Treatment waiting lists are currently impacted by data quality issues following the migration to SystmOne. Data cleansing work is ongoing within service to ensure that waiting list data is reported accurately.

4 - Further information is provided under Quality Headlines. Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm, and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.

5 - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data. The reported figure is a Trust wide position.

6 - Calculation for this is the number of suicides of services users under the care of the Trust during the reporting period (as recorded on our risk management system), divided by NHS registered population as per office of national statistics data. Appropriate range to be established for Q2 20/21 Q2

7 - Introduced into the summary for reporting from 18/19. Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other

9 - The figure shown is the proportion of eligible clients with a cardiometabolic assessment. This may not necessarily align to the CQUIN which focuses on the quality of the assessment.

10 - Staffing costs compared to plan is reported per month not cumulative.

*11 - Milestones assumed in the optimisation of SystmOne for mental health - reporting of this will commence in quarter 3 once the optimisation plan is agreed in quarter 2. Further detail related to this priority programme can be seen in the priority programmes section of the report. (see ** below)*

12 -Psychology waiting times - waiting time functionality in SystmOne is being tested. Once this process has been signed off, work can commence on the set up for services. This needs to be in place before reporting can flow. It is anticipated this data may be available during quarter 4.

13 - The Trust is involved in the urgent and emergency care pilot in conjunction with Mid Yorkshire Hospitals NHS Foundation trust. As part of this pilot, a dataset is being delivered with reporting set to commence from December 19.We have some provisional data that requires validing with service. This work will take place over the next month with a view to reporting in next months report.

*** - optimisation activities suspended for three months; implementation of the FIRM drisk assessment layed until mid September 2020.*

Lead Director:
• This section has been developed to demonstrate progress being made against Trust objectives using a range of key metrics.
• A number of targets and metrics are currently being developed and some reported quarterly.
• Opportunities for benchmarking are being assessed and will be reported back in due course.
• More detail on areas of underperformance are included in the relevant section of the Integrated Performance Report.

Quality
• No admissions of children to MH acute wards is positive
• Incident reporting within normal range – increases in moderate/severe harm to be reviewed
• Positive result for complaints reporting
• Increase in meds omissions subject to review

NHSI Indicators
• No young people were admitted to an adult ward in February. The first month this has been achieved since September 2019
• Inappropriate out of area bed usage increased to 170 days in February and the forecast for the year has moved to amber
• All other nationally reported targets are currently being achieved

Locality
• Teams are operating business continuity plans in light of the covid pandemic
• Areas for smoking within ward courtyards have been agreed as a temporary measure to support safe management of wards

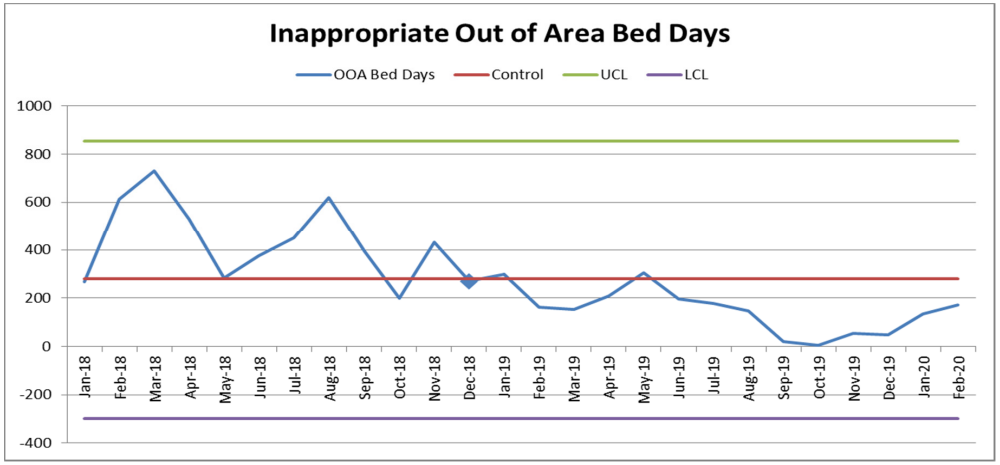
Priority Programmes
• Priorities recommended by the mental health alliance in Wakefield for 20/21 have been agreed cy the CCG
• Work continues on the development of integrated neighbourhood care in Barnsley as well as the implementation of early supported discharge within stroke services
• Current focus on extended hours patient flow to support out of area bed reduction
• All priority programmes being assessed to determine what work needs to take place on them in the coming weeks and months such that focus is placed on managing core service provision

Finance
• Pre Provider Sustainability Funding (PSF) deficit in month 11 of £49k. Cumulative position is a surplus of £0.1m which is £0.6m favourable to plan.
• Cumulative income is £0.6m lower than plan due to the agreement to return £0.5m funding for forensic outreach liaison services to commissioners and the recognition of a number of risks relating to CQUIN coupled with requirements for spending on waiting list initiatives and areas of new investment. These have been partly offset by income from Calderdale CCG in recognition of out of area bed and safer staffing cost pressures.
• Out of area bed costs were £230k in month, which represents the highest monthly costs since April 2019 and the fifth consecutive month there has been an increase in these costs. Cumulatively these costs now total £1,565k which is 56% lower than the spend incurred over the same period last year.
• Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend of £6.8m is already £1.5m above the full year cap of £5.3m, 40% above the year-to-date cap and 17% higher than the same period last year. Approximately £0.6m of the costs incurred relate to waiting list and other non-recurrent initiatives
• Net savings on pay amounted to £0.5m in-month and £6.0m year-to-date.
• CIP delivery of £8.5m is £1.1m lower than plan. Total non-recurrent CIP for the year is projected to be £5.1m (48%).
• Cash balance of £37.9m at the end of February
• Capital expenditure of £3.2m is £2.0m lower than plan, partly as a result of delays whilst the final capital plan was agreed. There is confidence the full year plan of £6.0m will be achieved.
• The financial risk rating remains at 2
• The full year forecast has improved from a deficit of £0.2m to a surplus of £0.1m

Workforce
• All mandatory raining targets achieved at the end of February including information governance
• Sickness absence improved to 4.6% in February, from 5.0% in January and compares to 5.2% last year
• Staff turnover reduced from 12.1% to 11.3% month on month

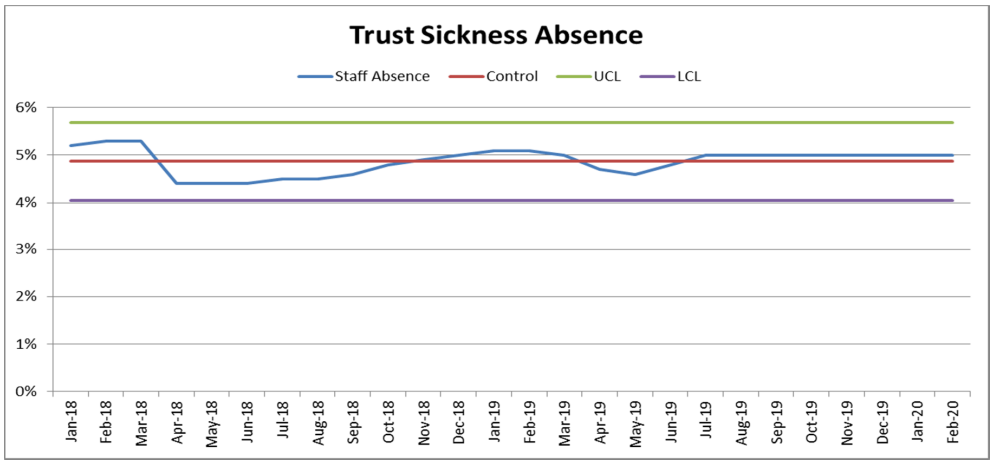
Statistical process control (SPC) is an analytical technique for plotting data over time. It helps understanding of variation and in so doing guides on the most appropriate action to take, as well as allowing tracking the impact of the changes made. The following four areas have been identifed as key indicators to view using SPC. Further charts are in development.

Inappropriate Out of Area Bed Days



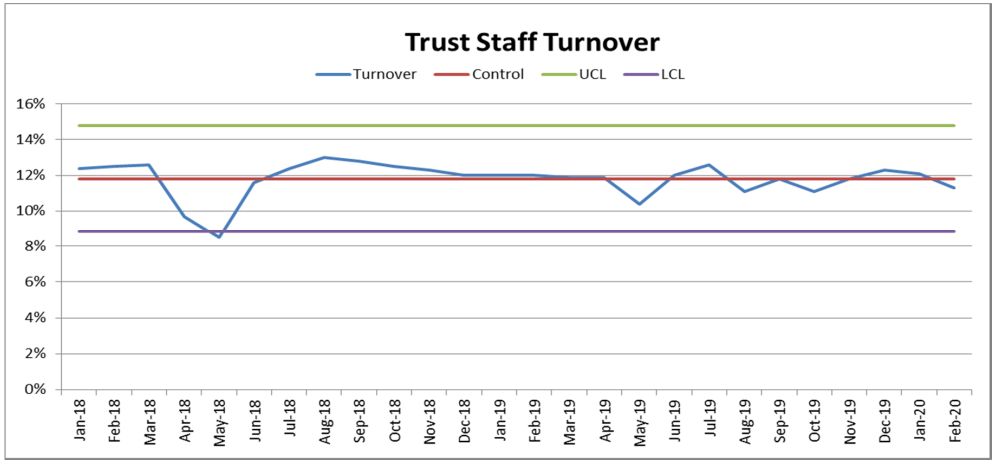
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in December 2018 has been highlighted for this reason.

Staff Sickness Absence



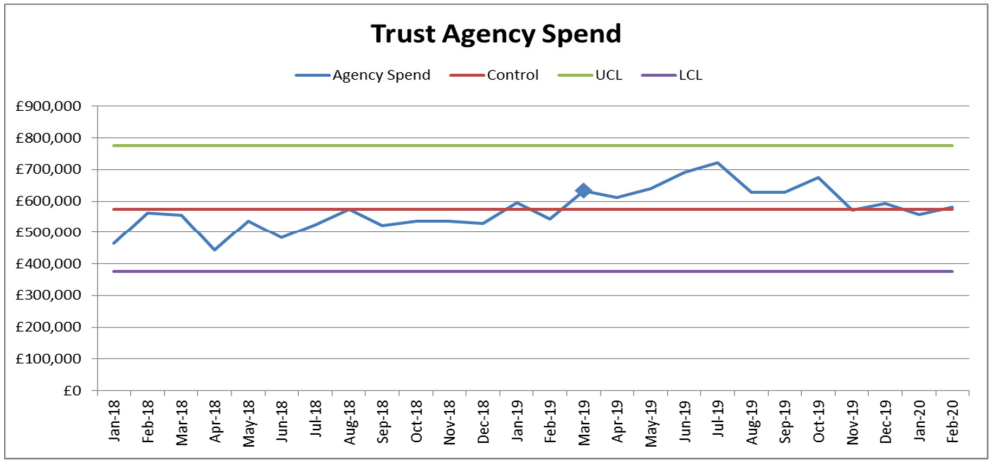
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that sickness levels are within the expected range.

Staff Turnover



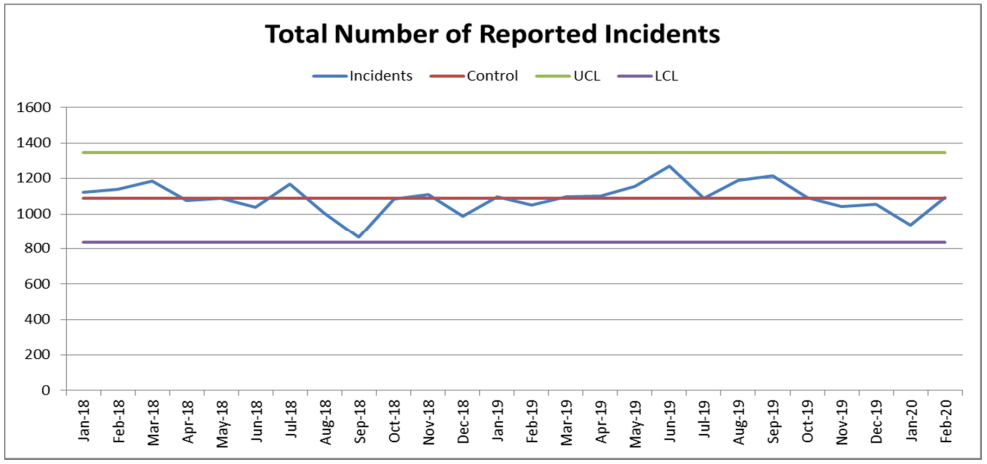
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that staff turnover levels are within the expected range.

Agency Spend



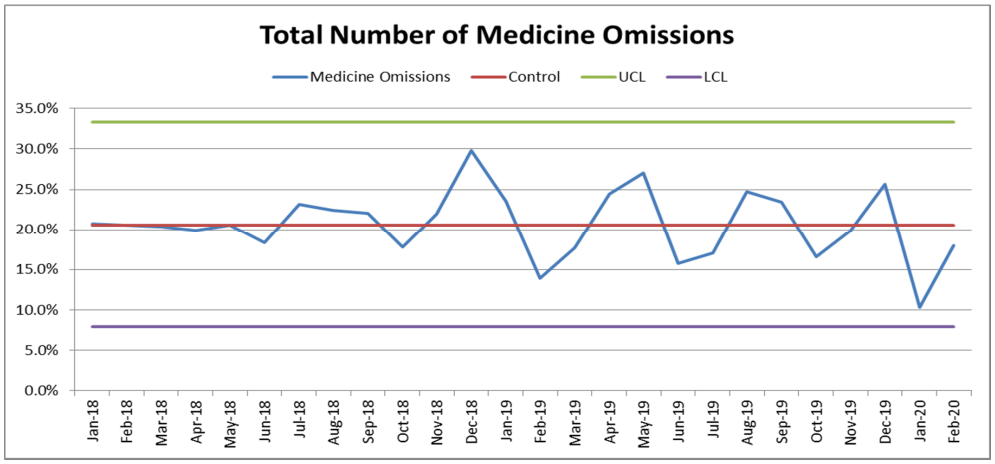
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in March 2019 has been highlighted for this reason.

Incidents



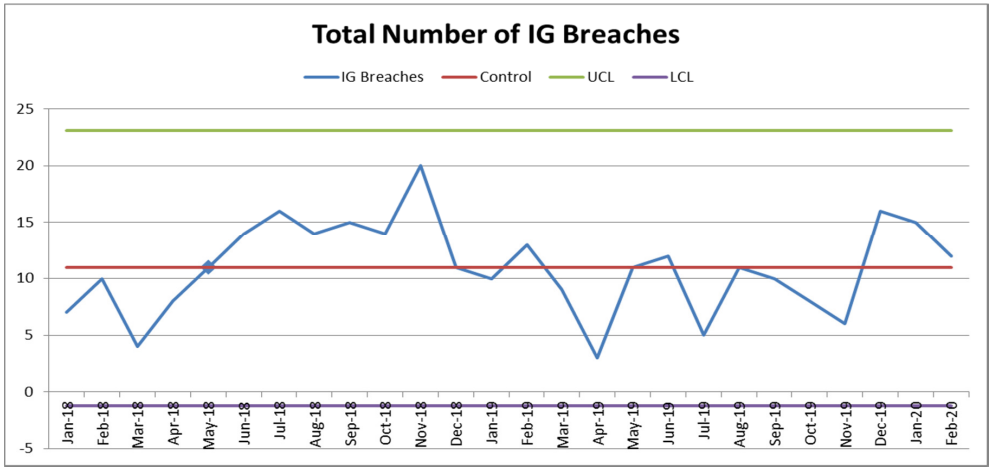
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

Medicine Omissions



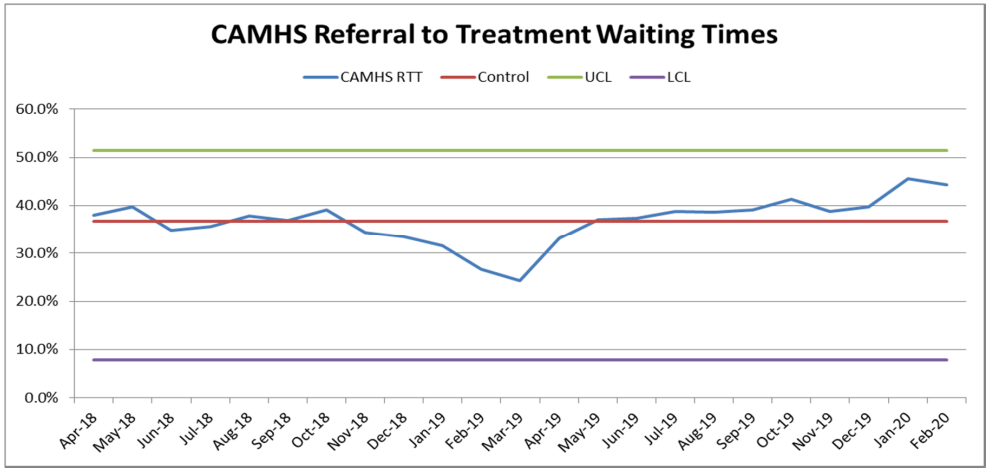
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that medicine omission levels are within the expected range.

IG Breaches



All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported IG breaches are within the expected range. The data point in May 2018 has been highlighted to indicate the introduction on GDPR.

CAMHS Referral to treatment waiting times



All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that waiting times are within the expected range. January 2020 data will be reported March 2020.

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	33.1%	37.1%	37.4%	38.9%	38.6%	39.1%	41.4%	38.9%	39.8%	45.6%	44.3%	N/A
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%	31% 4/13	44% 4/9	26% 4/15	40.0%	53.0%	45.0%	55.0%	54.0%	80.0%	71.0%	80.0%	2
	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	36% 4/11	28% 5/18	17% 12/71	20% 4/20	12% 2/17	33% 3/9	10% 2/22	0%	11% 2/11	6% 1/17	18% 4/22	1
	Written complaints – rate [14]				trend monitor									Due Mar 20			
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	95%	86%	86%	91%	86%	86%	83%	88%	88%	85%	90%	1
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	99%	97%	97%	96%	98%	99%	93%	98%	97%	97%	1
Quality	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	N/A	N/A	75%	N/A	N/A	88%	N/A	N/A	N/A	N/A	N/A	N/A
	Staff FFT survey - % staff recommending the Trust as a place to work [13]	Improving Health	Caring	AD	65%	N/A	N/A	66%	N/A	N/A	72%	N/A	N/A	N/A	N/A	N/A	N/A
	Number of compliments received	Improving Health	Caring	TB	N/A	15	64	14	10	34	32	38	24	17	35	17	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	trend monitor	21	39	30	34	32	26	21	19	17	39	Due Apr 20	
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	trend monitor	10										Due Apr 20	N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	0	0	0	0	0	0	0	0	0	0	Due Apr 20	1
	% Service users on CPA given or offered a copy of their care plan	Improving Care	Caring	CH	80%												1
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=9	3	11	12	5	11	10	8	6	16	15	12	2
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	3.5%	1.4%	1.4%	0.5%	1.2%	1.6%	2.7%	1.6%	1.0%	1.6%	0.7%	175.0%	1
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	95%	86.2%	86.3%	88.5%	89.5%	89.9%	90.1%	93.3%	88.5%	91.4%	89.2%	Due Apr 20	N/A
	Number of records with up to date risk assessment - Community [11]	Improving Care	Effective	CH	95%	65.6%	64.4%	67.9%	70.9%	73.9%	75.6%	70.5%	60.7%	72.3%	69.0%	Due Apr 20	N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	1100	1158	1270	1087	1190	1217	1091	1044	1057	937	1092	
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	19	19	26	25	20	23	19	18	17	14	30	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	3	1	5	1	2	3	5	0	0	1	1	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	7	2	4	5	9	1	5	7	5	2	10	
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	*17.7%*	24.5%	27.0%	15.8%	17.1%	24.7%	23.4%	16.6%	19.8%	25.7%	10.3%	18.0%	2
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	118%	117%	116%	116%	116%	116%	119.0%	119.0%	111.2%	117.8%	108.0%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	96.6%	94.9%	92.1%	91.8%	91.8%	89.4%	94.3%	95.9%	91.8%	96.6%	89.4%	1
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	trend monitor	41	46	34	41	42	44	50	42	46	44	36	
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less [8]	Improving Care	Safety Domain	CH	80%	75.8%	87.5%	90.6%	94.4%	92.5%	85.2%	90.5%	97.5%	97.0%	95.5%	94.5%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	52	37	41	56	54	33	30	38	46	48	47	
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	287	303	193	190	262	168	186	227	174	218	139	
	No of staff receiving supervision within policy guidance [7]	Improving Care	Well Led	CH	80%	75.5%			74.2%			72.5%			Due April 20		2
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	82.6%	86.1%	100.0%	96.6%	85.7%	88.0%	84.4%	87.5%	90.6%	86.5%	83.9%	1
	Smoking Cessation - 4 week quit rate 12	Improving Care	Effective	CH	tbc		65.0%			63%				Due April 20			N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	0	0	0	0	0	1	0	0	0	1
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	1

** See key included in glossary*
Figures in italics are not finalised
*** - figures not finalised, outstanding work related to 'catch up' activities in relation to the SystmOne implementation impacting on reported performance.*

Quality Headlines

1 - Attributable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
2 - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage
3 - The IG breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches
4 - These incidents are those where Duty of Candour is applicable. A review has been undertaken of the data and some issues identified with completeness and timeliness. To mitigate this, the data will now be reported a month in arrears. Target only applicable to breaches.
5 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Data quality (DQ) issues are impacting on the reported data from March 19. Some improvement in dq has seen in the latest month and this is expected to continue.
7- This shows the clinical staff on bands 5 and above (excluding medics) who were employed during the reporting period and of these, how many have received supervision in the last 12 months.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available eg when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available).
10 - In the 2017/18 mandate to NHS England, the Department of Health set a target for delayed transfers to be reduced to no more than 3.5 per cent of all hospital bed days by September 2017. The Trust's contracts have not been varied to reflect this, however the Trust now monitors performance against 3.5%.
11. Number of records with up to date risk assessment. Criteria used is - Older people and working age adult Inpatients, we are counting how many Sainsbury's level 1 assessments were completed within 48 hours prior or post admission and for community services for service users on care programme approach we are counting from first contact then 7 working days from this point whether there is a Level 1 Sainsbury's risk assessment.
12. This metric has been identified as suitable metric across all Trust smoking cessation services. The metric identifies the 4 week quit rate for all Trust smoking cessation services. The national quit rate for quarters 1-3 2018-19 was 52%.
13. The national benchmark (65%) for this indictaor has been used to monitor Trust performance against.
14 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return and is monitored under the NHS oversight framework.

Quality Headlines

Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.

• Number of restraint incidents - the number of restraint incidents during February has decreased to 139 compared to 218 last month. Prone restraint accounts for only 9% of all restraints and over 95% of these last lower than 3 minutes. Further detail can be seen in the managing violence and aggression section of this report.

• NHS Safety Thermometer - medicines omissions – performance has deteriorated below threshold in February to 18% following a positive improvement in January 2020, which saw the lowest rate in past 12 months.

• Number of falls (inpatients) – A slight decrease in February to 47 from 48 in January. All falls are reviewed to identify measures required to prevent reoccurrence and more serious falls are subject to investigation.

• Staffing fill rates are provided for the last 2 months where new planned staffing in acute MH wards is included and fill rates measured against these. As expected, some reductions in fill rates noted but only 2 acute wards below 100%, both at 99%.

• Patient safety incidents involving moderate or severe harm or death fluctuated over recent months (see section below). Increases mainly due to increased number of unavoidable pressure ulcers and slips, trips and falls. Increase in number of deaths although important to note that deaths are often re-graded upon receipt of cause of death/clarification of circumstances.

COVID-19

As at 8am on Wednesday 25th March, the Trust had 252 staff related absences either through sickness or self-isolation across all staff groups with the highest rate in clinical and nursing. There are a further 152 staff that are working from home due to COVID-19 isolation and risk guidance. This is obviously having a significant impact on operational services and resources are being deployed accordingly to ensure patient and staff safety during this challenging period.

• The Trust have established a Gold, Silver and Bronze command structure.

• Business continuity plans have been updated across the Trust

• Bank and agency availability is being reviewed to assist with resource availability.

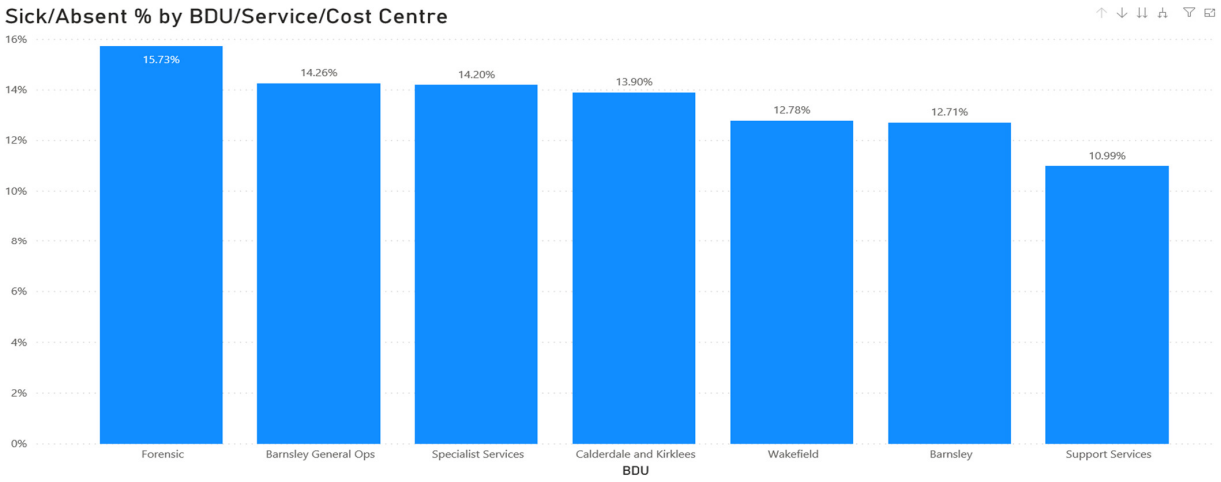
• Previous retired workers have been contacted and a number of those have agreed to come back to work to support.

• Corporate services have undertaken a piece of work to identify staff that can be released for duties that would assist with pressure on operational services – this includes working in a health care support worker role, domestic, estates and facilities and clinical admin functions.

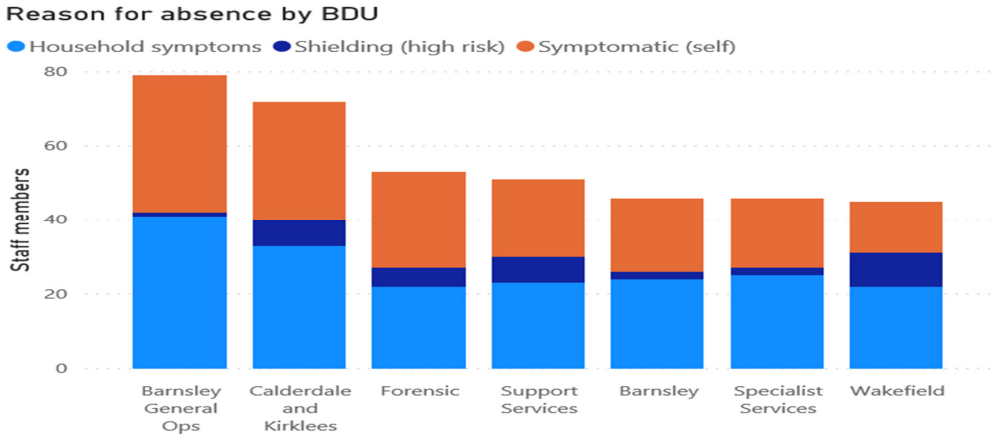
• Critical functions for corporate support services are now generally working from home to adhere to the government's social distancing guidelines.

• Communications team are ensuring guidance is distributed and working hard to keep staff up to date.

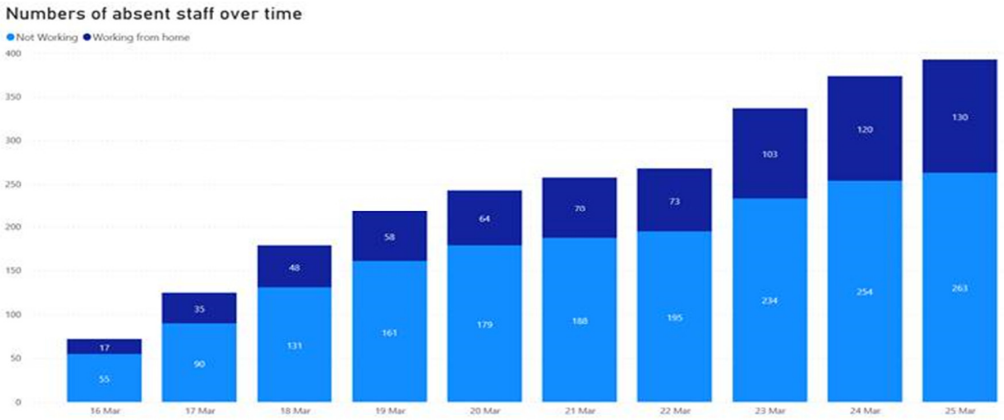
The following graph show the percentage of staff absences attributed to COVID-19 as a proportion of the BDU headcount. Forensic, Barnsley general operations and specialist services business delivery units are currently the greatest affected areas in the Trust. This equates to 13.5% of the workforce being absent (4.5% of those are able to work from home).



The following graph shows the reasons for COVID-19 absence by BDU. The largest reason for absence relates to others in the household having symptoms and staff therefore following self isolation guidelines.



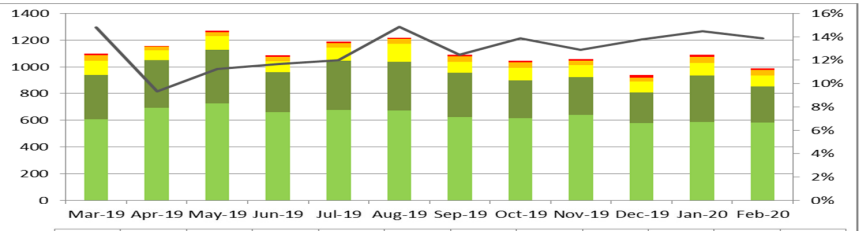
The following chart shows COVID-19 staff absences over the period16th March - 25th March:



Safety First

Summary of Incidents March 2019 - February 2020

Incidents may be subject to re-grading as more information becomes available



	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Red (should not be compared with SIs)	12	6	10	14	13	9	14	10	13	20	18	15
Amber	44	30	32	32	34	34	39	41	31	26	46	40
Yellow	107	72	101	81	96	138	83	94	92	83	94	82
Green	330	357	402	301	370	365	331	284	283	230	348	271
Green no harm	607	693	725	659	677	671	624	615	638	578	586	581
Total	1100	1158	1270	1087	1190	1217	1091	1044	1057	937	1092	989
Percentage of total that are Red/Amber/Yellow *	14.8%	9.3%	11.3%	11.7%	12.0%	14.9%	12.5%	13.9%	12.9%	13.8%	14.5%	13.9%

Patient safety incidents involving moderate or severe harm or death fluctuated over recent months. They reduced from 22 in November to 17 in December then increased to 41 in January and have dropped to 25 in February. The number in January is due to an increase in pressure ulcer grade 3 incidents that are unavoidable; December (12) January (20) and also Slip/Trip/Fall December (1) January (5). Deaths have increased from 2 in December to 10 in January and dropped to 4 in February. Of the spike in January, 6 were reported as serious incidents. Cause of death is awaited for some of these deaths. One is awaiting cause of death to determine review process. Degree of harm and severity are both subject to change as incidents are reviewed and outcomes are established. Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.

** A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety). The distribution of these incidents shows 86% are low or no harm incidents.*

Safety First cont…

Summary of Serious Incidents (SI) by category 2019/20

	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20 Jan and Feb 20 only	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Total
Suicide (incl apparent) - community team care - current episode	4	10	5	5	3	1	1	2	5	2	3	2	2	1	4	1	27
Death - cause of death unknown/ unexplained/ awaiting confirmation	3	0	0	3	0	1	2	0	0	0	0	0	0	0	3	0	6
Pressure Ulcer - Category 3	1	1	1	0	2	0	1	0	0	0	1	0	0	1	0	0	5
Physical violence (contact made) against staff by patient	1	0	1	2	0	0	0	1	0	0	0	0	1	0	1	1	4
Suicide (incl apparent) - community team care - discharged	1	1	1	0	0	0	0	1	1	0	0	0	0	1	0	0	3
Suicide (incl apparent) - inpatient care - current episode	0	0	0	2	1	0	0	0	0	0	0	0	0	0	1	1	3
Self harm (actual harm) with suicidal intent	2	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2
Death - confirmed from physical/natural causes	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Illegal Acts	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	1
Slip, trip or fall - patient	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1
Homicide by patient	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Total	13	12	9	14	6	3	5	5	6	2	4	2	3	4	10	4	54

- Incident reporting levels have been checked and remain within the expected range.
- Degree of harm and severity are both subject to change as incidents are reviewed and outcomes are established.
- Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
- All serious incidents are investigated using Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
- Risk panel meets weekly and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report, the format and content is regularly reviewed.
- No never events reported in February 2020
- Patient safety alerts not completed by deadline of February 2020 - None

Degree of harm analysis:

The patient safety support team add a provisional degree of harm at the point of an incident being reported based on information recorded at that point, and what the harm could be. This is checked and revised when an incident is finally approved, after the manager has reviewed and added outcome. This can be delayed due to length of time to review incidents, and volumes. This is a constantly changing position and we can only report on what is recorded at a point in time.

Deaths: Of the 4 deaths, 2 were reported as Serious Incidents (Ward 19 and Ward 18, both service users on leave from the wards), 1 Structured Judgment Review (enhanced team North 1 Kirklees) and 1 joint team Significant Event Analysis to be held (Enhanced team West Barnsley and Adult Epilepsy Team, Barnsley)

Severe harm: Of the 4 severe harm incidents, this included 2 serious self harm incidents and two inpatient falls (Crofton ward and Neuro rehab ward). There have been an increase in patient falls resulting moderate/severe harm in recent months.

Moderate harm: Of the 17 incidents – these have been analysed and these are across a range of incidents, however pressure ulcers continue to be the highest category of moderate harm incidents with 11 incidents (all Neighbourhood Nursing, Barnsley). There is no particular patterns or trend. There are 5 self harm incidents (2 Elmdale, 1 IHBTT Wakefield, 1 IHBTT Kirklees, 1 IHBTT Calderdale). 1 inpatient fall (Ward 19). There is medication error (Neighbourhood Nursing, Barnsley). Degree of harm will be updated when more information emerges and incidents are approved, so the position may change.

Mortality:

Learning: Work continues to develop thematic learning summaries for sharing across the Trust.

Regional work: The March 2020 Northern Alliance meeting was cancelled.

Reporting: The Trust's Learning from Healthcare Deaths information is reported through the quarterly incident reporting process in quarterly incident reports. Once agreed by Trust board, the latest information is added to the Trust website. Quarter 3 report has been added. See http://www.southwestyorkshire.nhs.uk/about-us/performance/learning-from-deaths/

Policy: the Learning from Healthcare Deaths policy has been revised to reflect reporting deaths on Datix where we have had contact from the coroner/legal process. Also EIA updated. The intranet is being updated with this version.

Safer Staffing

To note, the staffing fill rates for February 2020 for the adult working aged pathway have had the recommended establishment increase included. This was primarily for nursing associates who are currently being employed or are in training and are therefore counted in the healthcare assistant numbers until they qualify. These staff are also being counted at 100% despite their off the ward training commitments.
Elmdale has fallen below the 90% overall fill rate threshold. This was due to their vacancy levels and sickness. Of the 31 inpatient areas, 19 (60.8%) achieved greater than 100%. This was a reduction of 6 (19.2%) on the previous month. Indeed of those 19 areas, seven achieved greater than 120% fill rate.

	Dec-19	Jan-20	Feb-20
Ward Name	Average Fill Rate - All Staff (%)	Average Fill Rate - All Staff (%)	Average Fill Rate - All Staff (%)
Beamshaw	119.3%	112.6%	103.4%
Clark	106.7%	106.7%	91.4%
Melton Suite PICU	127.5%	132.3%	116.7%
Neuro Rehab Unit	144.6%	158.4%	161.3%
Stroke Rehab Unit	97.5%	94.3%	95.5%
Willow Ward	95.4%	110.3%	131.7%
Ashdale	97.2%	111.2%	92.2%
Beechdale	126.5%	122.7%	108.1%
Elmdale	109.8%	99.5%	89.0%
Enfield Down	91.2%	95.4%	93.1%
Lyndhurst	99.5%	100.9%	98.7%
Ward 18	106.5%	99.3%	92.1%
Ward 19 - Female	105.8%	102.3%	99.6%
Ward 19 - Male	116.0%	109.0%	108.5%
Appleton	92.0%	95.4%	97.8%
Bronte	110.1%	103.8%	104.5%
Chippendale	101.4%	96.7%	90.9%
Hepworth	100.9%	116.0%	125.7%
Johnson	153.4%	159.9%	152.3%
Newhaven	97.7%	100.8%	100.7%
Priestley	92.2%	102.0%	97.6%
Ryburn	115.5%	102.1%	105.4%
Sandal	98.6%	101.6%	106.2%
Thornhill	96.3%	101.2%	103.6%
Waterton	123.1%	130.6%	126.6%
Crofton	106.6%	133.4%	127.3%
Horizon	114.0%	115.4%	118.7%
Nostell	118.0%	112.7%	102.7%
Poplars	169.7%	149.6%	145.2%
Stanley	106.6%	112.5%	95.2%
Walton PICU	118.8%	124.2%	112.2%
All Wards	111.2%	112.9%	108.0%

Registered On Days -Trust total 83.8%. The number of wards that have failed to achieve 80% registered nurses increased on the previous month to 11 (25.2%). Six wards were within the forensic BDU, one in Wakefield, one in Barnsley and three in Calderdale and Kirklees (C&K). The forensic BDU remains under pressure from a staffing perspective. Contributory factors to that are high levels of acuity, high sickness/absence and existing vacancies. The service is implementing a recovery plan supported by corporate services. As part of that plan overtime continues to be offered to substantive staff to improve staffing numbers and consistency. Although these figures do not reflect significant improvement the service is confident the position will be improved. Forensic and C&K are the focal point for the band 5 recruitment campaigns with some success which will have an impact moving forward.
Registered On Nights- Trust total 99.6%. No ward fell below the 80% fill rate in the month of January. The number of wards which are achieving 100% and above fill rate on nights decreased to 18 (57.6%). Two wards utilised in excess of 120%.
Specialist services had an increase from 115.4% to 118.7%. Barnsley increased slightly from 116.46 to 116.7 %. Calderdale and Kirklees BDU decreased from 105% to 97.7%. Forensic BDU were 110.1%, a slight increase of 1.5%. Wakefield BDU increased from 106.1% to 116.52. The overall fill rate for the Trust was 111.9%. Significant pressures remain on our inpatient wards due various influences including demands arising from acuity of service user population, vacancies and sickness. February and March are also a high leave period. We will be anticipating an impact from the Coronavirus pandemic with interventions and business continuity plans in place.
The safecare tool is to be piloted in the Unity Centre from March 2020.

Information Governance

February saw a reduction in the number of confidentiality breaches reported, closing at 12. All but one of the incidents related to patient information being disclosed in error, largely due to correspondence being sent to the wrong recipient or wrong email or postal address. IG continue to write to managers when an incident occurs to recommendation improvement action and request confirmation that appropriate action has been taken.

None of the incidents reported during January met the criteria for reporting to the Information Commissioner.

Commissioning for Quality and Innovation (CQUIN)

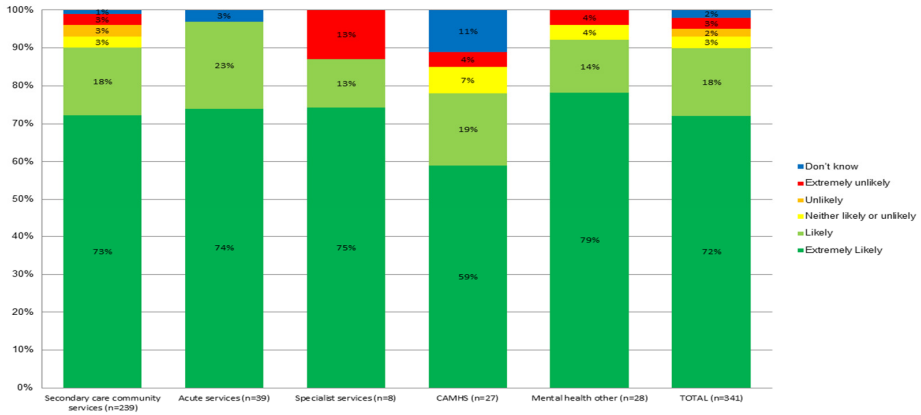
Q3 performance has been confirmed by most commissioners. Forecast for quarter 4 remains largely unchanged with risk identified against mental health services data set (MHSDS) interventions and improving access to psychological therapies indicator, however, in light of the current situation with COVID-19, there may be an impact on the reported data in a number of other indicators which is due towards the end of April. This will be flagged with the commissioner, NHS digital and NHS England.

Patient Experience

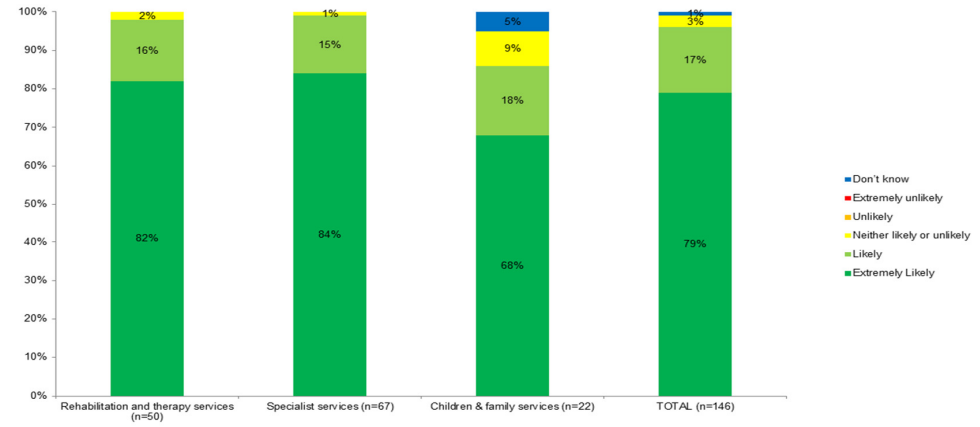
Friends and family test shows

- 92% of respondents would recommend Trust services.
- 97% of respondents would recommend community services.
  - There is a slight decline in the recommend rate for community services, although still in normal variation.
  - From 146 responses 142 would recommend services, the remaining respondents responded neither likely nor unlikely. This relates to three separate services.
  - A review of comments identified no themes and results have been shared with services.
- 90% of respondents would recommend mental health services.
- The number of responses declined by 49% (489) from the previous month (January 962).
  - There was a decline in the number of community responses received this month due to the changeover in electronic device type.
- Text messages provided 33% of the responses in January.
- Data collection devices have been tested across services and are working. However, as we have had a restricted service for a period of time some of the functions such as pushed reporting and dashboards will remain switched off. BDUs will receive monthly reporting to be shared with teams.
- Preparation continues for the new Friends and Family Test launch in April 2020. Updates will be provided through comms and BDU Governance meetings.

Mental Health Services



Community Services



Care Quality Commission (CQC)

On the 16th March it was announced there would be an immediate cessation of routine CQC inspections in light of the COVID-19.

Safeguarding

Safeguarding Children
• Named nurse attended the multi-agency safeguarding hubs (MASH) safeguarding partnership operational group meeting at Havertop police station.
• Safeguarding children nurse advisor attended a meeting with Barnsley safeguarding children partnership regarding discharging children with complex issues from the emergency department at Barnsley hospitals NHS foundation trust.
• Information has been submitted to the safeguarding childrens partnerships for potential child safeguarding practice reviews
• Information has been submitted to Wakefield safeguarding children partnership for a review of a "suicide near miss" of three teenage girls.

(Joint) Named Nurse Safeguarding Children and Specialist Advisor Safeguarding Adults
• Attended the section 11 event in Calderdale.
• Facilitated the annual safeguarding conference

Safeguarding Adults
• Attended the domestic abuse strategic partnership meeting
• Involved in the quality improvement care planning and record keeping group task and finish group
• Supported the conclusion of safeguarding concern regarding volunteer and service user
• Attended a safeguarding adults challenge event in Kirklees
• Submitted information for a potential safeguarding adults review to Barnsley

Infection Prevention Control (IPC)

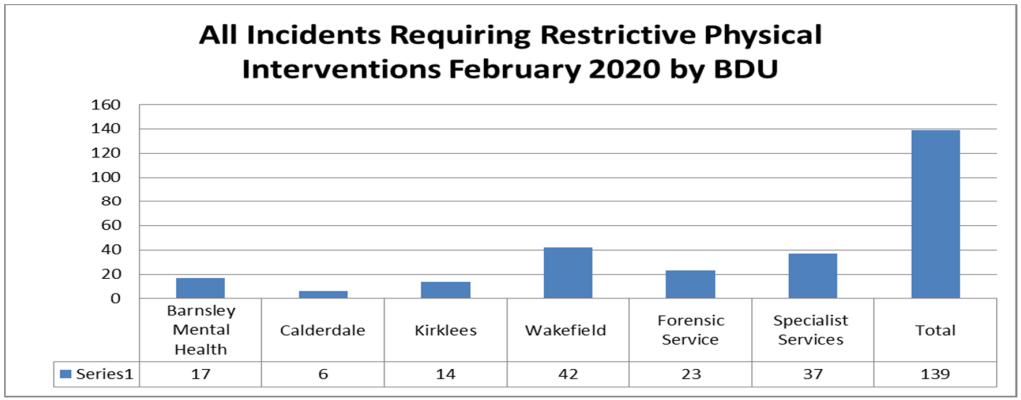
• Surveillance: there has been no cases of MRSA Bacteraemia, MSSA bacteraemia, or Clostridium difficile. There has been 0 case of ecoli bacteraemia case
• There has been an outbreak of D&V
• Mandatory training figures are healthy: Hand Hygiene-Trust wide Total – 93.6%, Infection Prevention and Control- Trust wide Total – 87.7%
• Infection prevention and control office covered from 8-6 Monday to Friday. On call cover 8-8 Saturday and Sunday
• Issues with procuring personal protective equipment (PPE). Now made available. BDUs now allocated leads who are distributing locally within their teams
• PPE and usage instructions allocated to emergency bags for use in the event of cardiac arrest
• Monitoring service users suspected as being COVID-19:
  - As of yesterday there were 2 service users isolating and awaiting swabs (inpatients)
  - 2 service users were self-isolating after being transferred from COVID-19 wards
  - Today there has been a confirmed case in Barnsley General Community (we are going in and administering insulin twice daily)
  - There has been a possible case for a service user who has died
• Allaying staff fears regarding being in contact with symptomatic service users (massive issue at present)
• Assisting with managing complaints from staff and service users families regarding infection prevention and control decisions based on the national guidance

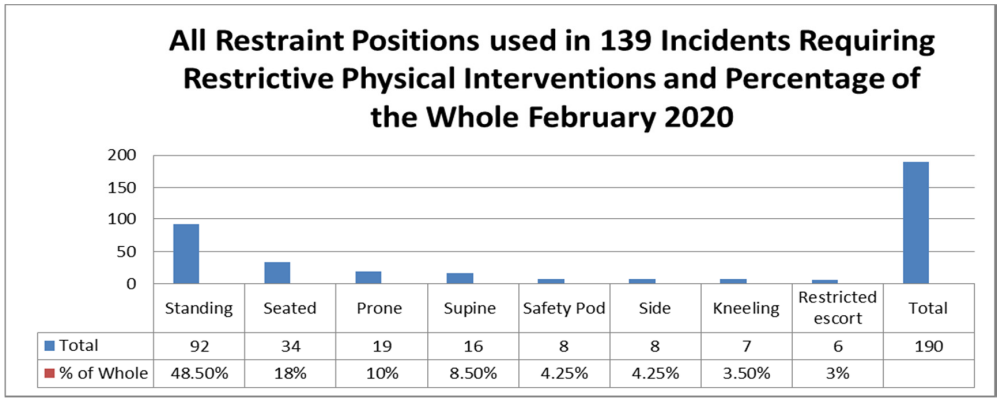
Complaints

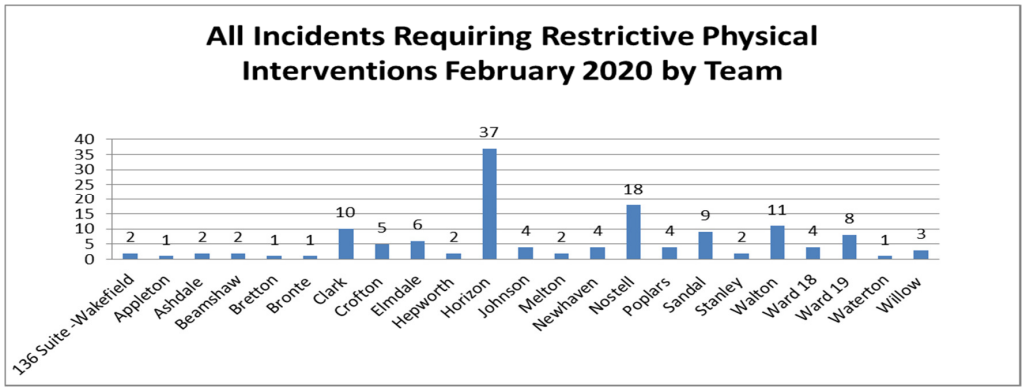
The number of complaints closed within 40 days continues to remain positive and has this month achieved 80%. The improvement is testimony to the effort the customer services team, in partnership with BDU's, have put into making the complaints pathway efficient and effective.
Work continues to make improvements to the complaints pathway to achieve and maintain the performance threshold.

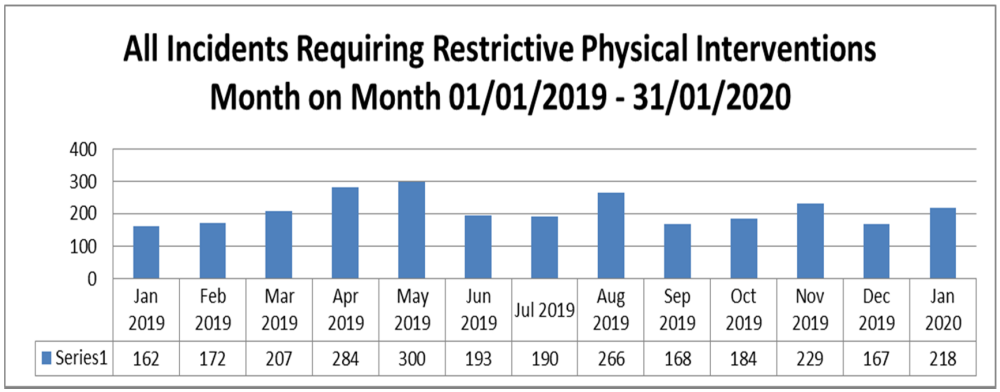
Reducing Restrictive Physical Intervention

There were 139 reported incidents of restrictive physical interventions (RPI) use in February this being a 36% reduction on the January figure that stood at 218. Out of 190 restraint positions used in the 139 incidents the highest proportion of all restraint positions used was again in the standing position (92) which equates to 48.5% of all positions used (190). Seated restraints stood at 34 that equates to 18% of all positions used. In relation to incidents of that would be deemed prone restraint 18 this is a 25% reduction in the use of prone restraint from January (24). Wakefield BDU had the highest number of prone restraints with 8. Forensics BDU had 5, Barnsley BDU had 3 and Kirklees had 2.
The reducing RPI team continues during training to place all the emphasis on non-physical interventions and when it comes to teaching and discussing prone restraint the course continues to inform staff of the risks associated with the prone position and the need to move from any prone restraint position as soon as possible. The Trust target of 90% of prone restraints lasting under 3 minutes is discussed at length, and the importance of striving to maintain this is strongly emphasised. In February 2020 only 1 incident of prone restraint lasted over 3 minutes (4 -5 minutes) due to the level of aggression displayed. 94.5% of prone restraints lasted under 3 minutes.









Mental Health Act

From September 2019, we are able to include some key metrics related to performance against the Mental Health Act (MHA) requirements. Development of these have been taking place over the last few months. Monthly reporting of performance against Section 17 leave is now available. Future developments will include reporting relating to Section 132 patients rights. Progress to date on this is as follows:

- The Trust section 132 policy and additional document amendments have been completed and agreed with the practice governance coach and the matrons.
- The Mental Health Act administrators have started attending the wards and meeting with registered staff to show them the new process, where to record on SystmOne and where to access The SystmOne white board (dashboard) so that the registered staff can at a glance and in real-time see what the activity is and what needs addressing / where the hotspots are.
- The MHA administrators will be developing a process to keep this under review and send reminders where needed to registered staff alerting that a patients' rights are due. Further update regarding this can be seen below.

Section 17 leave

The Care Quality Commission have regularly raised an issue with the non completion of page 2 of the Section 17 leave from. The recording of who has been informed of the leave and the involvement of the service users is a requirement of the MHA code of practice. Previous initiatives have not proven successful, therefore each form that is completed and submitted to the local MHA office is reviewed to ensure that it has been fully completed. If the form is not completed, it is sent back to the matrons/practice governance coach for action. The new process has been in place since September 2019 and has proven effective in most areas.
Guidance note for staff has been completed and circulated to all clinical services.
The numbers above are separated into :numbers of forms received in total, of those forms the number of forms that need to be returned for completion . The target for completion is 100% following action by MHA administration staff process of reviewing and returning where not completed. The 100% compliance target is what is expected by the MHA code of practice.

	Sep-19			Oct-19			Nov-19			Dec-19			Jan-20			Feb-20		
	Section 17 form			Section 17 form			Section 17 form			Section 17 form			Section 17 form			Section 17 form		
Service	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete
Older people services Trustwide	67	62	92.5%	89	76	85.4%	67	61	91.0%	91	85	93.4%	149	128	85.9%	72	55	76.4%
Working age adult - Trustwide	275	245	89.1%	217	177	81.6%	235	202	86.0%	257	230	89.5%	346	261	75.4%	245	160	65.3%
Specialist Forensic services	219	160	73.1%	58	39	67.2%	74	30	40.5%	47	5	10.6%	121	85	70.2%	193	161	83.4%
Rehabilitation services - trustwide	21	21	100.0%	11	10	90.9%	16	15	93.8%	33	27	81.8%	32	26	81.3%	18	18	100.0%

Please note, data will be refreshed each month as completed forms are received.

Patients rights

Work is progressing on reporting for the adherence to reading of patients' rights. This data is now being recorded on SystmOne. We are now in the process of writing a report to flow this data. It is likely that this will be available to flow into the report from the May20 IPR (April 20 data).
There is currently a manual process in place monitoring the reading of patients' rights which is being undertaken by the mental health act administrators in conjunction with the wards.

This section of the report outlines the Trusts performance against a number of national metrics. These have been categorised into metrics relating to:
• NHS Improvement Oversight Framework - NHS providers must strive to meet key national access standards, including those in the NHS Constitution. During 16/17, NHS Improvement introduced a new framework for monitoring provider's performance. One element of the framework relates to operational performance and this will be measured using a range of existing nationally collected and evaluated datasets, where possible. The table below lists the metrics that will be monitored and identifies baseline data where available and identifies performance against threshold.
• Mental Health Five Year Forward View programme – a number of metrics were identified by the mental health taskforce to assist in the monitoring of the achievement of the recommendations of the national strategy. The following table outlines the Trust's performance against these metrics that are not already included elsewhere in the report.
• NHS Standard Contract against which the Trust is monitored by its commissioners. Metrics from these categories may already exist in other sections of the report.
The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

NHS Improvement - Oversight Framework Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q1 19/20	Q2 19/20	Q3 19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Year End Forecast	Data quality rating [8]	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	98.7%	98.8%	98.2%	98.8%	97.2%	98.9%	98.2%	98.3%	98.3%	1		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	99.7%	99.7%	99.7%	100%	100%	99.1%	100%	100%	96.0%	1		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	294/301 =97.67%	344/354 97.18%	319/327 97.55%	100/102 =98.04%	114/115 =99.04%	111/116 =95.69%	94/96 =97.92%	89/87 =95.40%	81/85 =95.29%	1		
Data Quality Maturity Index [4]	Improving Health	Responsive	CH	95%	97.9%	97.1%	*98.3%*	98.1%	98.2%	98.3%	*98.3%*	*98.3%*	*98.6%*	1		
Out of area bed days [5]	Improving Care	Responsive	CH	19/20 - Q1 576, Q2 494, Q3 411, Q4 329	703	318	108	21	4	55	49	133	170	3		
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	CH	50%	53.9%	53.4%	*53.5%*	54.6%	52.4%	53.4%	*55.8%*	*55.4%*	*51.1%*	1		
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	CH	75%	83.8%	77.5%	*79.3%*	78.0%	78.1%	82.7%	*77.1%*	*85.7%*	*83.7%*	1		
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	CH	95%	97.4%	98.3%	*97.6%*	97.9%	97.5%	97.6%	*97.7%*	*99.1%*	*98.5%*	1		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	56%	83.1%	84.0%	82.6%	76.5%	75.9%	85.4%	81.8%	86.7%	84.4%	1		
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	87.8%	89.4%	*90.5%*	90.0%	90.2%	90.5%	90.8%	91.0%	*91.3%*	1	⚠	
% clients in employment [6]	Improving Health	Responsive	CH	*10%*	11.4%	11.6%	*11.8%*	11.6%	11.7%	11.8%	11.9%	11.8%	*12.0%*	1	⚠	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Improving Care	Responsive	CH		Due June 20											

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q1 19/20	Q2 19/20	Q3 19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Year End Forecast	Data quality rating [8]	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	90	28	27	0	4	2	21	12	0	2		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	9	2	3	0	1	1	1	1	0	2		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	214	183	206	183	206			Due Apr 20		N/A		
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	CH	*Trend Monitor*	14.5%	13.1%	11.2%	13.1%	11.2%			Due Apr 20		N/A		

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q1 19/20	Q2 19/20	Q3 19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Year End Forecast	Data quality rating [8]	Trend
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance [1]	Improving Health	Responsive	CH	90%	99.1%	99.2%	*98.8%*	100.0%	99.0%	98.3%	99.1%	*99.4%*	*99.0%*	1		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	99%	99.8%	99.9%	*99..9%*	99.9%	98.7%	99.9%	99.9%	98.8%	*98.8%*	1		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	90.2%	98.6%	*98.7%*	98.7%	99.9%	98.8%	98.8%	99.9%	*99.9%*	1		

** See key included in glossary.*
Figures in italics are provisional and may be subject to change.
1 - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data.
2 - Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other
4 - This indicator was originally introduced from November 2017 as part of the revised NHSI Oversight Framework operational metrics and changed from April 19 to extend the number of valid and complete data items from the MHSDS (now includes 36 data items).
5 - Out of area bed days - The reported figures are in line with the national indicator and therefore only shows the number of bed days for those clients whose out of area placement was inappropriate and they are from one of our commissioning CCGs. Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021. Sustainability and transformation partnership (STP) mental health leads, supported by regional teams, are working with their clinical commissioning groups and mental health providers during this period to develop both STP and provider level baselines and trajectories.
6. Clients in Employment - this shows of the clients aged 18-69 at the reporting period end who are on CPA how many have had an Employment and Accommodation form completed where the selected option for employment is '01 - Employed'
8 - Data quality rating - added for reporting from August 19. This indicates where data quality issues may be affecting the reporting indicators. A warning triangle idenfiies any issues and detailed response provided below in the data quality rating section.

Areas of concern/to note:

- The Trust continues to perform well against the NHS Improvement metrics
- Inappropriate out of area bed placements amounted to 170 days in February which is the highest number of days recorded since April. Year-end forecast .
- During February 2020, no service users aged under 18 years were placed in an adult inpatient ward. This is the first time this has been achieved since September. When this does occur the Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. We routinely notify the Care Quality Commission (CQC) of these admissions and discuss the detail in our liaison meetings, actioning any points that the CQC request. This issue does have an impact on total Trust bed availability and therefore the use of out of area bed placements. In addition, the Trust's operational management group have recently signed off a new standard operating procedure for admitting young people to adult wards which has now been put into operation.
- % clients in employment- the Trust is involved in a West Yorkshire and Harrogate Health & Care Partnership wave 1 three-year funding initiative, led by Bradford District Care, to promote, establish and implement an Individual Placement Support (IPS) scheme. IPS is evidence based vocational scheme to support people with mental health problems to gain and keep paid employment. Work is currently ongoing in Calderdale to expand the opportunities we can offer people under this scheme. A South Yorkshire & Bassetlaw partnership bid for individual placement support wave 2 funding has been successful which will see the creation of additional employment workers to support secondary care mental health services in Barnsley. There are some data completeness issues that may be impacting on the reported position of this indicator.
- The scope of the data quality maturity index changed in July 2019 as part of a national CQUIN, though the target has remained the same. The Trust has been achieveing this target since July.
- IAPT treatment within 6 weeks of referral has achieved the 75% target although there are continuing challenges in meeting this particularly in regard to staffing numbers.

Data quality:

An additional column has been added to the above table to identify where there are any known data quaity issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

For the month of February the following data quality issues have been identified in the reporting:

- The reporting for employment and accomodation for January shows 15% of records have an unknown or missing employment and/or accommodation status, this is an improvement on last month which was reported at 17%. This has therefore been flagged as a data quality issue and work takes place within business delivery units to review this data and improve completeness.

This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU). For the month of February, the narrative in this section is reduced compared to previous months as the focus has been on continued delivery of operational services in light of the current situation with COVID-19.

Barnsley general community services
Key Issues
• Much of the integrated neighbourhood development working is currently paused
• Significant pressure on community caseloads. Staff from GP federation are being transferred into the community to support discharges from intermediate care and Barnsley hospitals NHS foundation trust
• Concerns regarding infection control, isolation facilities and social distancing in Urban House raised with MEARS, who are the management company and with Public Health

Barnsley mental health services and Child and adolescent mental health services:

Key Issues
• CAMHS has high numbers of staff who are self-isolating and non-critical services are seeking to redeploy staff into critical services
• Appointments are taking place over the telephone wherever possible
• Barnsley CAMHS procurement process has paused

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Key issues
• Wakefield has a lower number of staff self-isolating
• Inpatient plans are reviewed routinely by the matrons in relation to the cohort of patients in each area and how these can be best managed in the event of an outbreak
• Focus is on optimising patient flow which is having positive effect on out of area placements and inpatient units
• Areas for smoking within ward courtyards have been agreed as a temporary measure to support the safe management of wards

Forensic business delivery unit and Learning Disability services:

Key Issues
• High number of staff who are self-isolating
• Forensic plan to address urgent actions is still being prioritised
• People with learning disability in the community are considered to be at an increased risk and contact is prioritised

Communications, Engagement and Involvement

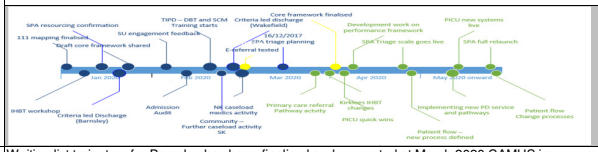
The team is currently focused on Covid communications activity.

This is the March 2020 priority programme progress update for the integrated performance report. It is a summary of the activity conducted in the period for February 2020. The priority programme areas of work providing an update in this report are:
• Wakefield Projects
• Barnsley Projects
• Camhs Improvement Projects
• West Yorkshire Projects
• SystmOne Optimisation
• Provide all care as close to home as possible (Out of Area)
The framework for this update is based on the Trust priorities for 2019/20 (as agreed in April 2019), and provides details of the scope, improvement aims, delivery and governance arrangements, and progress to date including risk management. Some areas of focus are for the Trust where the position is strategic and emergent; others are priority change programmes which will be delivered over 2019/20. The reporting arrangements for each programme of work are identified; some are hidden as they either report elsewhere on the IPR, do not report on the IPR, or do not report this month on the IPR. The proposed delivery is in line with the agreed integrated change framework. As a result of the Covid-19 pandemic all priorities programmes will be assessed to determine what work needs to take place on them in the coming weeks and months such that focus is placed on managing core service provision and supporting the work on the Covid pandemic.

Priority	Scope	SRO	Change Manager	Governance Route	Improvement Aim(s)	Reporting Frequency	Narrative Update	Progress RAG rating	
IMPROVE HEALTH									
Work with our partners to join up care in Wakefield	1. To develop and deliver partnership structures and relationships that underpins integrated working 2. To deliver integrated networks in the neighbourhoods of Wakefield which meet the requirements of primary care home objectives whilst fully engaging the communities 3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us 4. To deliver improvement programmes in key areas determined as priorities by the Wakefield ICP. These include (but not limited to): • Elderly and frailty • Mental health (via the Mental health (MH) alliance) • Dementia (via the MH alliance) 5. SWYPFT to take a lead partnership role in the development and delivery of a MH alliance for Wakefield that oversees • the delivery of priority work streams: - Crisis pathway - Personality disorder - Suicide prevention • the delivery of the 8 projects that make up the dementia programme • the delivery of legacy commitments for the following: - Peri-natal mental health investment - Psychiatric liaison core 24 - Children and young people eating disorders - Improving across to psychological therapies-long term conditions (in partnership with Turning Point). • the development and delivery of the Wakefield response to the NHS long term plan for mental health. 6. Working with partners, develop and implement the operational requirements of the districts response to the agreed strategy for the children and young peoples plan priority of emotional wellbeing and mental health.	Sean Rayner	Sharon Carter	Change and Partnership Group	By 31/03/20• All primary care home neighbourhoods will have: - an established integrated leadership team - co-produced priority areas of focus - population health data pack available to underpin decisions - produced stories that demonstrate impact for the people in their area • Each programme area will have delivered on key improvement aims as set out at the beginning of the year.	Monthly on IPR	In February, the Wakefield mental health alliance collectively agreed the work programme for 2020/2021 aiming to deliver the ambitions of the NHS long term plan for mental health and addressing local priorities. This has since been presented to and was endorsed by the Wakefield clinical commissioning group governing body on 10th March 2020, and the investment approved for the following schemes: Children and young people talking therapy Children and young people community navigation Improving access to psychological therapies 25% access rate Preparation for individual placement support Child and adolescent mental health services demand and capacity Trauma aware care Child and adolescent mental health services waiting list initiative 0-18 autistic spectrum disorder pathway Peri-natal mental health Patient flow Mid Yorkshire navigator proposal Electro convulsive therapy (ECT) Lessons learned – review of the mental health alliance systems and processes. Integration of primary and community care Psychology review Wakefield mental health alliance will report progress on both of these key sets of national and local mental health metrics to Wakefield's integrated care partnership during 2020/21. Close working with the mental health stakeholder group, including capturing patient case studies alongside patient/service user feedback from a mental health ongoing engagement programme, will capture the impact that this new investment has had for our residents.	Progress Against Plan	
							Risks are managed by each programme of work, led by transformation lead, reporting to mental health alliance development group on a monthly basis. Areas of risk to report include: individual schemes in the plan will not be measured effectively in terms of their respective impact. The alliance is working on an outcomes and benefits framework as part of risk mitigation.	Management of Risk	
							By 31/03/20 each scheme in the plan will have delivered to the outcomes framework developed. It is envisaged that the schemes will commence reporting against the outcomes measures during 2020/21.		

Work with our partners to join up care in Barnsley	1. To develop and deliver partnership structures and relationships that underpin integrated working 2. To deliver integrated care networks in the six neighbourhoods of Barnsley which meet the requirements for primary care networks whilst fully engaging the communities 3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us 4. To deliver improvement programmes in key areas as identified by the partnership groups. These include: a. Frailty b. Cardio vascular disease c. Stroke 5. To develop and deliver a communication and engagement plan that promotes integrated working, inspires staff to work in different ways and helps create an empowered public that takes more responsibility for their health and wellbeing. To underpin this work with a clear plan for SWYPFT in via the Barnsley and South Yorkshire internal integration group	Salma Yasmeen	Sue Barton	Change and partnership group	By 31/03/20 All six neighbourhoods will have • an established integrated leadership team • co-produced priority areas of focus • population health data pack available to underpin decisions • produced stories that demonstrate impact for the people in their area • The integrated care outcomes framework will be used by partners to begin to demonstrate impact of the different pieces of work • Each programme area will have delivered on key improvement aims as set out at the beginning of the year	Monthly on IPR	Highlights from neighbourhood team mobilisation are as follows: significant work continues on mobilisation of the neighbourhood teams in response to the specification. The majority of this work is in line with the plan with extra focus on estates, information management and technology and performance and information. Partnership mobilisation group continues and regular updates/bulletins via SWYPFT intranet continue. The management of change continues with staff engagement sessions on schedule for completion mid April. Staffing in neighbourhood teams is now established and the physical movement of staff into the neighbourhoods completed. Work has commenced on the Lodge so it is fit for purpose for hosting the single point of access. SystmOne reconfiguration is in progress, as is work on key performance indicators and reporting arrangements. Highlights from the Barnsley integrated care delivery group are as follows: integrated care delivery group (ICDG) have undertaken work to scope out proposed priority areas of work for 2020/21 with a focus on enabling work including workforce, estates and population health management. This will be discussed with the integrated care partnership group (ICPG) in March prior to confirmation. The work on primary care network development, integrated wellbeing teams and the neighbourhood networks will be more closely aligned going forward. The job description for the new programme management role across the integrated care partnership has been submitted for agenda for change banding and the shared leadership model is under development. • Stroke service mobilisation continues with key performance indicators now developed agreed with the clinical commissioning group. • Early supported discharge (ESD) service mobilisation is underway , recruitment to the team is progressing well, and early supported discharge key performance indicators have been agreed with the CCG. The ESD team is expected to commence 16th April 2020; this will be a gradual process to allow training and induction to take place. SWYPFT and Barnsley hospitals NHS foundation trust are linking with information management and technology colleagues regarding SystmOne configuration for new service in order to be able to record and report accordingly.	Progress Against Plan	
							Risks are managed by each programme of work, reporting to the Barnsley integrated care delivery group on a monthly basis. Risks relate to inadequate resources to deliver core hours beyond current service offers and resource envelope. The financial detail is yet to be agreed. Work has been done on this as part of the integrated community teams modelling. In addition a new risk has been identified in relation to e-rostering as the team are unable to accommodate the roll out as planned due to capacity	Management of Risk	
							Implementation plan/key milestones: By 31/07/19 Programme areas have identified key improvement aims for 19/20 By 31/03/20 New integrated community teams to be mobilised		

Working with our partners to join up care in West Yorkshire	Work across the West Yorkshire and Harrogate health & care partnership (WY&HHCP) integrated care system (ICS), including active membership of the West Yorkshire mental health, learning disabilities & autism service collaborative, to deliver shared objectives with our partners in the areas of: • Forensic services including adult, children and learning disability project. SWYPFT is the lead provider for the WY&H adult secure provider collaborative. • Adult mental health services • Learning disability transforming care partnerships • Children and adolescent mental health services whole system pathway development • Suicide prevention • Autism and attention deficit hyperactivity disorder We aim to underpin this work with a clear plan for SWYPFT via the WY internal integration group.	Sean Rayner	Sharon Carter	Change and Partnership Group	By 31/03/20 Each programme area will have delivered on key improvement aims as set out at the beginning of the year, and/or reshaped (rescoped) as determined by the ICS programme board in autumn 2019.	Monthly on IPR	West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) work continues on the programme workstreams, with the following key points reported in February 2020: • Adult secure provision lead provider collaborative (LPC): Following the appointment of Niche in January, the overall LPC project plan has been shared at Board, agreed with partners and programme meeting structures and governance established. Additional funding to support the specialist community forensic team (SCFT) has been secured, procurement process completed and provider confirmed. Implementation of SCFT has been begun and recruitment to the team has commenced. • Operational delivery network (ODN) for learning disability & autism Yorkshire & Humber: The ODN have been invited to support a housing event in March which is been arranged by West Yorkshire ICS. The dynamic risk register group have created 10 minimum standards for dynamic risk register. The next step for the group is to produce a standard operating procedure that services across Yorkshire and Humber would be able to use. The co-production group have conducted a survey which asked people what they think of advocacy. On the 8th January the group held a workshop, the group discussed how advocacy services can access more people in the community and the ODN can support with the changes of advocacy over the last few years. The final version of the out of area agreement has been agreed and this will be distributed to each provider for sign-up. The ODN are hoping this will be signed up to and agreed by the end March. • Suicide prevention: Suicide bereavement/postvention service continues to meet targets despite high levels of referrals. Over 90 referrals to date with average response time of 1.4 days from point of referral. Pathfinder development workers (PDWs) continue to build links throughout WY&H with projects supporting men. WY&H joint work keynote address at PHE national mental health summit. Plans for a suicide prevention campaign across WY&H continue. Final wave funding bid submitted to NHSE/I for next 3 years for WY&H. Funding from NHSE for year 2 (2020/2021) confirmed for postvention service at £173,000. • West Yorkshire transforming care partnership: Working with Inclusion North (IN) to identify opportunities to include people with lived experience in developing the 5 year strategy across West Yorkshire. Identified that forensic new care model has sufficient co production and that Inclusion North are to propose a plan of co-production to support the children & young people work programme. The model/service specification development for safe space continues. Early intervention & prevention - Bradford District Care Trust are to lead on this project and have agreed the scope in line with the initial bid submitted to NHSE. • Perinatal mental health (PMH): In WYHHCP have a partnership approach to regional PMH work and the programme is working closely with the maternity programme. The maternity programme has funded a PMH strategic transformation lead for 12 months and the two programmes have collectively set up a regional PMH steering group with representation from different functions/professions and organisations (including obstetricians, psychiatry leads, PMH provider leads, health visiting, and healthwatch as well as commissioner representation). The core focus of the work is to better understand who is and who is not accessing services and to inform the way in which engagement with and provision of services are undertaken to different communities to ensure equity of access. A regionally commissioned research piece is central to gaining this understanding. One meeting has taken place so far with another one planned in March 2020. • Children and young people attention deficit hyperactivity disorder (ADHD)/autistic spectrum condition (ASC): project agreement to fund AHSN to create case studies around teenagers/young adults with ASC/neurodiversity (capturing their experiences) is now being mobilised. Pre-diagnostic support for families/carers in Bradford (pilot with VCS) is now mobilising through recruitment of peer support workers funded through NHSE bid. • Learning disabilities admission treatment unit (ATU): Mobilisation plan agreed; Joint OSC took place on 18 February 2020 where it was agreed that further engagement, rather than formal consultation, was proportionate to the change. Engagement documentation (including easy read) is being developed. Provider collaboration model and commissioning model being developed to enable the move to mobilise regional ATU bed base to “one ATU system” across existing sites. • Adult autism project: Work continues to formalise a clear work plan including formalising priority areas. A workshop planned for March 2020 to complete this work plan and report to next programme board.	Progress Against Plan	
								Risks are managed by each programme of work, reporting to West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) on an agreed scheduled basis.	Management of Risk	
								Each programme of work has its own implementation plan, overseen and governed via a robust WY&H ICS programme management team.		

IMPROVE CARE									
Provide all care as close to home as possible	To reduce the use of inpatient beds (both out of area and within the Trust) in a way which contributes to increased quality and safety across the whole pathway and improves staff wellbeing.	Carol Harris	Ryan Hunter	Operational management group (with monthly report to executive management team)	To deliver the programme of work described in the driver diagram and associated plans. The programme of work is a mixture of significant change & important improvement projects.	Monthly on IPR	• Recent increase in demand has continued through early 2020 and into March. Psychiatric intensive care unit (PICU) out of area placements remain high particularly for gender specific beds. • A recent out of area stocktake has taken place. Initial findings have found: o Around half of admissions reviewed were not known or not current and we didn't have an opportunity to stop the admission. o Opportunities to do things differently to avoid some admissions in intensive home based treatment, core and enhanced services. Planning now taking place to consider how improvements can be made based on these finding and developing a follow up action plan. • Project briefs have now been established for PICU and performance management / visibility. Activity on PICU is now being taken forward. Performance management / visibility needs agreement of resources and governance route and will then be progressed. Key work strands - update: • Appropriate Inpatient Stays: The CLD refresh check point reviews are underway at the Barnsley wards and feedback so far has been positive. CLD refresh was launched at the Wakefield wards on 27th February and their first check point reviews were held on 12th March. The project is continuing to monitor and support Ashdale ward. Work continues on finding a more permanent solution via SystmOne and a meeting with TPP (S1 suppliers is taking place on 17th March). • Patient flow – The current focus is to work toward an extended hours patient flow that can coordinate activity across the bed based into the evening and at weekends. Extra funding has been agreed across West Yorkshire, though still awaiting confirmation from Barnsley. • Recruitment into the single point of access team has now commenced and a plan is being developed to implement the new triage scale when the additional resourcing is in place. Work is now being taken forward to test e-referral.	Progress Against Plan	
							1) Failure to deliver timely improvement due to lack of resource, other work priorities and skills - There has been some slippage on parts of the programme. This has been highlighted to the steering group and by SSG. Plans have being rebased where there has been slippage. Activity across the programme likely to run well into 2020. CLD refresh to run until Apr 2020. Single point of access set to refresh has slipped – still aiming for early 2020/21 financial year but some elements (i.e. e-referral may take longer). 2) Lack of relevant information and poor data quality could lead to poor decision making and / or poor assessment of changes, leading to: - being unable to quantify impact of some changes - changes having a negative impact - changes leading to other unintended consequences Plans are being developed for longer term sustainability of performance management systems. When the project is given approval to go ahead the likelihood may reduce. 3) Activity required to reduce admissions to beds may not be sustainable in the long term, either due to resources or external pressures. Refresh of sustainability model via self assessment has taken place. 4) Differing cultures across the trust and varying levels of engagement could lead to failure to deliver the proposed changes. Reducing due to work that has already taken place with stakeholders across the Trust. The programme continues to work with key stakeholders including staff to develop and implement the required changes. Regular communication to include thanks and appreciation. To bring even more people into the engagement, including staff, service users/carers.		
									
Make care quickly and easily available in child and adolescent mental health services	Greater positive impact on the lives of young people and their families (Wakefield) Deliver internal quality improvement and be able to demonstrate this to others (Both) Make CAMHs a greater place to work (Both) Work in partnership across the system (Both) Meet the requirements of external bodies (Barnsley)	Carol Harris	Carmain Gibson-Holmes (Wakefield) Kate Jones (Barnsley) Supported by Micele Ezro (Wakefield) and Maeve Boyle (Barnsley)	CAMHs improvement group with monthly report to operational management group	To deliver the programme of work described in the driver diagram, improvement plans and associated action plans. The programme of work is a mixture of significant change & important improvement projects.	Monthly on IPR	Waiting list trajectory for Barnsley has been finalised and presented at March 2020 CAMHS improvement board meeting. Waiting list trajectories for February 2020 have been met by both Barnsley and Wakefield. First meeting regarding common data definitions and performance management involving all CAMHS general/service managers, performance & information manager and improvement leads for Wakefield and Barnsley. Second round of training for all age liaison services has been completed with participants from both Barnsley and Wakefield. Referral process mapping for emergency presentations for Barnsley All Age Liaison Team has been finalised and shared with colleagues in Calderdale & Kirklees and Wakefield. Wakefield CAMHS has been successful in its bids for MH Alliance monies. Wakefield CAMHS crisis service offer in place 7 days a week 8am-9pm. Process mapping of 'current state' completed for Barnsley specialist and ADHD pathways.	Progress Against Plan	
							Barnsley CCG is undertaking another procurement exercise for the Barnsley CAMHs service. Unsettling period for staff due to uncertainty. Regular communications with CAMHs staff as well as staff side representatives.	Management of Risk	
							Implementation plan/key milestones include: By 29/02/20 Wakefield demand and capacity plan refinements to be completed in conjunction with business development team and finance dept. By 29/02/20 - Second round of training for Barnsley all age liaison team with offer of any spare places to Wakefield service. By 02/03/20 - Barnsley and Wakefield all age liaison services are expected to be operational including finalisation of the referral pathway for emergency presentations (for Barnsley). By 28/02/20 - First meeting regarding common data definitions and performance management to be held involving all CAMHs general/service managers, P&I manager and improvement leads for Wakefield and Barnsley.		

IMPROVE RESOURCES									
Make the most of our clinical information	Delivering SystmOne optimisation plan - Following review at programme steering group in October 2019, and agreed at EMT in November, scope for SystmOne optimisation has now reduced to 6 main projects – care plans, risk assessment, tasks, sharing out, and e-referrals, together with an overarching priority around reducing variation/improving data quality. Schedule of programme of work extended to September 2020.	Salma Yasmeen	Sharon Carter	Change and Partnership Group	Completion of phase 1: implementation of clinical record system, SystmOne for MH, project closure report. Completion of phase 1: SystmOne for mental health post implementation review. Build on from lessons learnt into phase 2: optimisation Co create and co deliver all priority areas of optimisation plan	Monthly on IPR	**Formulation Information Risk Management (FIRM)** Work continues to ensure the programme steering group (PSG) and Clinical Safety Design Group (CSDG) are assured of readiness to sign off the co-delivery phase and for roll out of FIRM tool to commence on 20th April 2020. A final series of consolidation events have taken place focussing on the functionality of the tool on SystmOne. These included attendance at SystmOne Improvement Groups (SIGs), demonstration sessions in all localities and attendance at the February Academic Meetings. The feedback from these sessions and further user testing on SystmOne Demo has informed the final amendments to the FIRM framework on SystmOne. Final configuration was signed off on 28th February 2020. As part of the optimisation work plan, an action plan and staff support and guidance plan has been put in place to manage the delivery and go live of the FIRM functionality on SystmOne ahead of implementation. **Sharing** A high level action plan for turning on Record Sharing has been developed giving consideration to Standard Operating Procedure, patient consent and management of risks. The programme team have undertaken an initial scoping exercise/document for consultation with SIGs ahead of submission to the next PSG on 3rd March 2020. **E-Referral** An e-RS Project Group has been established. A high-level scoping document for e-Referral has been developed. Standardisation work for an e-Referral document is complete and has been tested on the local system. It has now been exported to Primary Care SystmOne to set up on the GP practice system for a pilot to commence. Timeline for the pilot to be determined and the outcomes used to inform wider internal discussions for Trust standardisation/adoption, and in evaluation of e-RS options available and their applicability to MH services.	Progress Against Plan	
							Tasks A high level action plan for tasks has been developed giving consideration to Standard Operating Procedure, patient consent and management of risks. The option for using tasks within SystmOne forms part of the wider optimisation programme and closely aligns with the sharing-out of the Trust SystmOne record. Sharing out and task management are system-wide settings so cannot be enabled for a particular GP practice or area. The programme team have undertaken an initial scoping exercise/document for consultation with SIGs ahead of submission to the next PSG on 3rd March 2020. **Reducing Variation/Data Quality** 1. The IHBT and SPA team Event Details Templates have been available in the live environment for these services since 21st October 2019 and reports show a significant improvement in quality of activity recording in these teams since that date. Final sign-off of the Event Templates in Forensic, Mental Health Community and Learning Disability Services are planned at the March SIGs. User Guides and further communications will be provided. 2. Work to review configured lists on SystmOne is complete. The new activity codes have gone live in the LD and ADHD units. Systems team are currently rolling out the changes in other units. This work will assist the organisation in achieving CQUIN CCG5b.		
							CHANGE MANAGEMENT/CLINICAL: The lack of engagement and support to the changes from internal and external stakeholders this will impact on the success of major optimisation activities such as tasks IM&T WORKSTREAM: conflicting priorities for the systems, training, and P&I workstreams (Barnsley reconfiguration) may result in insufficient resources for optimisation activities. CLINICAL RISK: Inadequate number of staff attending the (non-system clinical practice) training and not demonstrating competency through practice will result in the organisation not getting the best use out of the clinical records system and no improvements identified. CLINICAL RISK: missed opportunities to reduce practice/system variation during optimisation may result in inconsistencies in system/operational requirements/applications CLINICAL RISK: The organisation and local policies/procedures do not keep pace with system change which could lead to gaps in practice that will have an impact on patient safety.	Management of Risk	
							Implementation of new MH Care Plans Sept 19 - Dec 19 Risk assessment Sept 19 - Apr 20 Share out Feb 20 - Sept 20 Tasks Feb 20 - Sept 20 E-referral Sept 19 - Sept 20 Reducing variation and improving data quality Sept 19 – Sept 20		
MAKE THIS A GREAT PLACE TO WORK							These programmes of work report at key milestones directly to EMT and thus no update is required via the IPR		

Progress against plan rating	
	On target to deliver within agreed timescales / project tolerances
	ability/confidence to deliver actions within agreed timescales / project tolerances
	ability/capacity to deliver actions within agreed timescales / project tolerances
	Actions will not be delivered within agreed timescales / project tolerances
	Action complete

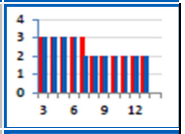
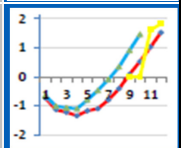
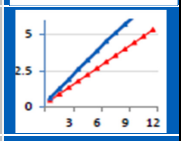
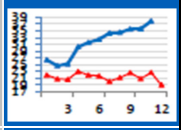
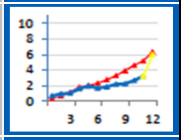
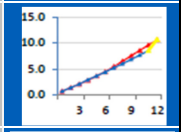
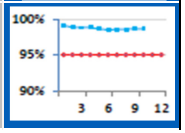
Risk Rating	Likelihood			
Consequence	1 Rare	2 Unlikely	3 Possible	5 Almost certain
5 Catastrophic	5	10	15	25
4 Major	4	8	12	20
3 Moderate	3	6	9	15
2 Minor	2	4	6	10
1 Negligible	1	2	3	5

Green	1 – 3	Low risk
Yellow	4 – 6	Moderate risk
Amber	8 – 12	High risk
Red	15 – 25	Extreme / SUI risk

Glossary:	
C&YP Children and Young People	ATU Assessment and Treatment Unit
ICS Integrated Care System	HASU Hyper acute stroke unit
WY West Yorkshire	SPA single point of access
SYB South Yorkshire and Bassetlaw	NHSEI National Health Service England/ NHS Improvement
NHS National Health Service	IPS individual placement support
PCH Primary Care Hub (also referred to as Primary Care Network)	NMOC new model of care
PCN Primary Care Network (also referred to as Primary Care Hub)	OMG organisational management group
IHBT – Intensive Home Based Treatment	OPS older peoples services
MH mental health	SRU stroke rehabilitation unit
VCS voluntary and community sector	FIRM Formulation informed risk assessment
DBT Dialectic Behavioural Therapy	CSDG clinical safety design group
MOU memorandum of understanding	QI quality improvement
IAPT Improving Access to Psychological Therapies	SPC statistical process control
LTC long term conditions	IHI Institute for Health Improvement
CCG Clinical Commissioning Group	QSIR Quality, Service Improvement and Redesign)
IM&T Information management and technology	SSG an external consultancy company
P&I performance and information	EMT executive management team
ESD Early Supported Discharge	GP General practitioner
WY&H West Yorkshire and Harrogate	TIPD Trauma Informed Personality Disorder
HCP Health Care partnership	SBAR Situation - Background - Assessment – Recommendation – quality improvement tool
LD Learning Disabilities	AMHP Approved mental health professional
UEC Urgent and Emergency Care	RACI roles and responsibilities indicator
BDCFT Bradford District Care Trust	LTP long term plan
SWYPFT South West Yorkshire Partnership Foundation Trust	ICT Integrated change team

Overall Financial Performance 2019/20

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The NHS Improvement risk rating has remained at 2 in February.	
2	Normalised Deficit (excl PSF)	£0.1m	£0.1m	February financial performance is a small deficit of £0.05m excluding Provider Sustainability Fund (PSF). The year to date position is now a £0.06m surplus. Following a review of the risks and opportunities associated with the full year forecast a £300k improvement has been reported in month 11.	
3	Agency Cap	£6.8m	£7.5m	Agency expenditure is higher than plan with £0.6m spent in February, £0.1m above the agency cap set by NHS Improvement. Current projection is that our agency cap will be exceeded by over £2m. Action, lead by the Trust recruitment and retention group, remains focussed on ensuring that any agency expenditure is minimised and as cost effective as possible.	
4	Cash	£37.9m	£34.7m	Cash in the bank continues to be above planned levels; due to opening balances being higher than plan, receipt of provider sustainability funding, timing of capital expenditure and focused working capital management.	
5	Capital	£3.2m	£6m	Capital spend is below plan at the end of February. Forecast remains at £6m and is being closely managed to ensure delivery.	
6	Delivery of CIP	£8.5m	£10.7m	Year to date £8.5m cost reductions have been secured against the original plan with £1.2m of this original plan rated as red with a high risk on delivery. A non-recurrent income benefit of £1.3m will be realised in year enabling achievement of the full year target.	
7	Better Payment	99%		This performance is based upon a combined NHS / Non NHS value and is ahead of plan.	

Red	Variance from plan greater than 15%
Amber	Variance from plan ranging from 5% to 15%
Green	In line, or greater than plan

Plan
Actual
Forecast

Contracting - Trust Board

Contracting Issues - General

In light of the COVID-19 position the 2020/21 operational planning round including contract negotiations has been suspended. For the period 1 April - 31 July commissioners will put in place block account contracts with providers based on nationally determined values. Details of this are likely to be made available by the end of March/early April.

CQUIN

Quarter 3 CQUINs confirmed as achieved across Barnsley and West contracts. Awaiting formal confirmation from NHSE related to medium and low secure services.

Contracting Issues - Barnsley

Work continues in relation to the implementation of the 2019/20 mental health investment plan including Improving access to psychological therapies (IAPT) expansion, extension to development of all age and crisis liaison services and support for children and young people with a diagnosis of attention deficit hyperactivity disorder (ADHD) waiting for treatment. Work continues on the development of integrated neighbourhood teams. The review of neighbourhood nursing implications have been fed into this wider work related to the Barnsley integrated care system specification. Implementation of work related to children's therapies expansion and waiting list reduction is ongoing. Work on the additional waiting list initiate across children's and young people's mental health services is ongoing. Work continues to implement the new early supported discharge team in stroke services. Winter funded proposals include use of discharge co-ordinators and expansion of patient flow work to cover out of hours and weekends. An initial contract offer was received and under review for 2020/21 - now suspended in light of the national COVID-19 position.

Contracting Issues - Calderdale

Implementation continues to develop the mental health crisis intervention services for older people. Key ongoing work priorities include early intervention in psychosis (EIP), reduction in out of area (OOA) in adult mental health, continued development of perinatal services and further development of children and young people's services in line with implementation of the THRIVE model. Work is ongoing to implement individual placement support and to implement additional crisis investment gained through bids to NHSE. Winter funded initiatives are being implemented including children and young peoples crisis service expansion and all age liaison, use of discharge co-ordinators and expansion of patient flow work to cover out of hours and weekends and provision of structured training to support personality disorder pathways. 2020-21 contract offer was under negotiation - now suspended in light of the national COVID-19 position.

Contracting Issues - Kirklees

Kirklees CCGs are providing additional investment for 2019/20 related to key mental health investment standard priority areas including, expansion of children's and young people's crisis services/all age liaison and further expansion of perinatal and IAPT services. Kirklees CCGs have also confirmed additional investment for adult ADHD services. Contract negotiations for 2020/21 are underway. Key ongoing work priorities include continued development of psychological therapies for adults covering both core and long term conditions services, expansion of early intervention in psychosis services, continued development of perinatal services transformation of mental health services for older people to support provision of care closer to home through community based provision. Commissioners are making additional investment to support the further development of pathways for people with personality disorder. Work is ongoing to implement additional crisis investment gained through bids to NHSE. Winter funded initiatives include discharge co-ordinators and expansion of patient flow work to cover out of hours and weekends and provision of structured training to support personality disorder pathways. 2020-21 contract offer was under negotiation - now suspended in light of the national COVID-19 position.

Contracting Issues - Wakefield

Key ongoing work priorities include continued development of perinatal mental health services, development of all age liaison psychiatry and the expansion of crisis services and support for addressing waiting lists for children and young people with a mental health need. Work continues in implementation of the additional mental health investment streams related to increasing capacity within the intensive home based treatment team, expanding capacity for police liaison and providing new capacity to offer dialectic behavioural therapy within community mental health teams. Work has commenced in relation to contract negotiations for 2020/21 contracts. Additional waiting list initiatives are progressing related to children's and young people's services in Wakefield as part of the 2019/20 mental health investments. Wakefield CCG has confirmed additional investment to March 2020 to provide additional resources to support health screening and those with substantial health needs residing at the Urban House initial accommodation centre. Winter funded initiatives include children and young people's expansion to crisis services and all age liaison services, use of discharge co-ordinators, expansion of patient flow work to cover out of hours and weekends and additional support for the intensive home based treatment support line. A contract offer was received and under review for 2020/21- now suspended in light of the national COVID-19 position.

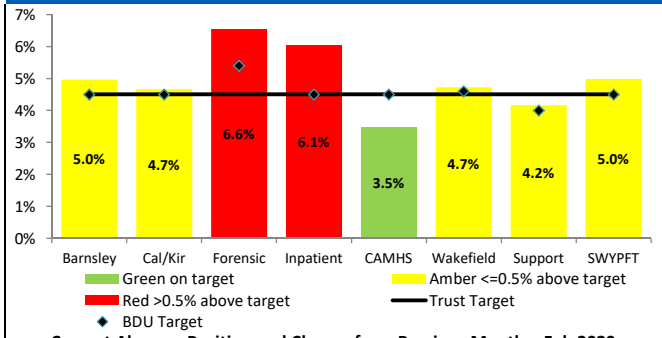
Contracting Issues - Forensics

The key priority work stream for 2019/20 remains the review and reconfiguration of the medium and low secure service beds as part of the work with NHS England in addressing future bed requirements as part of the wider regional and West Yorkshire integrated care system work. SWYPFT successful in a bid to become the lead provider for the West Yorkshire collaborative for adult secure services on the further development track work stream to commence from April 2021. 2020-21 contract offer was awaited - now suspended in light of the national COVID-19 position.

Workforce

Human Resources Performance Dashboard - February 2020

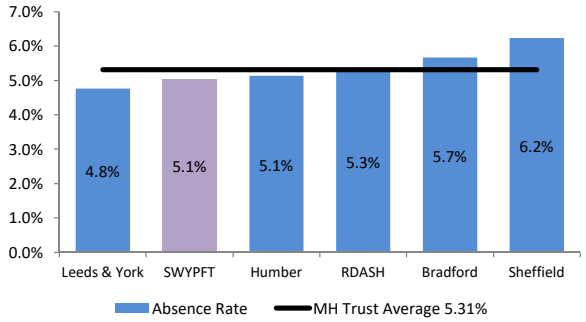
Sickness Absence



Current Absence Position and Change from Previous Month - Feb 2020

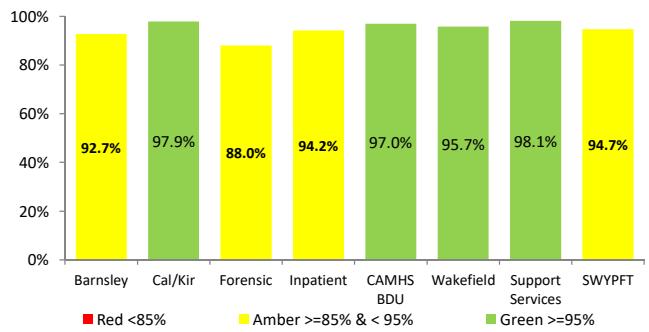
	Barn	Cal/Kir	Fore	Inpat	CAMHS	Wake	Supp	SWYPFT
Rate	5.1%	4.5%	6.1%	5.6%	2.4%	3.9%	3.6%	4.6%
Change	↑	↓	↑	↓	↓	↓	↑	↓

The Trust YTD absence levels in January 2020 (chart above) were above the target at 5%.
The YTD cost of sickness absence is £5.6m. If the Trust had met its target this would have been £5.0m, saving £0.5m.



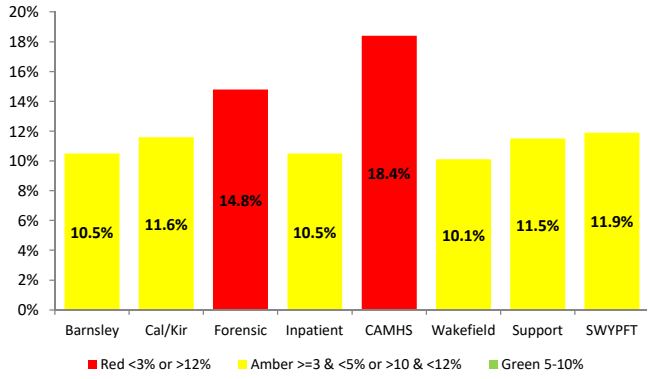
The above chart shows the YTD absence levels in MH/LD Trusts in our region for 2018-19 financial year.
During this time the Trust's absence rate was 5% which is below the regional average of 5.3%.

Appraisals - All Staff

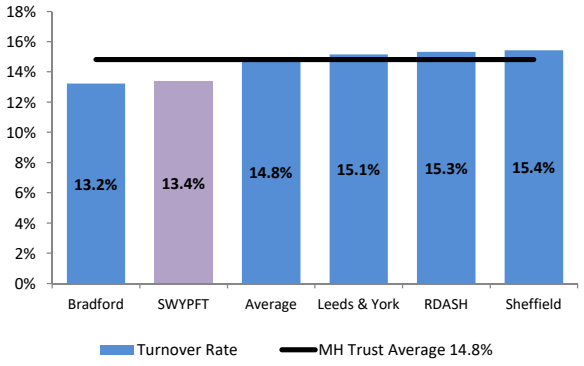


The above chart shows the appraisal rates for the Trust to the end of January 2020.
Until August, the figures only included staff on Band 6 and above. From September's report onwards, they include all staff.
The Trust target for all staff is to reach 95% by the end of September.

Turnover and Stability Rate Benchmark

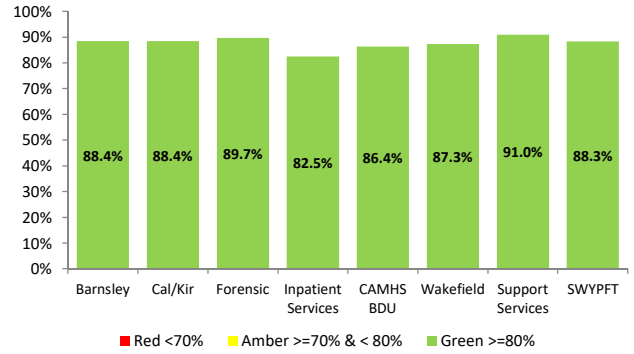


This chart shows the YTD turnover levels up to the end of February 2020.
The Recruitment, Retention, and Agency steering group is reviewing areas of high turnover.
The turnover data excludes decommissioned services.



This chart shows turnover rates in MH Trusts in the region 2018-19.
This is calculated as: leavers/average headcount
These figures include temporary staff who are usually excluded from the Trust's local reports and so these figures are higher than ours.
Decommissioned services are included in this benchmark data.

Fire Lecture Attendance



The chart shows the 12 month rolling year figure for fire lectures to the end of February 2020.
All areas and the Trust continue to achieve the 80% target.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	5.1%	5.0%	4.7%	4.7%	4.9%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	5.1%	4.6%	4.7%	4.7%	5.20%	5.30%	5.10%	5.10%	5.10%	5.0%	5.30%	5.0%	4.6%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	99.1%	99.1%	6.3%	19.8%	66.20%	76.20%	80.30%	83.80%	91.6%	93.0%	93.2%	94.1%	95.3%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	97.5%	97.5%	0.2%	1.5%	7.8%	26.40%	39.10%	69.70%	86.8%	89.7%	91.7%	93.2%	94.2%
Aggression Management	Improving Care	Well Led	AD	>=80%	82.9%	81.7%	81.6%	82.8%	84.0%	84.3%	84.0%	82.8%	82.8%	81.3%	80.5%	80.9%	81.6%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	81.4%	80.7%	80.2%	80.1%	81.3%	81.3%	82.8%	83.0%	83.6%	83.6%	81.9%	81.2%	80.9%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	88.7%	88.4%	87.9%	88.7%	88.3%	86.8%	87.8%	88.7%	88.6%	88.5%	88.6%	89.2%	89.0%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	91.0%	90.3%	89.6%	89.8%	90.3%	91.2%	91.2%	91.5%	92.0%	92.3%	92.1%	92.6%	92.4%
Fire Safety	Improving Care	Well Led	AD	>=80%	84.9%	84.6%	84.6%	84.6%	85.7%	86.1%	85.5%	86.6%	86.8%	87.4%	87.9%	88.3%	88.3%
Food Safety	Improving Care	Well Led	AD	>=80%	83.7%	83.4%	83.6%	83.6%	83.3%	83.8%	83.0%	82.0%	81.9%	82.5%	83.0%	82.3%	81.6%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	90.4%	89.9%	90.5%	90.8%	91.1%	91.7%	91.7%	92.2%	92.0%	91.3%	91.0%	90.4%	89.1%
Information Governance	Improving Care	Well Led	AD	>=95%	97.6%	98.5%	97.2%	94.3%	94.5%	94.5%	94.0%	94.2%	94.0%	92.8%	94.1%	90.4%	98.0%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	88.9%	90.5%	90.4%	91.4%	91.8%	92.0%	91.9%	91.7%	92.1%	91.9%	92.0%	92.1%	92.2%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	92.5%	91.7%	91.2%	91.7%	91.6%	92.4%	92.7%	93.2%	93.9%	93.5%	92.5%	92.3%	90.5%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	86.4%	84.5%	84.2%	85.2%	86.8%	88.2%	88.6%	88.8%	90.2%	90.8%	89.8%	90.1%	87.2%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	86.8%		75.5%			74.2%			72.5%			Due April 20	
Prevent	Improving Care	Well Led	AD	>=80%						80.8%	81.5%	83.5%	86.0%	87.1%	88.8%	90.8%	91.1%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	93.4%	92.9%	92.4%	92.5%	93.2%	93.5%	93.8%	94.2%	94.4%	94.1%	94.1%	94.0%	94.3%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	90.9%	91.1%	89.6%	91.0%	91.7%	92.2%	92.3%	91.5%	91.8%	89.8%	89.0%	89.8%	90.7%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	94.5%	94.9%	94.0%	94.8%	95.1%	95.2%	95.9%	96.0%	96.3%	96.0%	96.5%	97.3%	97.1%
Bank Cost	Improving Resources	Well Led	AD	-	£1048k	£772k	£625k	£844k	£695k	£708k	£889k	£770k	£700k	£887k	£705k	£769k	£685k
Agency Cost	Improving Resources	Effective	AD	-	£545k	£634k	£613k	£641k	£619k	£722k	£629k	£628k	£674k	£572k	£559k	£537k	£581k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£476k	£482k	£479k	£494k	£513k	£543k	£501k	£501k	£545k	£509k	£548k	£518k	£440k
Business Miles	Improving Resources	Effective	AD	-	270k	289k	274k	240k	293k	281k	245k	284k	264k	317k	272k	273k	302k
Health & Safety																	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	Reporting commenced 19/20		7			4			Due Feb 20			Due April 20	

1 - this does not include data for medical staffing.

Mandatory Training
• The Trust is meeting its mandatory training targets including information governance which achieved 98% at the end of February. A review of mandatory training requirements is taking place in light of the impact of the Covid pandemic

Appraisals
• Appraisal completion rate for band 6 and above improved to 95.3% and is therefore above target

Sickness Absence
• Year to date sickness at the end of February remains at 5.0%. Sickness reduced from 5.0% to 4.6% month on month and compares to 5.2% in February 2019. Clearly we should expect an adverse impact from Covid on sickness rates in the coming months.

Turnover
• Turnover reduced from 12.1% in January to 11.3% February. The comparative for last year is 12.0%.

Publication Summary

This section of the report identifies publications that may be of interest to the board and its members.

Direct access audiology waiting times: November 2019

NHS workforce statistics: October 2019

NHS sickness absence rates: July 2019 to September 2019, provisional statistics

Diagnostic imaging dataset: September 2019

Seasonal flu vaccine uptake in children of primary school age: monthly data, 2019 to 2020

Seasonal flu vaccine uptake in health care workers: monthly data, 2019 to 2020

Provisional monthly Hospital Episode Statistics for admitted patient care, outpatient and accident and emergency data: April 2019 – December 2019

Mental health services monthly statistics: final November, provisional December 2019

Out of area placements in mental health services: November 2019

Psychological therapies: reports on the use of IAPT services, England November 2019 final, including reports on the IAPT pilots

Community services statistics: October 2019

Mental health community teams activity: Q3 2019/20

Diagnostic imaging dataset: October 2019

Quarterly hospital activity data: Q3 2019/20

NHS vacancy statistics: England, February 2015 - December 2019, experimental statistics

NHS sickness absence rates: October 2019, provisional statistics

NHS workforce statistics: November 2019

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

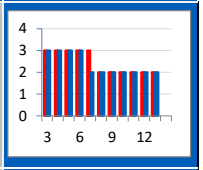
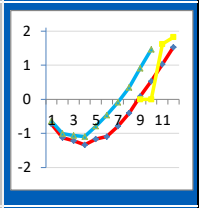
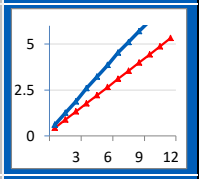
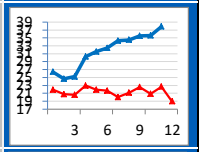
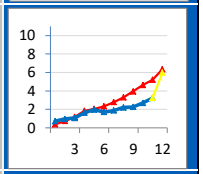
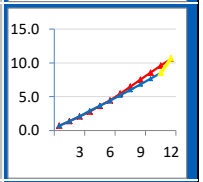
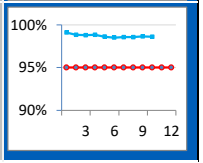
Month 11
(2019 / 20)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0 Executive Summary / Key Performance Indicators

	Performance Indicator	Year To Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The NHS Improvement risk rating has remained at 2 in February.	
2	Normalised Surplus / (Deficit) (excl PSF)	£0.1m	£0.1m	February financial performance is a small deficit of £0.05m excluding Provider Sustainability Fund (PSF). The year to date position is now a £0.06m surplus. Following a review of the risks and opportunities associated with the full year forecast a £300k improvement has been reported in month 11.	
3	Agency Cap	£6.8m	£7.5m	Agency expenditure is higher than plan with £0.6m spent in February, £0.1m above the agency cap set by NHS Improvement. Current projection is that our agency cap will be exceeded by over £2m. Action, lead by the Trust recruitment and retention group, remains focussed on ensuring that any agency expenditure is minimised and as cost effective as possible.	
4	Cash	£37.9m	£34.7m	Cash in the bank continues to be above planned levels; due to opening balances being higher than plan, receipt of provider sustainability funding, timing of capital expenditure and focused working capital management.	
5	Capital	£3.2m	£6m	Capital spend is below plan at the end of February. Forecast remains at £6m and is being closely managed to ensure delivery.	
6	Delivery of CIP	£8.5m	£10.7m	Year to date £8.5m cost reductions have been secured against the original plan with £1.2m of this original plan rated as red with a high risk on delivery. A non-recurrent income benefit of £1.3m will be realised in year enabling achievement of the full year target.	
7	Better Payment	99%		This performance is based upon a combined NHS / Non NHS value and is ahead of plan.	

Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

Plan
Actual
Forecast

1.1 NHS Improvement Finance Rating

The Trust is regulated under the Single Oversight Framework and the financial metric is based on the Use of Resources calculation as outlined below. The Single Oversight Framework is designed to help NHS providers attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right.

			Actual Performance		Plan - Month 11	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	3.8	1	3.4	1
	20%	Liquidity (Days)	31.6	1	17.8	1
Financial Efficiency	20%	I & E Margin	0.8%	2	0.5%	2
Financial Controls	20%	Distance from Financial Plan	0.5%	1	0.0%	1
	20%	Agency Spend	39%	3	11%	2
Weighted Average - Financial Sustainability Risk Rating				2		1

Impact

The rating remains at 2 for February. The I & E margin needs to increase to 1% for this rating to be 1.

The agency rating is the only metric which is lower than planned. If spend increases to 50% more than cap then this would reduce to 4 and mean that a maximum 3 rating could be achieved.

Definitions

Capital Servicing Capacity - the degree to which the Trust's generated income covers its financing obligations; rating from 1 to 4 relates to the multiple of cover.

Liquidity - how many days expenditure can be covered by readily available resources; rating from 1 to 4 relates to the number of days cover.

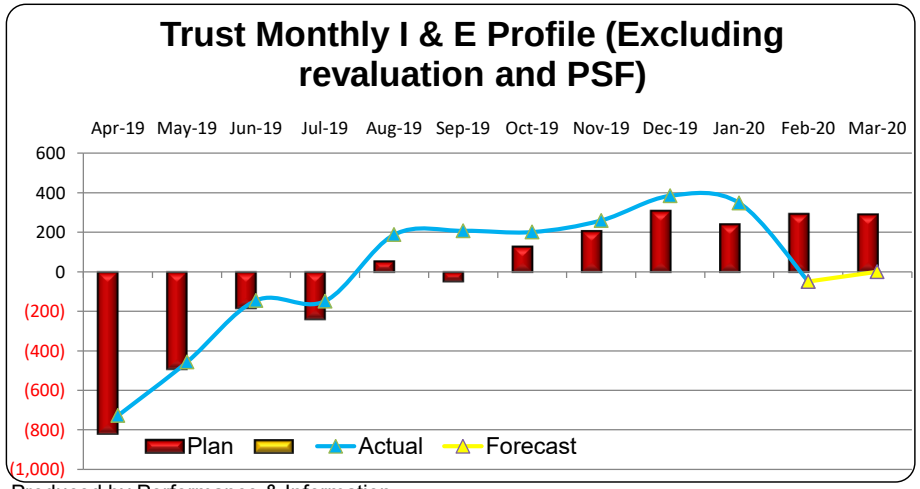
I & E Margin - the degree to which the organisation is operating at a surplus/deficit

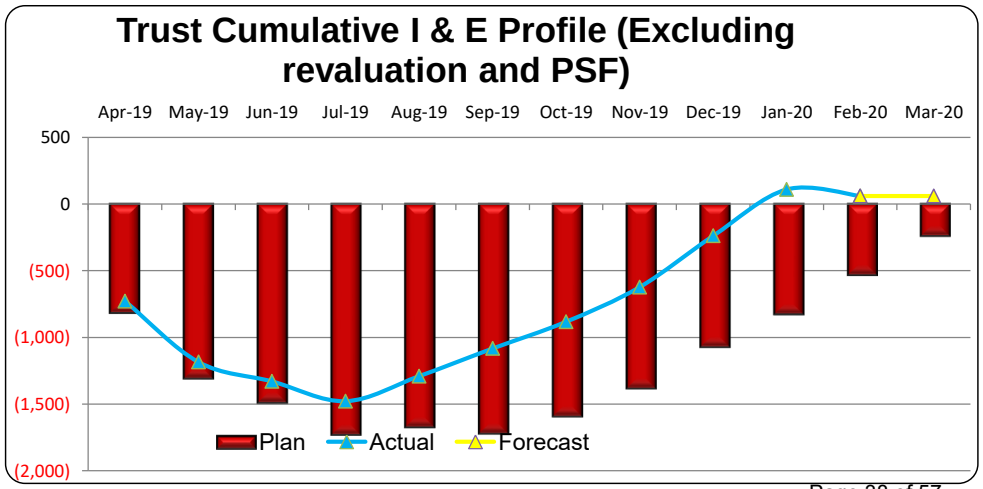
Distance from plan - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

Agency Cap - A cap of £5.3m has been set for the Trust in 2019 / 2020. This metric compares performance against this cap.

2.0 Income & Expenditure Position 2019 / 2020

Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				18,438	18,334	(104)	Clinical Revenue	197,025	196,327	(698)	215,687	215,055	(632)
				18,438	**18,334**	**(104)**	**Total Clinical Revenue**	**197,025**	**196,327**	**(698)**	**215,687**	**215,055**	**(632)**
				1,316	1,403	87	Other Operating Revenue	13,870	13,984	114	15,091	15,491	400
				19,754	**19,737**	**(17)**	**Total Revenue**	**210,895**	**210,311**	**(584)**	**230,778**	**230,546**	**(232)**
4,389	4,160	(229)	5.2%	(15,430)	(14,896)	534	Pay Costs	(166,518)	(160,436)	6,081	(181,993)	(175,686)	6,306
				(3,740)	(4,954)	(1,214)	Non Pay Costs	(39,655)	(40,044)	(389)	(43,541)	(45,482)	(1,941)
				370	948	578	Provisions	2,014	(2,024)	(4,037)	2,444	(849)	(3,293)
				0	(175)	(175)	Gain / (loss) on disposal	0	(220)	(220)	0	(220)	(220)
4,389	**4,160**	**(229)**	**5.2%**	**(18,799)**	**(19,077)**	**(278)**	**Total Operating Expenses**	**(204,159)**	**(202,723)**	**1,435**	**(223,090)**	**(222,237)**	**853**
4,389	**4,160**	**(229)**	**5.2%**	**955**	**660**	**(295)**	**EBITDA**	**6,736**	**7,587**	**851**	**7,688**	**8,308**	**620**
				(442)	(504)	(62)	Depreciation	(4,860)	(5,242)	(382)	(5,302)	(5,746)	(444)
				(227)	(227)	0	PDC Paid	(2,499)	(2,499)	0	(2,726)	(2,726)	0
				8	22	13	Interest Received	92	214	122	100	224	124
4,389	**4,160**	**(229)**	**5.2%**	**294**	**(49)**	**(343)**	**Normalised Surplus / (Deficit) Excl PSF**	**(531)**	**60**	**591**	**(240)**	**60**	**300**
				206	206	0	PSF (Provider Sustainability Fund)	1,560	1,560	0	1,765	1,765	0
4,389	**4,160**	**(229)**	**5.2%**	**500**	**157**	**(343)**	**Normalised Surplus / (Deficit) Incl PSF**	**1,029**	**1,620**	**591**	**1,525**	**1,825**	**300**
				0	0	0	Revaluation of Assets	0	5,719	5,719	0	5,719	5,719
4,389	**4,160**	**(229)**	**5.2%**	**500**	**157**	**(343)**	**Surplus / (Deficit)**	**1,029**	**7,339**	**6,310**	**1,525**	**7,544**	**6,019**





Income & Expenditure Position 2019 / 20

February 2020 position is a small deficit due to the timing of expenditure agreed in year.

Month 11

The February position is a pre PSF deficit of £49k and a post PSF surplus of £157k, this is £343k behind plan. This is the first month in the last seven months where the Trust has been in deficit. This is due to the timing of some expenditure ahead of the financial year-end, particularly IT and furniture and fittings identified through the Trust PLACE audits.
Pay expenditure has continued to be lower than plan; however this has been offset by income being lower than plan with some income risks being recognised.

Income

The year to date clinical revenue position recognises risk around CQUIN delivery and other known risks. We continue to work with commissioners to finalise potential additional investment in 2019/20 (effectively priming recurrent investment in 2020/21).

Pay Expenditure

Pay budgets have continued to underspend; £534k in February. Trust working groups on recruitment and retention continue to progress action plans and as such additional recruitment is planned meaning increased expenditure in future months. Additional analysis is included within the pay information report to highlight the different expenditure levels across the services.

Additional information is also highlighted within the report on agency spend. The maximum agency cap set by NHSI for 2019/20 has been set at £5.3m. In February agency costs are £581k which is higher than cap.

Non Pay Expenditure

Non pay is more than plan in February (£456k) and is cumulatively is £0.4m more than the same period last year. This is the first month where 2019/20 spend surpasses 2018/19. The report highlights expenditure on out of area placements which, whilst still a major area of focus, is £2m lower than last year. More details are included within the out of area focus page. However expenditure control continues in the majority of categories.

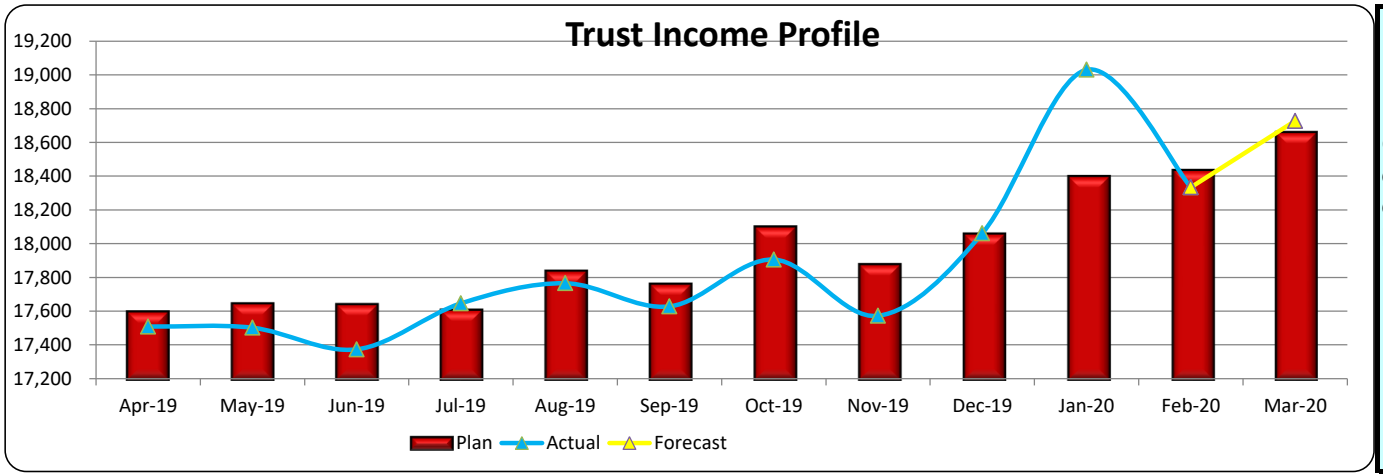
Forecast

Following a review of financial risks and opportunities the Trust has revised the forecast to a surplus, pre PSF, of £0.1m. This is an improvement of £0.3m from the overall total. This is based on individual Trust risks but in doing so will help the Integrated Care System (ICS) delivery its control total and in turn secure the collective PSF funding.

Income Information

The table below summarises the year to date and forecast income by commissioner group. This is identified as clinical revenue within the Trust income and expenditure position (page 5). The majority of Trust income is secured through block contracts and therefore there has traditionally been little variation to plan. This is subject to regular discussions and triangulation with commissioners to ensure that we have no differences of expectation. This is periodically formally assessed by NHS England and Improvement.

	Apr-19 £k	May-19 £k	Jun-19 £k	Jul-19 £k	Aug-19 £k	Sep-19 £k	Oct-19 £k	Nov-19 £k	Dec-19 £k	Jan-20 £k	Feb-20 £k	Mar-20 £k	Total £k	Total 18/19 £k
CCG	9,999	9,999	9,868	10,028	9,973	10,032	10,211	10,053	10,177	11,132	10,380	10,353	**122,203**	**146,036**
Specialist Commissioner	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,075	2,025	2,025	**24,347**	**23,356**
Alliance	1,295	1,295	1,295	1,295	1,295	1,334	1,332	1,264	1,388	1,453	1,408	1,337	**15,991**	**14,596**
Local Authority	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**5,074**
Partnerships	614	614	670	631	633	494	744	499	751	583	623	641	**7,495**	**7,172**
Other	3,576	3,570	3,516	3,668	3,839	3,743	3,594	3,732	3,721	3,789	3,898	4,372	**45,018**	**6,708**
Total	**17,509**	**17,502**	**17,373**	**17,646**	**17,765**	**17,628**	**17,906**	**17,572**	**18,061**	**19,031**	**18,334**	**18,727**	**215,055**	**202,942**
18/19	16,696	16,620	16,853	17,044	16,707	16,750	16,684	16,858	17,169	16,752	17,303	17,506	**202,942**	



Income is broadly in line with plan in February 2020.

Good progress has already been made in contract discussions for 2020/21 with further investment being discussed in line with national planning guidance and the Mental Health Investment Standard.

2.1 Pay Information

Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for 79% of our budgeted total expenditure.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs. Additional analysis has been included to highlight the varying levels of overspend by service and is the focus of the key messages below.

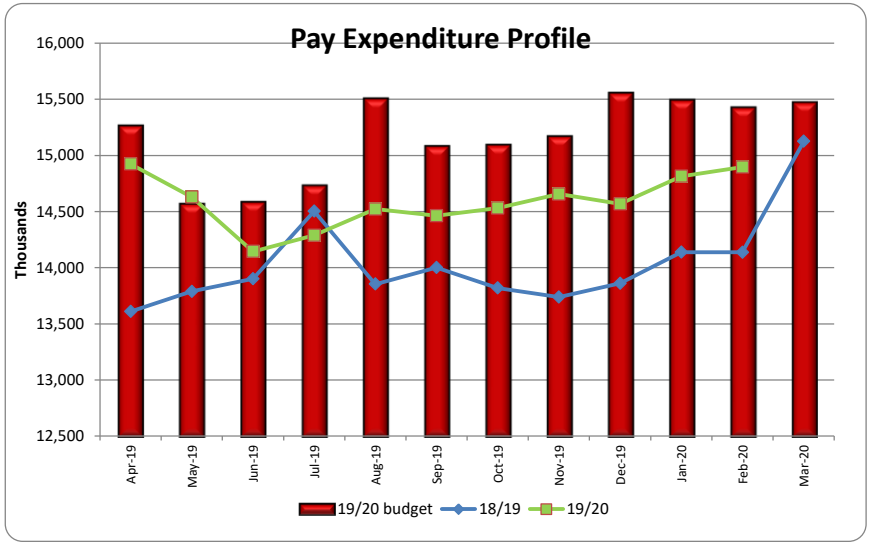
	Apr-19 £k	May-19 £k	Jun-19 £k	Jul-19 £k	Aug-19 £k	Sep-19 £k	Oct-19 £k	Nov-19 £k	Dec-19 £k	Jan-20 £k	Feb-20 £k	Mar-20 £k	Total £k
Substantive	13,647	13,082	12,768	12,819	12,959	13,014	13,063	13,147	13,207	13,404	13,568		**144,679**
Bank & Locum	663	906	752	747	934	821	794	938	767	853	746		**8,922**
Agency	613	641	624	722	628	628	674	572	594	558	581		**6,836**
Total	**14,923**	**14,629**	**14,145**	**14,288**	**14,522**	**14,463**	**14,531**	**14,656**	**14,568**	**14,815**	**14,896**	**0**	**160,436**
18/19	13,610	13,789	13,901	14,503	13,854	14,000	13,819	13,738	13,861	14,138	14,137	15,126	**168,476**
Bank as %	4.4%	6.2%	5.3%	5.2%	6.4%	5.7%	5.5%	6.4%	5.3%	5.8%	5.0%		5.6%
Agency as %	4.1%	4.4%	4.4%	5.0%	4.3%	4.3%	4.6%	3.9%	4.1%	3.8%	3.9%		4.3%

Year to Date Budget v Actuals - by staff group

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
Medical	21,646	17,236	624	3,334	21,193	453
Nursing Registered	59,738	48,551	3,093	473	52,117	7,621
Nursing Unregistered	18,137	16,291	4,192	1,690	22,173	(4,037)
Other	40,872	39,192	395	1,290	40,877	(5)
BDU Admin	11,725	9,981	443	10	10,434	1,291
Corporate Admin	14,418	13,428	175	39	13,642	776
Total	**166,536**	**144,679**	**8,922**	**6,836**	**160,436**	**6,099**

Year to date Budget v Actuals - by service

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
MH Community	72,765	61,778	1,726	4,164	67,669	5,097
Inpatient	42,434	34,462	6,235	2,255	42,952	(518)
BDU Support	6,149	5,909	170	10	6,089	60
Community	19,716	18,798	353	247	19,398	318
Corporate	25,473	23,732	438	160	24,329	1,143
Total	**166,536**	**144,679**	**8,922**	**6,836**	**160,436**	**6,100**



Key Messages

The Trust has received significant additional investment during 2019/20 for new services and further commissioner investment in existing services. This investment remains primarily workforce based and as such mobilisation and recruitment has been taking place. As a result absolute pay expenditure is higher than last year (including the impact of pay awards, increments etc under Agenda For Change).

In January pay underspent by £534k. Year to date underspend is £6.1m. Temporary staffing provided by both agency and bank totals £15.8m (10% of total pay expenditure). Often staffing requirements and vacancies are required within different services or BDUs within the Trust. The service, quality and financial impact of this is considered as part of the monthly internal review.

These differences are shown in the tables above with overspends in adult acute inpatient wards. Mobilisation of a sustainable workforce strategy continues although the financial effectiveness to date has been impacted by exceptional levels of sickness and cases of acuity above those normally expected. This has included utilising additional unregistered nurses to support known recruitment and retention issues in registered nurses.

The shortfall in registered nursing compared to plan is clearly evident from the numbers above. This is being partly compensated for by additional spend on the non-registered workforce.

2.1 Agency Expenditure Focus

The NHS Improvement agency cap is £5.3m

Spend, for the year to date, is £2m more than cap.

Agency costs continue to remain a focus for the NHS nationally and for the Trust. As such separate analysis of agency trends is presented below.

The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.

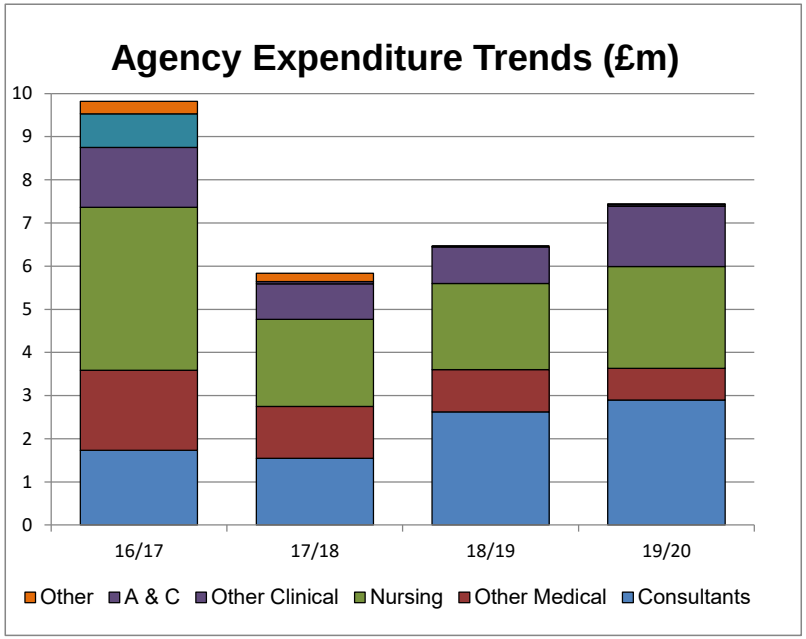
The maximum agency cap established by NHSI for 2019/20 is £5.3m which is £0.1m higher than the 2018/19 cap. In 2018/19 spend was £6.5m which breached the cap by £1.3m (24%). The NHSI agency cap has been profiled equally across the year with a maximum spend of £443k a month. The Trust plan assumed spend in excess of the cap at £5.9m.

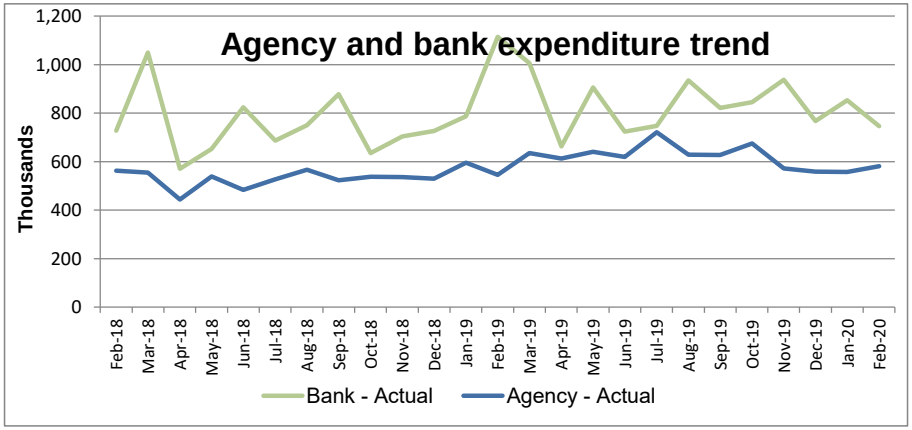
Actual agency usage continues to be reported to NHS England and Improvement on a weekly basis.

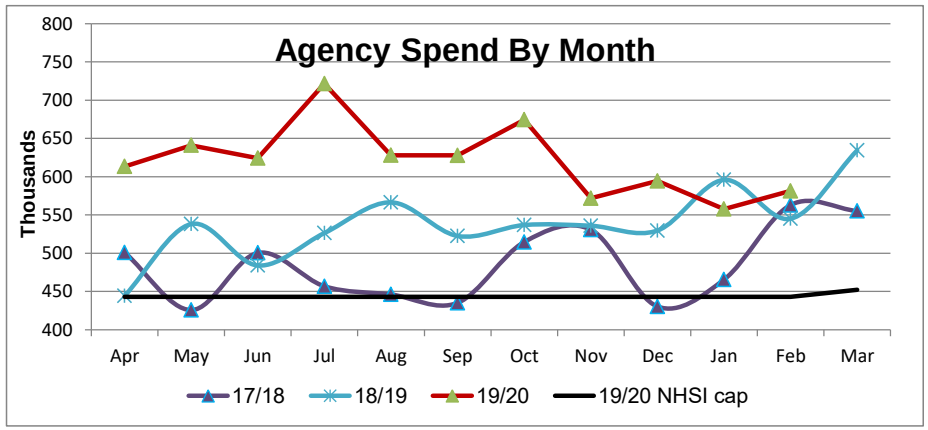
February spend is £581k, 26% above cap. This is slightly lower than the average monthly run rate. Cumulative spend is £6.8m which is 40% above cap and 17% higher than the same period last year.

The current forecast, based upon these plans, is £7.5m although this continues to be assessed. Currently £0.5m relates to additional staffing from commissioner investment (waiting lists etc) with the remainder covering recurrent issues such as vacancies. This could potentially increase as additional investment is identified in year. Due to the one off nature of this investment, agency is often the only real option.

Bank and locum expenditure in February 2020 is £0.7m which is a marginal reduction from the last couple of months.





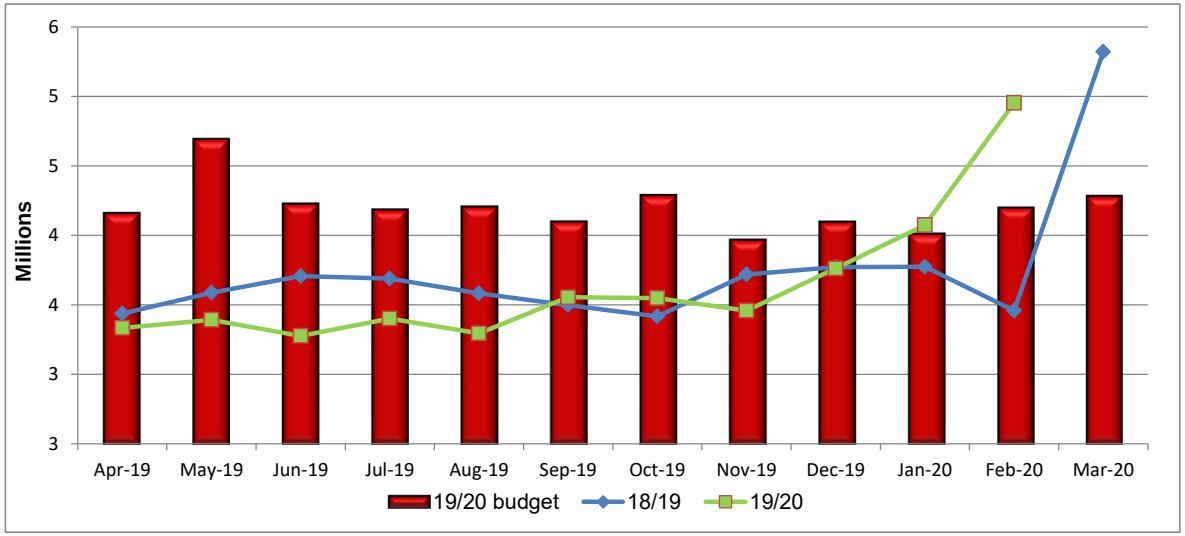


2.1 Non Pay Expenditure

Whilst pay expenditure represents over 80% of all Trust expenditure, non pay expenditure presents a number of key financial challenges. This analysis focuses on non pay expenditure within the BDUs and corporate services and therefore excludes provisions and capital charges (depreciation and PDC).

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
2019/20	3,333	3,391	3,276	3,400	3,295	3,554	3,547	3,458	3,762	4,073	4,954		**40,044**
2018/19	3,437	3,588	3,706	3,689	3,582	3,498	3,417	3,719	3,771	3,773	3,458	5,321	**44,959**

	Budget	Actual	Variance
	Year to date	Year to date	
Non Pay Category	£k	£k	£k
Clinical Supplies	2,412	2,618	(206)
Drugs	3,350	3,256	94
Healthcare subcontracting	4,702	4,515	188
Hotel Services	1,703	1,607	96
Office Supplies	4,823	5,399	(577)
Other Costs	4,448	4,571	(123)
Property Costs	6,327	6,662	(335)
Service Level Agreements	5,685	5,638	47
Training & Education	546	459	87
Travel & Subsistence	3,254	2,866	388
Utilities	1,172	1,315	(144)
Vehicle Costs	1,232	1,137	95
Total	**39,655**	**40,044**	**(389)**
Total Excl OOA and Drugs	**31,602**	**32,273**	**(671)**



Key Messages

As noted in the overall financial position there has been increased spend in February 2020. The majority of this has been non pay related with a sharp rise in the graph above, c. £1.4m higher than average.

A contributing factor has been the increased level of spend in the out of area placement category. Full details of spend is provided on the out of area focus page with February 2020 being the highest indiviudal month since April 2019. Other areas of spend include investment in IT equipment such as laptops (office supplies) to support the Windows 10 implementation. .

We continue to see savings in travel and subsistence costs and, to a lesser extent, in training.

To support this the non pay review group continues to focus on areas of waste and inefficiency to ensure that all non pay expenditure offers value for money in line with the Trust priorities.

2.1 Out of Area Beds Expenditure Focus

In this context the term out of area expenditure refers to spend incurred in order to provide clinical care to service users in non-Trust facilities. The reasons for taking this course of action can often be varied but some key reasons are highlighted below.

- Specialist health care requirements of the service user not available directly from the Trust or not specifically commissioned.
- No current bed capacity to provide appropriate care

On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Wherever possible service users are placed within the Trust geographical footprint.

This analysis is for the out of area placements relating to adult acute beds including PICU in all areas. This excludes activity relating to locked rehab in Barnsley

Out of Area Expenditure Trend (£)

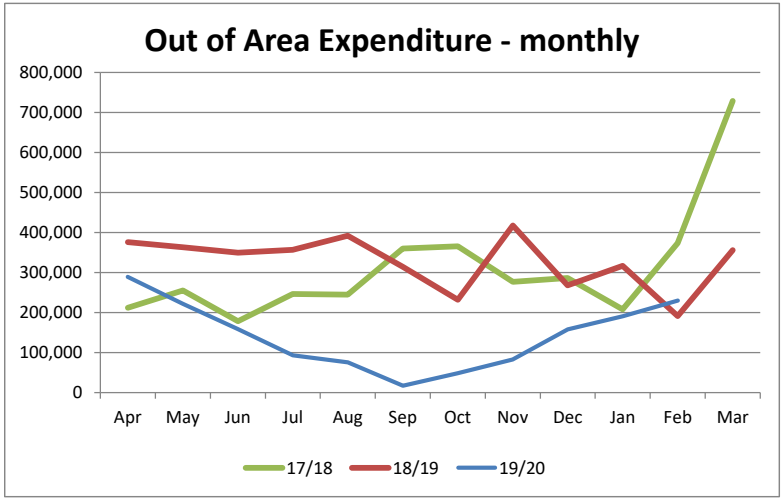
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**
19/20	289	222	158	93	76	17	48	82	158	191	230		**1,565**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
17/18	282	367	253	351	373	427	479	434	414	276	626	762	**5,044**
18/19	607	374	412	501	680	473	245	508	329	358	197	220	**4,904**
19/20	282	354	238	206	156	28	53	129	166	218	302		**2,132**

Bed Day Information 2019 / 2020 (by category)

PICU	32	26	30	26	0	0	15	18	29	26	32		**234**
Acute	160	277	178	150	142	24	7	41	42	124	143		**1,288**
Appropriate	90	51	30	30	14	4	31	70	95	68	127		**610**
Total	282	354	238	206	156	28	53	129	166	218	302	0	**2,132**



In 2019/20 the PICU out of area budget has been set to fund 2 appropriate out of area placements at any time. The acute out of area budget is phased to fund 9 out of area placements in April 2019 reducing to 5 placements by March 2020.

Reductions have been achieved in the first half of the year which have helped in reducing spend by £2m compared to the same 11 month period the previous year. This equates to 2,552 less bed days.
Monthly increases since October 2019 have demonstrated the issues with maintaining low levels sustainably going forwards. Focus remains on reducing this and ensuring minimised future requirements. Costs incurred in February were the highest since April 2019, which is a concerning trend as we move into 2020/21.

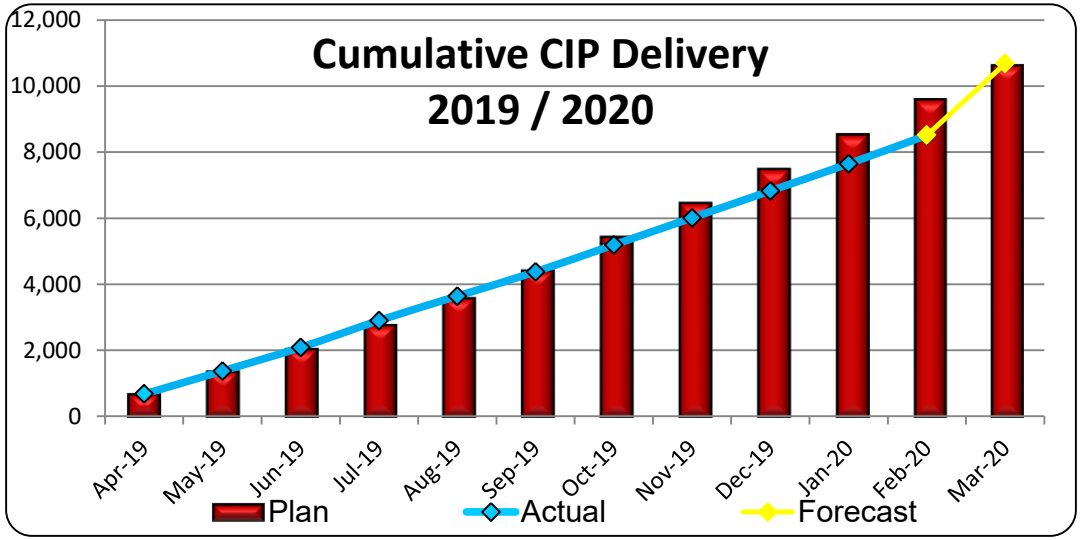
2.1 Cost Improvement Programme 2019 / 2020

The Trust priorities for 2019/20 includes Improving the Use of Resources. This is the drive to improve quality and reduce costs in order to meet our financial targets. We will do this by ensuring we spend money wisely and reduce waste.

The financial element of this priority is recorded below with schemes identified as part of the Trust Cost Improvement Programme (CIP) being monitored for actual performance against those originally planned.

There are additional efficiencies and savings made within the overall financial position; only those with identified schemes and Quality Impact assessments are captured here, although all contribute to the overall position.

The Trust has set a challenging CIP target for 2019/20 of £10.6m which included £1.4m of unidentified savings at the beginning of the year.



CIP Monitoring	Year to Date Plan £k	Year to Date Actual £k	Forecast Plan £k	Forecast Actual £k
Recurrent	6,632	5,065	7,368	5,570
Non Recurrent	2,964	3,447	3,256	5,111
Total	**9,596**	**8,512**	**10,624**	**10,681**
Shortfall		1,083		(57)

Year to date performance is £1.1m behind plan. This is increasing due to the phasing of the unidentified savings target which were profiled later in the year and still require schemes to be identified. Confirmed additional non-recurrent income of £1.3m will enable the full year target to be achieved although it must be noted that 48% of the total will be non-recurrent.

3.0 Balance Sheet 2019 / 2020

	2018 / 2019 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	100,005	101,892	105,961	1
Current Assets				
Inventories & Work in Progress	259	232	259	
NHS Trade Receivables (Debtors)	3,019	2,996	2,497	2
Non NHS Trade Receivables (Debtors)	1,007	1,626	1,025	3
Prepayments, Bad Debt, VAT	1,559	1,675	1,167	
Accrued Income	5,138	4,855	4,578	4
Cash and Cash Equivalents	27,823	22,663	37,873	5
Total Current Assets	**38,806**	**34,047**	**47,399**	
Current Liabilities				
Trade Payables (Creditors)	(4,663)	(1,888)	(3,522)	6
Capital Payables (Creditors)	(1,070)	(552)	(433)	
Tax, NI, Pension Payables, PDC	(6,002)	(7,136)	(7,010)	
Accruals	(8,020)	(9,469)	(11,796)	7
Deferred Income	(276)	(1,064)	(1,318)	
Total Current Liabilities	**(20,031)**	**(20,109)**	**(24,080)**	
Net Current Assets/Liabilities	**18,775**	**13,938**	**23,318**	
Total Assets less Current Liabilities	**118,780**	**115,830**	**129,279**	
Provisions for Liabilities	(7,221)	(5,775)	(6,974)	
Total Net Assets/(Liabilities)	**111,560**	**110,055**	**122,306**	
Taxpayers' Equity				
Public Dividend Capital	44,221	44,221	44,265	
Revaluation Reserve	9,453	9,845	12,818	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	52,666	50,769	60,002	8
Total Taxpayers' Equity	**111,560**	**110,055**	**122,306**	

The Balance Sheet analysis compares the current month end position to that within the annual plan. The previous year end position is included for information.

1. Capital expenditure is detailed on page 14.The revaluation of estate was actioned in Month 10.

2. Minimisation, and timely recovery, of debt continues to be a focus to ensure that cash is maximised and we do not have any stored problems.

3. Non NHS debtors are lower than plan, all debt over 30 days is actively chased every week.

4. Accrued income is lower than plan, all invoices that need to be raised prior to the year end will be raised in March. £0.9m relates to PSF.

5. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 16.

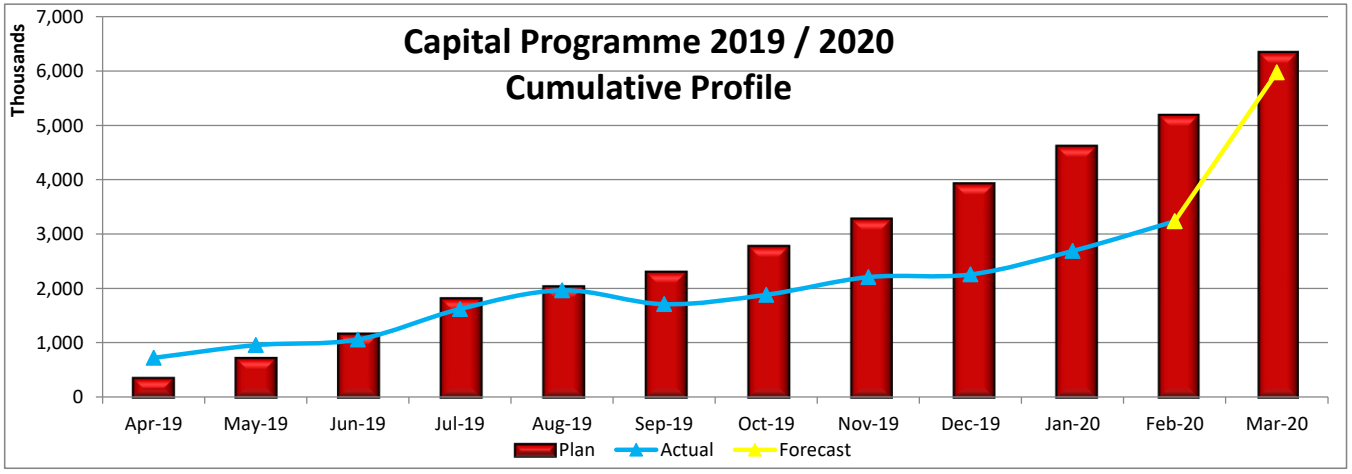
6. Payments to creditors continue to be paid in line with the Better Payment Practice Code (page 17).

7. Accruals are higher than plan as the Trust awaits invoices for goods and services received.

8. This reserve represents year to date surplus plus reserves brought forward.

3.1 Capital Programme 2019 / 2020

	REVISED Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	2,715	2,215	1,077	(1,138)	2,675	(41)	
Equipment Replacement	93	40	71	31	118	25	
IM&T	2,195	1,631	1,267	(364)	2,337	142	
Major Capital Schemes							
Fieldhead Non Secure	936	936	463	(473)	463	(473)	
Nurse Call system	200	168	179	11	200	0	
Clinical Record System	211	208	210	1	214	4	
VAT Refunds	0	0	(32)	(32)	(32)	(32)	1
TOTALS	**6,350**	**5,199**	**3,235**	**(1,964)**	**5,975**	**(375)**	



The capital programme has undertaken a number of revisions in year. The current plan is £6.35m.

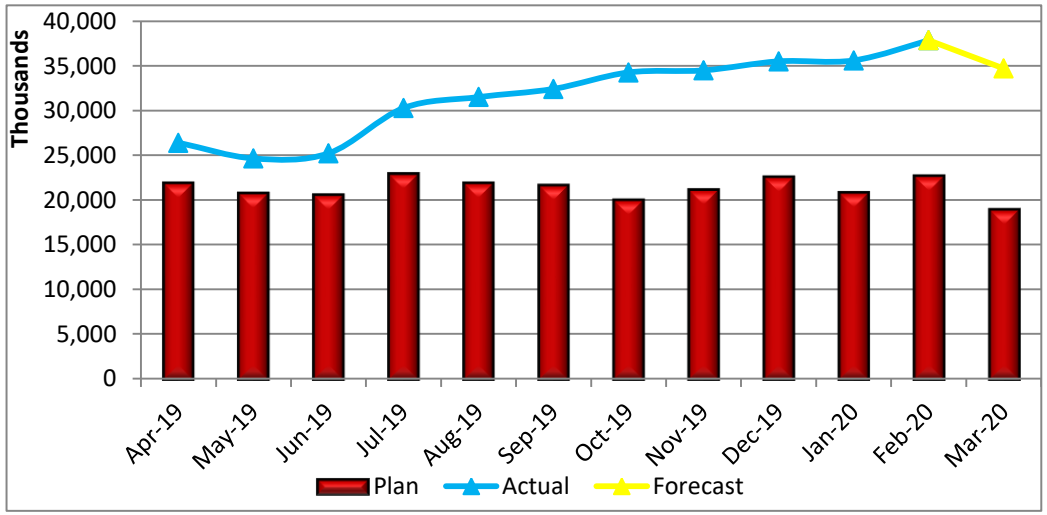
Capital Expenditure 2019 / 2020

1. The originally agreed capital plan for 2019 / 20 was £7.0m and schemes are guided by the current estates and digital strategies.

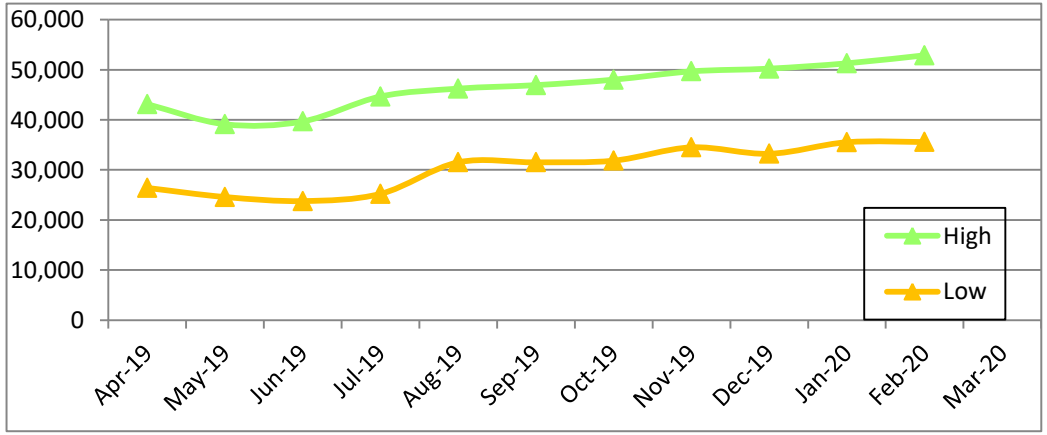
All schemes continue to be reviewed to ensure that they will be delivered in 2019/20. This includes a review of orders placed and ensuring that all work will be complete by 31st March 2020.

Based on this the forecast remains at £6m which means a significant level of spend in March 2020.

3.2 Cash Flow & Cash Flow Forecast 2019 / 2020



	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	27,823	
Closing Balance	22,663	37,873	15,210



The Trust cash position remains positive and higher than plan.

The Trust cash position remains favourable to plan driven by a higher opening balance than originally assumed, timing of capital expenditure, recent monthly surpluses and focused working capital management.

A detailed reconciliation of working capital compared to plan is presented on page 16.

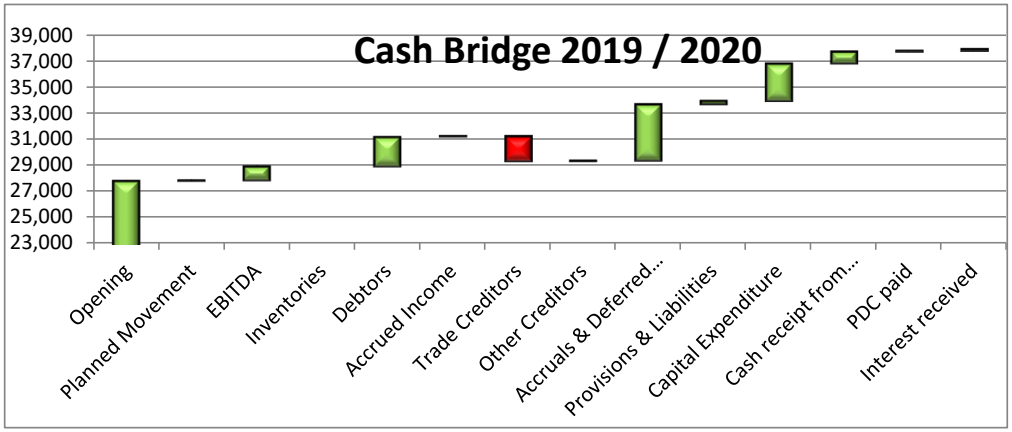
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£52.9m
The lowest balance is:	£35.6m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**22,617**	**27,823**	5,206	1
Surplus / Deficit (Exc. non-cash items & revaluation)	8,289	9,367	1,078	2
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(778)	1,457	2,235	3
Trade Payables (Creditors)	517	(1,331)	(1,848)	6
Other Payables (Creditors)	0	44	44	
Accruals & Deferred income	505	4,818	4,313	4
Provisions & Liabilities	(500)	(247)	253	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(6,713)	(3,871)	2,842	5
Cash receipts from asset sales	0	899	899	
PDC Dividends paid	(1,362)	(1,300)	62	
PDC Dividends received			0	
Interest (paid)/ received	88	214	126	
Closing Balances	**22,663**	**37,873**	**15,210**	



The plan value reflects the April 2019 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. The opening cash balance was higher than what was assumed in the annual plan submission.

2. The in year I & E position is better than plan.

3. Debtors, including accrued income, continue to be better than plan. Historical debt issues have been escalated and all aim to be resolved prior to the current financial year end.

4. Accruals are higher than plan whilst we await invoices. This improves cash as we have not yet paid for goods and services received.

5. Capital programme is currently behind plan, work is ongoing to ensure orders are placed and work scheduled to deliver the outstanding schemes by the end of the year.

Factors which decrease the cash position against plan:

6. Creditors are higher than planned. Invoices are paid in line with the Trust Better Payment Practice Code and any aged creditors are reviewed and action plans for resolution agreed.

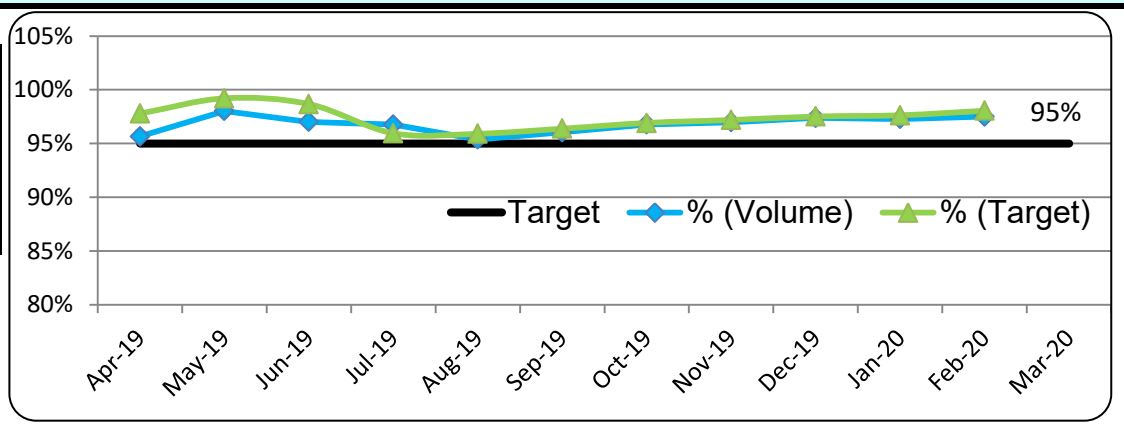
The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

4.0 Better Payment Practice Code

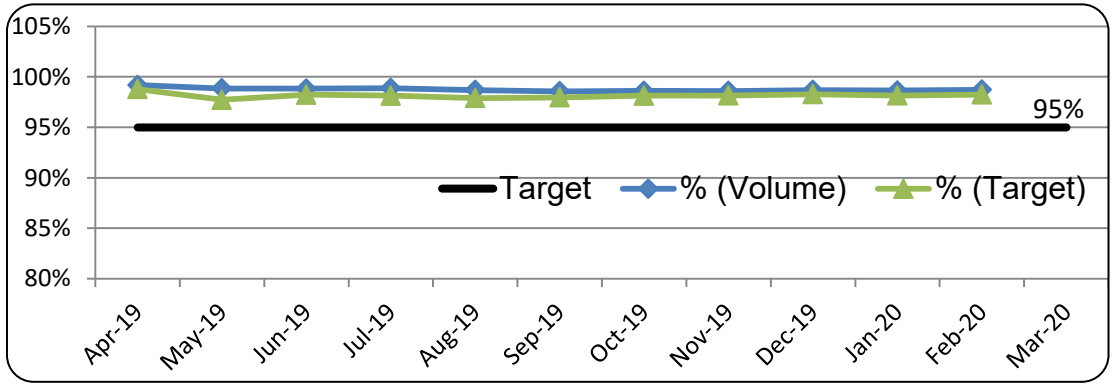
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

The team continue to review reasons for non delivery of the 95% target and identify solutions to problems and bottlenecks in the process. Overall year to date progress remains positive.

NHS	Number %	Value %
Year to January 2020	97%	98%
Year to February 2020	98%	98%



Non NHS	Number %	Value %
Year to January 2020	99%	98%
Year to February 2020	99%	98%



4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000.

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
08-Jan-20	Estate Management	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3127965	300,000
07-Feb-20	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3131070	232,879
03-Feb-20	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3130630	232,879
04-Feb-20	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3130584	149,873
18-Feb-20	Property Rental	Wakefield	Assura HC Ltd	3132318	90,000
31-Jan-20	Furniture	Trustwide	Pineapple Contracts	3130451	61,951
28-Jan-20	Computer Hardware Purchases	Trustwide	Dell Corporation Ltd	3130084	46,140
29-Jan-20	Computer Hardware Purchases	Trustwide	Dell Corporation Ltd	3130242	46,140
27-Jan-20	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3130011	44,363
11-Feb-20	Drugs	Trustwide	Lloyds Pharmacy Ltd	3131355	42,146
15-Jan-20	Drugs	Trustwide	Lloyds Pharmacy Ltd	3128699	41,343
31-Jan-20	Staff Charges	Trustwide	Leeds and York Partnership NHS FT	3130373	38,631
27-Feb-20	Property Rental	Kirklees	Mid Yorkshire Hospitals NHS Trust	3132888	37,977
06-Feb-20	Property Rental	Kirklees	Mid Yorkshire Hospitals NHS Trust	3130994	37,977
24-Feb-20	Property Rental	Barnsley	Dr M Guntamukkala	3132599	35,593
07-Feb-20	Purchase of Healthcare	Out of Area	Cygnet Health Care Ltd	3131110	35,121
13-Feb-20	Computer Software / License Fees	Trustwide	MRI Software EMEA Limited	3131589	32,118
15-Jan-20	Drugs	Trustwide	Lloyds Pharmacy Ltd	3128699	28,790
08-Jan-20	Utilities	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3128053	27,552
17-Feb-20	Mobile Phones	Trustwide	Vodafone Corporate Ltd	3131885	27,262
12-Feb-20	Purchase of Healthcare	Forensics	Humber NHS Foundation Trust	3131499	27,015
11-Feb-20	Drugs	Trustwide	Lloyds Pharmacy Ltd	3131355	26,243
24-Feb-20	Telephone Rental and call charges	Trustwide	Virgin Media Payments Ltd	3132550	25,386

4.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect

* Non-Recurrent - an action or decision that has a one off or time limited effect

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. For 2018 / 2019 the Trust were set a control total deficit.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

* Provider Sustainability Fund (PSF) - is an income stream distributed by NHS Improvement to all providers who meet certain criteria (this was formally called STF - Sustainability and Transformation Fund)

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.00%	5.00%	4.90%	4.90%	5.00%	5.00%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.80%	5.00%	4.50%	5.00%	5.10%	5.20%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	84.20%	91.20%	91.30%	90.90%	91.10%	91.60%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	70.00%	88.50%	90.00%	93.00%	93.70%	93.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	79.90%	78.20%	80.40%	77.40%	77.40%	75.80%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.20%	86.00%	86.20%	84.70%	84.00%	82.70%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	83.40%	84.10%	85.70%	86.30%	87.60%	87.60%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.70%	93.10%	93.60%	94.10%	94.30%	95.50%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	84.90%	86.20%	88.00%	88.80%	90.00%	88.40%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.40%	82.90%	81.40%	82.40%	84.10%	79.90%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	94.00%	94.50%	93.30%	93.50%	91.90%	89.60%
Information Governance	Resources	Well Led	AD	>=95%	93.70%	93.90%	94.00%	93.70%	88.60%	87.10%
Moving and Handling	Resources	Well Led	AD	>=80%	89.20%	88.60%	88.20%	88.50%	88.50%	89.40%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.40%	92.90%	92.70%	91.70%	91.40%	90.60%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.10%	88.30%	89.40%	89.10%	90.70%	88.50%
Prevent	Improving Care	Well Led	AD	>=80%	82.90%	86.00%	85.90%	88.00%	90.70%	91.60%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.10%	93.70%	93.60%	93.40%	93.70%	94.20%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.90%	90.90%	90.00%	90.10%	90.90%	91.80%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	96.20%	97.30%	97.40%	97.90%	98.30%	98.30%
Agency Cost	Resources	Effective	AD		£35k	£51k	£36k	£23k	£34k	£39k
Overtime Costs	Resources	Effective	AD		£1k	£3k	£0k	£2k	£3k	£2k
Additional Hours Costs	Resources	Effective	AD		£15k	£16k	£14k	£18k	£14k	£16k
Sickness Cost (Monthly)	Resources	Effective	AD		£130k	£142k	£128k	£144k	£139k	£126k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		100.62	115.96	102.93	100.87	95.61	85.82
Business Miles	Resources	Effective	AD		104k	96k	121k	91k	115k	111k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.20%	4.30%	4.40%	4.60%	4.70%	4.70%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.40%	5.00%	5.10%	5.80%	5.30%	4.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	83.90%	95.90%	97.90%	98.20%	98.20%	98.20%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	67.80%	91.50%	92.90%	95.00%	97.00%	97.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.20%	84.30%	81.40%	80.80%	82.70%	84.30%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	91.10%	79.80%	80.40%	80.10%	76.20%	77.40%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	87.90%	87.50%	88.10%	88.60%	88.60%	89.40%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.90%	91.90%	92.30%	92.10%	92.90%	93.90%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.20%	87.80%	86.80%	87.60%	87.90%	88.40%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	77.10%	76.80%	76.70%	81.50%	82.60%	81.80%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	89.90%	90.40%	90.80%	90.90%	89.80%	88.50%
Information Governance	Resources	Well Led	AD	>=95%	94.50%	94.20%	93.50%	95.40%	94.20%	89.90%
Moving and Handling	Resources	Well Led	AD	>=80%	90.70%	92.30%	92.60%	92.40%	91.10%	90.90%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.20%	94.10%	94.60%	93.60%	93.10%	91.50%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	91.90%	92.10%	92.90%	92.10%	91.90%	89.10%
Prevent	Improving Care	Well Led	AD	>=80%	88.40%	84.00%	86.30%	88.60%	91.10%	91.00%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.00%	93.70%	94.00%	94.40%	93.80%	93.90%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	91.00%	91.60%	90.50%	89.30%	90.90%	92.20%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	97.00%	97.20%	96.50%	96.90%	9.50%	97.10%
Agency Cost	Resources	Effective	AD		£124k	£138k	£88k	£124k	£125k	£135k
Overtime Costs	Resources	Effective	AD		£2k	£2k	£0k	£1k		£0k
Additional Hours Costs	Resources	Effective	AD		£3k	£4k	£2k	£2k	£2k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£94k	£119k	£117k	£134k	£129k	£101k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		98.9	82.88	78.48	71.54	81.1	94.32
Business Miles	Resources	Effective	AD		62k	58k	63k	61k	63k	63k

Appendix - 2 - Workforce - Performance Wall cont....

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	7.10%	6.80%	6.70%	6.70%	6.60%	6.50%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	7.00%	5.80%	6.40%	6.40%	5.80%	6.10%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	83.10%	87.00%	88.20%	89.30%	94.50%	94.50%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	78.90%	81.80%	86.90%	86.80%	83.30%	84.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.30%	85.10%	84.00%	82.20%	82.40%	84.40%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.50%	87.40%	85.00%	83.10%	87.50%	87.90%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	89.70%	91.00%	91.50%	87.10%	91.30%	93.50%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.90%	92.60%	92.40%	90.40%	91.20%	90.90%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	90.00%	89.90%	88.60%	88.70%	88.40%	89.70%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	81.30%	82.60%	83.80%	82.70%	78.70%	78.70%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.90%	92.40%	92.40%	90.40%	89.30%	88.60%
Information Governance	Resources	Well Led	AD	>=95%	93.90%	91.40%	93.00%	89.50%	88.60%	97.40%
Moving and Handling	Resources	Well Led	AD	>=80%	93.30%	93.10%	92.40%	91.60%	94.40%	94.10%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.80%	91.40%	88.90%	87.80%	90.00%	85.70%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	89.70%	90.20%	89.10%	86.50%	88.80%	83.70%
Prevent	Improving Care	Well Led	AD	>=80%	82.00%	83.70%	84.40%	86.10%	86.50%	88.20%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.70%	95.10%	95.10%	93.30%	91.40%	94.30%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.40%	88.90%	88.20%	85.60%	83.10%	86.20%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	90.00%	96.80%	96.60%	84.80%	97.00%	96.30%
Agency Cost	Resources	Effective	AD		£70k	£69k	£62k	£71k	£139k	£132k
Overtime Costs	Resources	Effective	AD		£2k	£9k	£2k	£4k	£9k	£64k
Additional Hours Costs	Resources	Effective	AD		£2k	£2k	£0k	£3k	£1k	£6k
Sickness Cost (Monthly)	Resources	Effective	AD		£98k	£81k	£85k	£91k	£80k	£75k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		78.86	80.53	75.41	81.04	127.14	128.69
Business Miles	Resources	Effective	AD		10k	8k	12k	8k	29k	26k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	3.40%	3.50%	3.60%	3.70%	3.60%	3.50%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.20%	4.40%	4.50%	3.90%	2.90%	2.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	74.20%	83.80%	87.80%	89.00%	91.10%	98.30%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	49.60%	59.50%	66.70%	68.00%	80.80%	94.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.40%	78.80%	77.00%	76.10%	71.40%	75.10%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	79.60%	79.50%	81.60%	79.90%	73.40%	74.90%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	96.90%	96.00%	93.50%	93.70%	90.70%	87.25%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.30%	86.50%	86.30%	87.00%	88.90%	87.20%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	79.50%	79.30%	83.00%	83.40%	87.00%	86.40%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	69.20%	59.30%	66.70%	56.00%		100.00%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.60%	88.70%	87.60%	88.20%	88.10%	86.00%
Information Governance	Resources	Well Led	AD	>=95%	94.30%	93.90%	90.80%	92.90%	81.00%	94.50%
Moving and Handling	Resources	Well Led	AD	>=80%	91.60%	92.60%	93.30%	94.10%	93.50%	92.80%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	89.70%	91.80%	92.00%	90.80%	89.30%	88.30%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.30%	88.40%	91.40%	91.40%	88.90%	86.50%
Prevent	Improving Care	Well Led	AD	>=80%	79.70%	81.70%	83.70%	86.10%	90.70%	88.20%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.10%	91.60%	89.50%	90.30%	90.80%	91.30%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.40%	89.20%	88.20%	78.00%	79.30%	85.30%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.00%	94.70%	93.90%	95.90%	96.40%	96.50%
Agency Cost	Resources	Effective	AD		£257k	£281k	£233k	£269k	£21k	£168k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£1k	£2k	£0k	£2k
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£9k	£4k	£4k	£5k
Sickness Cost (Monthly)	Resources	Effective	AD		£22k	£32k	£34k	£32k	£25k	£18k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		89.17	85.78	91.58	86.3	48.93	46.9
Business Miles	Resources	Effective	AD		36k	38k	47k	37k	23k	30k

Appendix 2 - Workforce - Performance Wall cont....

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.40%	4.40%	4.40%	4.30%	4.20%	4.20%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	4.40%	4.30%	4.20%	3.60%	3.40%	3.60%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	85.30%	93.60%	95.70%	95.60%	96.20%	97.80%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	77.20%	96.30%	97.60%	97.80%	98.00%	98.30%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	79.00%	83.90%	76.60%	80.90%	78.00%	77.70%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	91.70%	91.70%	90.90%	87.50%	91.70%	91.70%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.10%	91.50%	91.10%	91.30%	90.20%	89.10%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	92.60%	90.40%	91.80%	91.00%	90.50%	91.60%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	97.50%	99.50%	97.80%	97.10%	96.40%	96.40%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.50%	91.80%	91.70%	89.80%	90.90%	91.60%
Information Governance	Resources	Well Led	AD	>=95%	92.90%	93.10%	89.30%	95.10%	92.50%	98.70%
Moving and Handling	Resources	Well Led	AD	>=80%	95.20%	95.80%	95.10%	95.10%	95.70%	95.60%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.70%	99.70%	99.70%	99.60%	99.00%	98.90%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	88.20%	88.90%	93.80%	94.10%	88.90%	88.90%
Prevent	Improving Care	Well Led	AD	>=80%	98.90%	98.40%	98.00%	97.70%	97.60%	98.80%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.70%	97.70%	97.30%	97.50%	97.10%	96.60%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	97.20%	97.70%	97.50%	97.20%	97.00%	96.80%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Agency Cost	Resources	Effective	AD		£4k	£10k	£12k	£-11k	£5k	£9k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£1k	£0k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£12k	£10k	£10k	£11k	£13k	£13k
Sickness Cost (Monthly)	Resources	Effective	AD		£70k	£68k	£66k	£58k	£51k	£51k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		39.08	41.59	38.29	47.19	47.63	41.08
Business Miles	Resources	Effective	AD		25k	30k	32k	35k	21k	31k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.60%	4.80%	4.80%	4.80%	4.80%	4.70%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.50%	5.80%	5.00%	4.80%	5.10%	4.60%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	96.00%	96.00%	95.30%	95.90%	95.80%	95.90%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	66.20%	80.70%	87.20%	93.40%	94.80%	95.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.70%	81.40%	83.80%	82.10%	81.80%	82.20%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	80.30%	82.20%	82.20%	75.80%	74.60%	74.60%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	83.90%	85.70%	85.90%	86.70%	87.30%	86.70%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.20%	92.90%	94.00%	93.40%	94.30%	94.20%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.60%	87.70%	86.90%	87.30%	86.00%	87.30%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	89.80%	86.70%	86.70%	91.20%	84.60%	81.70%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.50%	91.30%	88.80%	90.10%	89.80%	88.40%
Information Governance	Resources	Well Led	AD	>=95%	97.00%	96.70%	93.20%	86.30%	91.60%	99.40%
Moving and Handling	Resources	Well Led	AD	>=80%	90.60%	90.70%	91.50%	91.70%	92.30%	91.70%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.70%	92.90%	91.80%	90.90%	90.90%	88.70%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	89.50%	91.20%	91.20%	90.80%	91.80%	89.50%
Prevent	Improving Care	Well Led	AD	>=80%	77.10%	79.50%	83.60%	84.50%	86.50%	87.30%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.60%	94.30%	94.00%	93.60%	93.70%	95.00%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.90%	91.50%	90.40%	90.90%	90.40%	90.30%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.30%	95.10%	95.40%	95.00%	95.90%	96.00%
Agency Cost	Resources	Effective	AD		£38k	£44k	£40k	£28k	£33k	£33k
Overtime Costs	Resources	Effective	AD		£2k	£2k	£1k	£2k	£2k	£1k
Additional Hours Costs	Resources	Effective	AD		£2k	£3k	£2k	£2k	£1k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£41k	£56k	£43k	£37k	£43k	£30k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		34.46	34.58	33.89	36.02	61.8	58.04
Business Miles	Resources	Effective	AD		45k	33k	42k	39k	37k	39k

Appendix 2 - Workforce - Performance Wall cont....

Inpatient Service										
Month	Objective	CQC Domain	Owner	Threshold	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	6.00%	6.00%	5.90%	6.00%	6.10%	6.00%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.40%	6.00%	5.20%	6.90%	6.40%	5.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%		80.00%	80.40%	81.40%	82.20%	89.50%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%		80.20%	84.30%	87.80%	92.00%	93.70%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	87.30%	86.80%	86.00%	85.40%	85.20%	83.60%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	85.40%	86.30%	84.90%	84.20%	84.70%	81.90%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	90.80%	89.20%	85.50%	88.20%	90.60%	87.60%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.40%	94.80%	95.10%	94.90%	94.70%	93.70%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	82.40%	84.00%	84.70%	84.80%	82.50%	82.50%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.60%	74.00%	76.20%	76.20%	75.50%	76.40%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	91.90%	92.30%	91.50%	90.70%	90.60%	89.40%
Information Governance	Resources	Well Led	AD	>=95%	95.00%	96.00%	96.70%	94.80%	91.80%	89.40%
Moving and Handling	Resources	Well Led	AD	>=80%	94.70%	95.10%	93.60%	94.00%	93.00%	94.30%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	89.10%	90.10%	89.30%	87.50%	87.10%	83.90%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.60%	89.60%	88.30%	86.10%	86.60%	85.40%
Prevent				>=80%	74.40%	80.20%	81.40%	83.90%	88.00%	88.50%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.80%	93.80%	93.90%	94.90%	92.70%	93.10%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	88.10%	88.90%	84.50%	83.60%	83.60%	82.50%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.20%	95.80%	96.40%	98.80%	98.20%	97.60%
Bank Cost	Resources	Well Led	AD		£213k	£191k	£237k	£182k	£218k	£176k
Agency Cost	Resources	Effective	AD		£100k	£83k	£101k	£53k	£64k	£64k
Overtime Costs	Resources	Effective	AD		£2k	£1k	£0k	£0k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£0k	£0k	£0k	£0k	£1k	£0k
Sickness Cost (Monthly)	Resources	Effective	AD		£48k	£47k	£36k	£53k	£50k	£38k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		60.37	52.41	52.78	43.18	52.8	56.35
Business Miles	Resources	Effective	AD		1k	2k	1k	0k	1k	1k

Glossary

ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View
HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement
NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

KEY for dashboard Year End Forecast Position / RAG Ratings	
1	On-target to deliver actions within agreed timeframes.
2	Off trajectory but ability/confident can deliver actions within agreed time frames.
3	Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
4	Actions/targets will not be delivered
	Action Complete

NB: The year end forecast position for the dashboards was reviewed in October 2019 and revised to alisgn with the NHSI rating system.

NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020
Confidential agenda item 6.3

Title:	**Serious incident report Quarter 3 2019/20 (including Learning from healthcare deaths Quarter 3 2019/20)**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This report provides information in relation to incidents in Quarter 3 and more detailed information in relation to serious incidents. Also to provide assurance that learning from healthcare deaths arrangements are in place. The report provides cumulative data for 2019/20 deaths. The learning from healthcare deaths report requires publication on the Trust website.
Mission / values:	➢ We are respectful, honest, open and transparent ➢ We put the person first and in the centre ➢ We are always improving
Any background papers / previously considered by:	Previous quarterly reports which have been submitted to Trust Board, along with annual incident reports, Our learning journey reports. Trust Board has also received papers about the introduction of the national requirement for learning from healthcare deaths and the policy.
Executive summary:	• This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each Business Delivery Unit. Data is also available at service line level. All managers have access to Datix dashboards to interrogate data further. • This report has overall figures for incident reporting. Q3 had 3019 incidents; lower than the previous quarter (3497). • 86% of incidents are graded as “low” or “no harm” showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs). • We benchmark well based on National Reporting and Learning System (NRLS) report on patient safety incidents with consistent and timely reporting and no evidence of under reporting. • “Physical aggression/threat (no physical contact): by patient” 331 incidents (10%) remains as the most reported category. • “Violence and Aggression” continues to be the highest reported incident type (32% (988) of all incidents reported in the quarter, consistent with the previous quarter) [fig 1]. . • There have been no ‘Never Events’ reported in the Trust during Q3: the last Never Event reported was in 2010/11. • The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Quarter 3 was 9; this is lower than what was reported in Quarter 2 (12). • In quarter 3, the highest category of serious incident is “Suicide (including apparent suicide) community team care – current episode” (5).

	This is lower than quarter 2 which was 10. • We are implementing our Trust wide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern. • The actions from incidents are managed at Business Delivery Unit level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational management group. • Within the report are some examples of learning from specialist advisors and work streams for the highest reported incidents. **Learning from healthcare deaths** • The Learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes. • Total number of deaths reported on Datix by staff between 01/10/2019 – 31/12/2019 (by reported date, not date of death) = 94, all of which have been reviewed. • Total in scope as described in report = 81. • This report contains themes identified through reviews from deaths occurring 01/04/2017 – 30/09/2019. • The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. For learning from healthcare deaths Trust has developed Datix and worked with performance and information to ensure information is available. A policy has been developed which meets current national requirements. Training to review records has been provided. The outcome which is now the important aspect continues to be developed. The report was **scrutinised by the Clinical Governance & Clinical Safety Committee** on 11 February 2020 who commented as follows:- ➢ The report remains of good quality and well structured. ➢ Robust systems remain in place to report and investigate incidents. ➢ It will be important to understand how the suicide prevention work can demonstrate an impact on the current national trend and this should be considered in the annual apparent suicide report. ➢ The pressures on serious incident reporting were acknowledged and the planned action to resolve capacity was welcomed. This will be reviewed on receipt of the next report ➢ The areas that require review and action are addressed through the revised patient safety strategy or through local BDU review governance **Risk appetite** Risk identified – the Trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting, analysing and investigating healthcare deaths. This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-6. The clinical risk – risk to service user/public safety and risk to staff safety which

	is again low risk appetite and a risk target of 1-6.
Recommendation:	**Trust Board is asked to NOTE the quarterly report on incident management.**

South West Yorkshire Partnership NHS Foundation Trust

Trust wide Incident Management Report

Quarter 3 2019/20

Incorporating Serious Incidents and Learning from Healthcare Deaths reporting for the period 01/04/2019-31/12/2019

Report prepared by Patient Safety Support Team

January 2020

Contents

Executive Summary

This report provides information in relation to incidents reported in Quarter 3 2019/20 and more detailed information in relation to serious incidents. A brief analysis of actions arising from completed Serious Incident investigations submitted to commissioners for the period of 1 October 2019 to 31 December 2019 is included. The report also includes the Trust's report on Learning from Healthcare Deaths to provide assurance that arrangements are in place and to provide cumulative data for the period 01/04/2019 – 31/12/2019. The Learning from Healthcare Deaths report will be available separately on the Trust website.

This report does not cover the work of the BDUs in terms of implementing the learning; this will be available separately.

Quarter 3 2019/20 Headlines

- **3019** incidents reported
- **86%** of incidents resulted in no/low harm
- **9** Serious incidents reported
- Serious Incidents account for **0.2%** of all incidents reported
- No homicides
- No Never Events

High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

- This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each Business Delivery Unit. Data is also available at service line level. All managers have access to Datix dashboards to interrogate data further.
- This report has overall figures for incident reporting. Q3 had 3019 incidents; lower than the previous quarter (3497).
- 86% of incidents are graded as "low" or "no harm" showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs).
- We benchmark well based on National Reporting and Learning System (NRLS) report on patient safety incidents with consistent and timely reporting and no evidence of under reporting.
- "Physical aggression/threat (no physical contact): by patient" 331 incidents (10%) remains as the most reported category.

- "Violence and Aggression" continues to be the highest reported incident type (32% (988) of all incidents reported in the quarter, consistent with the previous quarter) [fig 1]. Staff have reported that this can be linked to individual service users but also say some incidents are linked to the trust's current smoking policy.
- There have been no 'Never Events' reported in the Trust during Q3: the last Never Event reported was in 2010/11.
- The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Quarter 3 was 9; this is lower than what was reported in Quarter 2 (12). The range of serious incidents reported this quarter has included deaths (7), pressure ulcers (1) and violence and aggression (1).
- In quarter 3, the highest category of serious incident is "Suicide (including apparent suicide) community team care – current episode" (5). This is lower than quarter 2 which was 10.
- Trust-wide, there were 47 apparent suicides that occurred during the rolling 12 month period between 1 January 2019 to 31 December 2019. All apparent suicides are reviewed by teams, and in line with the learning from healthcare deaths policy and subject to further review. Deaths will be reviewed either be serious incident investigations, service level investigations, Mortality Structured Judgement Reviews, first stage case record review or considered through safeguarding processes. Please note that not all apparent suicides are reported as serious incidents.
- All incidents that are graded red or amber are extracted from Datix for inclusion in a report that is reviewed at the weekly risk panel.
- All deaths are reviewed in line with the learning from healthcare deaths policy.
- We are implementing our Trust wide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern.
- We have taken the lead on the West Yorkshire and Harrogate Health Care Partnership 5-year suicide prevention strategy, which has adopted an evidence-based approach to suicide prevention and zero suicide philosophy for targeted areas and hotspots.
- 10 serious incident investigations have been submitted to the Commissioner during the quarter and 8 previous serious incidents have been closed by Commissioners.
- The actions from incidents are managed at Business Delivery Unit level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational management group.
- A number of investigations are outside the 60 working day target; these have agreed extensions with Commissioners. The complexity of investigations has contributed to delays.
- Within the report are some examples of learning from specialist advisors and work streams for the highest reported incidents.

Learning from healthcare deaths

- The Learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes.
- The Trust started reviewing all deaths reported on Datix using an incremental approach from April 2017
- The Learning from healthcare deaths policy came into effect from 1 October 2017, and has been reviewed in January 2019 and January 2020.

- The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
  - Death Certification
  - Case record review, including Structured Judgment Record Reviews. The managers 48 hour review on Datix is also classed as a first stage case record review.
  - Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding.
- Total number of deaths reported on Datix by staff between 1/10/2019 – 31/12/2019 (by reported date, not date of death) = 94, all of which have been reviewed.
- Total in scope as described in report = 81.
- This report contains themes identified through reviews from deaths occurring 1/4/2017-30/9/2019.

1. Introduction

This report has been prepared by the Patient Safety Support Team to bring together Trust wide information on incident activity during Quarter 3 2019/20 (1 October 2019 to 31 December 2019) including reported serious incidents and Learning from Healthcare Deaths for the period 1 April 2019 to 31 December 2019.

Please note that figures within this report may vary from the individual Business Delivery Unit reports due to movement/grading changes of incidents whilst producing the reports from a live system.

2. Updates from the Patient Safety Support Team

During Quarter 3, the Patient Safety Support Team priority areas have included:

- Continuing to develop our processes for learning from healthcare deaths.
- Reducing the back log of incidents awaiting final approval.
- Data collection to support the 360 Assurance internal audit on Incidents
- Data collection to support Health and Safety at Work inspection
- Review of Being Open policy and Learning from Healthcare Deaths policy
- Continue to amend data flows for severe harm and death incidents to the CQC.
- Responding to 6 FOI requests. (Including information related to assaults, restraint and overall incident data).
- Data production and reporting for annual MH and LD Benchmarking.
- Recruitment for the Incident Management Support Officer post.
- Appointed substantive Band 7 investigator.

3. Incident Reporting Analysis

This report has overall figures for incident reporting. Q3 had 3019 incidents which is lower than the levels in the previous two quarters.

86% of all incidents reported on Datix are graded as green severity rating meaning they had “low” or “no harm”. This shows a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs).

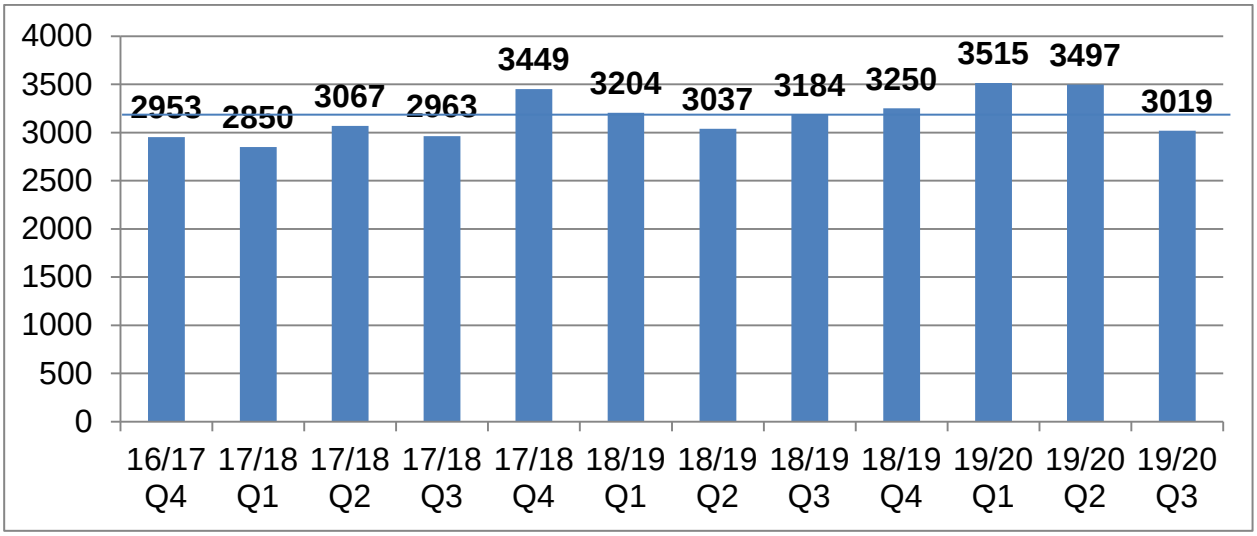
Headlines

Quarter 3 2019/20 Headlines

- **3019** incidents reported
- Decrease on reporting compared with Q2 (3497)
- **86%** of incidents remain **no/low harm**
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

Figure 1 below shows the pattern and number of incidents reported by quarter in the Trust from Q4 16/17 to Q3 19/20. The rate fluctuates as would be expected. Quarter 3 2019/20 was slightly below as expected the average for a quarter. However with the Trust changing profile of services, direct comparisons should be viewed with caution.

Figure 1 Comparative number of incidents reported by financial quarter Q4 2016/17 to Q3 2019/20



Severity

In Figure 2 there have been 42 red incidents reported. This data is live data at the point of producing the report. The incident may be initially graded red for a number of reasons. An example would be a death (for healthcare deaths we have been encouraging staff to report on Datix) but we later find out this is natural causes or where the individual has not been involved with Trust services for over six months so this may be re-graded and not reported on STEIS, this can take some time to get this information. Not all red incidents will meet the criteria for a serious incident (see page 20).

Figure 2 All incidents reported Trust wide between 01/10/2018 – 31/12/2019 by severity and financial quarter

	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3
Green (no harm)	1923	1850	2077	1970	1819
Green	896	975	1060	1068	793
Yellow	248	295	254	317	270
Amber	89	96	94	107	95
Red	28	34	30	35	42
Total	**3184**	**3250**	**3515**	**3497**	**3019**

Many of the red incidents will be downgraded once they have been reviewed locally and by risk panel as staff reporting will initially rate as red pending review. The apparent increase in red incidents is likely due to the date that the data is run for the production of the report as the incidents may not have been reviewed by the manager and/or the 48 hour management report may not have been completed. In some cases, we may be waiting for the cause of death or the incident may not have been reviewed at risk panel. The table below (Figure 3) provides a further breakdown of Q3 reported incidents by severity and BDU.

Figure 3 All incidents reported Trust wide between 1/10/2019 - 31/12/2019 by severity and BDU

	Barnsley Mental Health	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide	**Total**
Green (no harm)	156	229	148	263	304	477	227	15	1819
Green	80	171	78	101	144	125	87	7	793
Yellow	26	20	20	35	111	46	9	3	270
Amber	8	40	7	11	19	7	3	0	95
Red	8	0	6	17	9	1	1	0	42
Total	**278**	**460**	**259**	**427**	**587**	**656**	**327**	**25**	**3019**

Type and Category of incidents

Figure 4 shows the overarching type of incidents reported in the Trust. All incidents are coded using a three tier method to enable detailed analysis. Type is the broadest grouping, with type breaking into categories, and then onwards into subcategories. This report provides details of the number for type (Figure 4) and the top 10 categories of incidents reported in the quarter (Figure 5).

Figure 4 Type of incident reported in Quarter 3 by BDU

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Violence and Aggression	83	11	86	133	187	293	193	2	**988**
Care Pathway, Clinical and Pressure Ulcer Incidents	14	323	5	8	37	5	13	0	**405**
Medication	26	43	26	61	53	49	9	8	**275**
Self-Harm	68	2	40	29	45	18	30	1	**233**
Legislation and Policy	6	1	27	23	49	66	2	0	**174**
All Other Incidents	12	10	7	30	39	53	6	2	**159**
Health and Safety (including fire)	14	14	9	16	29	58	12	3	**155**
Slips, Trips and Falls	9	14	15	35	52	9	2	1	**137**
Security Breaches	9	2	2	12	25	56	5	4	**115**
Safeguarding Adults	8	11	6	18	13	22	12	0	**90**
Death (including suspected suicide)	12	1	12	24	22	1	10	1	**83**
Missing/absent service users	7	0	11	17	25	13	1	0	**74**
Information Governance Incidents	3	14	2	8	4	4	14	3	**52**
Safeguarding Children	3	4	8	3	0	5	10	0	**33**
IT Related Issues	2	5	2	5	3	3	8	0	**28**
Infection Prevention/Control	2	5	1	5	4	1	0	0	**18**
Total	**278**	**460**	**259**	**427**	**587**	**656**	**327**	**25**	**3019**

Figure 5 Trust-wide Top 10 most frequently reported incident categories in rolling 5 quarters (1/10/2018 – 31/12/2019)

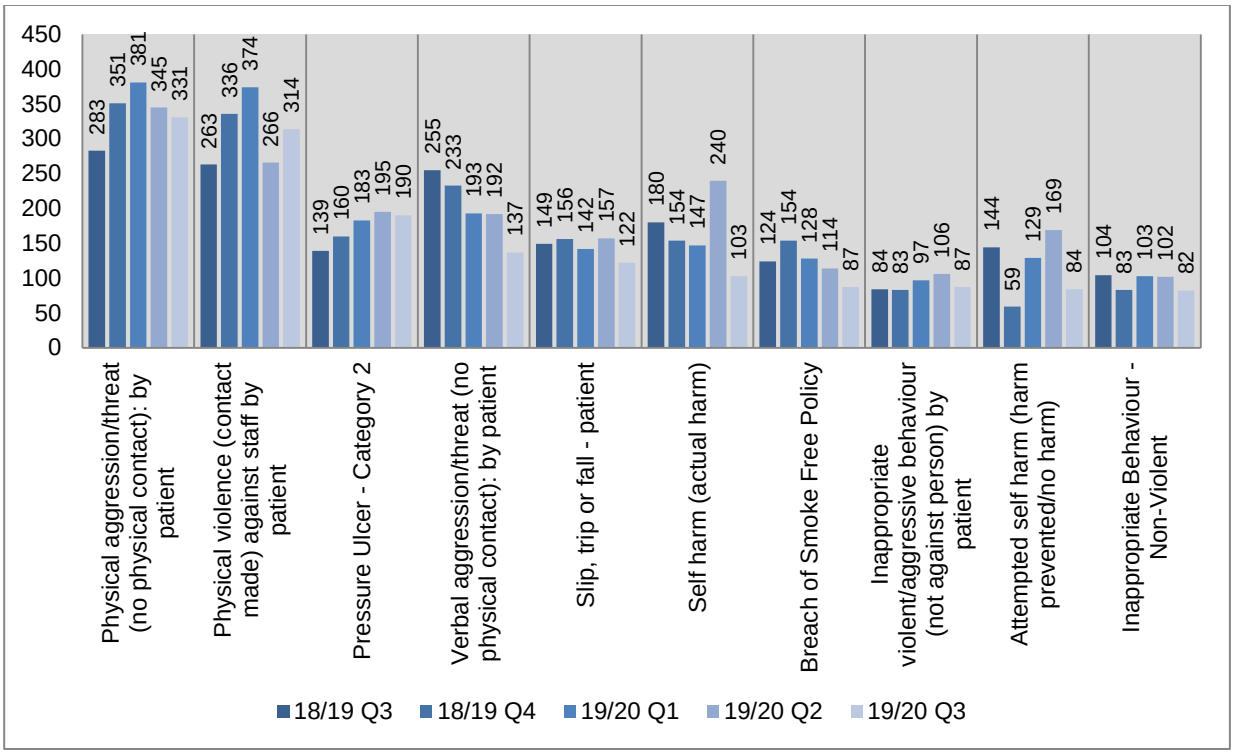


Figure 5 shows that in Quarter 3 2019/20 physical aggression/threat (no physical contact) by patient was the highest reported category of incident. Figures for previous quarters are included for comparison.

Although the Grade 2 Pressure ulcer category appears in the top 10, it should be noted that these are incidents that are generally identified by staff in the community and many are attributable to other agencies. The Datix system is used to capture the identification and actions taken by our staff.

Reporting to National Reporting and Learning System

The Trust captures the severity of all incidents locally on Datix using the risk matrix which scores incidents ranging from green through to red. This includes actual and potential harm of all incidents and near misses (i.e. psychological harm, potential risks).

The Trust uploads patient safety incidents[1] (which are a subset of all incidents reported) from Datix to the National Reporting and Learning System (NRLS) on a weekly basis and has done so since 2004. Local information on Datix is mapped to the national system in the background. The National Reporting and Learning System shares patient safety incidents with the Care Quality Commission (CQC). The CQC may then contact the Trust to enquire further about specific incidents.

Patient Safety incidents **do not include non-clinical incidents**, or where staff were the affected party (e.g. violence against staff incidents). These are not reportable to NRLS as the harm was not to a patient. The NRLS scores the **actual** degree of harm caused, as opposed to including potential harm as collected locally.

The NHS Patient Safety Strategy [2] published in July 2019 sets out plans for a new national reporting and learning system which will combine NRLS and the Strategic Executive Information System (for reporting serious incidents). This is expected to be launched around 2020/21.

External comparison

Patient Safety Incidents are uploaded to the National Reporting and Learning System (NRLS) when they have been through the internal management review and governance processes. This data uploaded externally is as accurate as it can be. Incidents are exported to NRLS when these reviews have been completed, which results in a natural delay in uploading patient safety incidents to the NRLS.

NHS Improvement publish data from the NRLS system on a six monthly basis.

Prior to August 2018, the National Reporting and Learning System (NHS Improvement), provided reports which enabled the Trust to be directly compared with other similar Trusts in the mental health cluster.

New report formats have since been released by NHS Improvement, which are designed to assist NHS trust boards to understand and improve their organisation's patient safety culture and reporting of patient safety incidents to the NRLS. The updated report encourages organisations to compare against themselves over periods of time, rather than with other organisations which may not be comparable for a number of reasons.

The Trust's latest report is available below or through the NHS Improvement website.

[1] A patient safety incident is defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

[2] https://improvement.nhs.uk/resources/patient-safety-strategy/

NHS Improvement
SWYPFT NRLS report

This report compares the Trust's data for the last two financial years against each other.

Reporting culture and reporting patterns

- No evidence of potential under-reporting
- Our reporting rate per 1,000 bed days, October 2017 to March 2018 compared to October 2018 to March 2019 – remains consistent

Has the timeliness of your incident reporting improved?

- Our reporting timeliness improved compared with the previous year due to focussed quality improvement time on reviewing incidents internally. This improved the speed with which incidents were uploaded to NRLS. Further work to protect time for this continues.

Are you improving the accuracy with which you report degree of harm?

- There are some small variations (0-3%) in comparative data by degree of harm. The Patient Safety Support Team quality check local data against provisional data from NRLS on a monthly basis and amendments are made as needed. The actions recommended in the report are in place.

Do you understand your most frequently reported incident types?

- The incident types reported on from the national system do not directly correlate with those collected locally. Work takes place every 3 years to confirm our mapped data with NHS Improvement.

Have the care settings of your incidents changed?

- There are very small variations in comparative data by care setting but this would be as expected.

4. Learning from incidents

Learning from incidents is identified at all levels in the organisation. Some specialist advisors have provided the following examples.

Safeguarding

Learning from Domestic Homicide Reviews, Safeguarding Practice Reviews and Safeguarding Adult Reviews

A number of safeguarding reviews has led to the development of a Safeguarding Toolkit to support staff with information sharing. This has been uploaded on to the Trust intranet pages and shared with the safeguarding link professionals to cascade within clinical teams.

Infection Prevention and Control

Example 1 - An audit of the cleaning of toys, games and play equipment
Tightening up of schedules in relation to decontamination of all toys, games and play equipment.

Staff to have more clarity on what items can be used and how.

Example 2 - Laboratory results

Urine sample was sent to laboratories and appears to have gone missing. Staff have not chased this up for 14 days. The service user had a ten day course of antibiotics that may have been unnecessary or inappropriate.

Urine sample should have been available within three days but appears to have been lost.
At three days staff should have enquired as to the whereabouts of the sample and sent a new one if sample was missing.

Delays could result in the wrong treatment, over exposure to antibiotics, a risk of Clostridium difficile, sepsis and increased risk of antimicrobial resistance.

SBAR learning document shared in headlines and on trust intranet.

Example 3 – Needle stick injury

Student nurse visiting patient in his own home sustained a needle stick injury when patient passed a used needle to her.

The patient was being taught how to use an Insulin pen and he was struggling to get the needle off the pen and thrust it towards the student nurse who went to take hold of it and sustained an injury.

Correct procedure should have been to have refused to take hold of the device.

The service has now as a result of this incident asked Diabetic Services to supply two weeks of safety needles, for the purpose of District Nursing services teaching patients to use the Insulin pens.

Example/s of learning from incidents

The learning library has been developed as a way to gather and share examples of learning from experience. A summary of our learning process is described in the image below.

The latest content has been added to the shared network folder -K:\#allofusimprove and the intranet page is being further developed.

Examples of recently added content include:

SBAR learning library blood and body fluid samples
SBAR for external criminal investigation - sexual exploitation
Learning summary SPA protocol.docx
Use of a wheelchair during an incident of violence and aggression

Greenlight alerts

Greenlight alerts have been created to provide a way to share important information and learning related to medication safety.

Greenlight alerts are available on the intranet:

- Greenlight on fluoroquinolone antibiotics
- Greenlight on adrenaline availability and use in community teams
- Greenlight on flu vaccines 2018/19
- Greenlight to take care with when required (PRN) medicines
- Greenlight on prescribing and administering liquid medicines
- Greenlight on valproate and haloperidol
- Greenlight on Buccolam (midazolam)
- Greenlight on paraffin
- Greenlight on clozapine

Bluelight Alerts

Bluelight alerts have been created to provide a way to share urgent learning quickly across the Trust.

The Bluelight alerts that have already been circulated in Quarter 3 are available on the intranet and below:

Bluelight alert 24 - 2 December - seclusion room door double-lock

Bluelight alert 23 - 2 October 2019 - ligature risk from door barrel

If you have urgent safety or learning information that needs to be shared across the Trust urgently, please discuss the information you want to share with your managers to firstly to agree if a Bluelight is the appropriate route for circulation, then follow the process on the intranet http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Bluelight-alerts.aspx

Learning from Serious Incidents

Section 7 is the Serious Incident report. Further information on this is available in the incident management annual report.

Learning from Healthcare Deaths

Section 8 of this report contains our report on learning from healthcare deaths. This includes examples of areas for improving practice identified by the reviewers.

5. Incident reporting processes

Resources

The Datix team continue to provide a range of training options for managers. Further details of our training offer are available on the Patient Safety intranet pages.

Previous quarterly and annual reports on incidents and learning are available on the Patient Safety intranet pages.

Key messages regarding incident reporting processes:

Being open and learning from healthcare deaths policy

The Patient Safety Support Team continues to receive a number of queries in relation to reporting of deaths, and they have been referred to the policy. Staff should be familiar with the learning from healthcare deaths policy to understand what to do when there is a death and which require reporting. http://nww.swyt.nhs.uk/learning-from-deaths/Pages/default.aspx

It doesn't have to be a Duty of Candour incident for us to write a letter and say we are sorry to hear about the death of someone we have been working with, this is just compassionate care. We should also be asking if families have any questions about the care of their family member and ensuring they know where they can seek support.

This should be updated on Datix. We also need to ensure that the clinical records have been reviewed to ensure any concerns about care delivered are identified early. Again, this should be added to death of a service user section.

Manager's Investigation – outcome

A document has been produced for managers to provide guidance on how to complete the field named 'What are the findings and outcome (to date) of your review or investigation of this incident?' within the Manager's Investigation section on Datix. The document can be found on the intranet here

6. Update on some improvement work

#allofusimprove includes Patient Safety as one of its key areas. A number of case studies have been developed to share good practice and improvement work.

Learning library – this is part of #allofusimprove and is our name for our repository of information from a range of sources of learning from experience. A standard template that can be completed by any member of staff using the Situation, Background, Assessment/Analysis, Recommendation (SBAR) headings has been developed. This helps us to share information in a concise way. These will be shared through the Headlines with links to a shared network drive. Further details are available here http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx

Safety Huddles – the implementation of safety huddles sits under the patient safety strategy. There are currently 9 teams actively involved with safety huddles. The focus of huddles is broad, with some teams looking at reducing violence and aggression, falls, seclusion. Achievements of targets continue to be made.

Human Factors – Bronze level on-line training is available to all staff through the Improvement Academy. Silver training is available from the Improvement Academy and several staff have now attended. Human Factors has been incorporated into the Systems Analysis training delivered by the Serious Incident Investigators. Further details are available here. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

Significant event analysis (SEA) – This tool, which has been developed in the Trust, which incorporates Human Factors, is now available. Specialist Advisors have been trained and they can support teams with its use. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

7. Trust wide Serious Incident (SI) Report[3] for Quarter 3 2019/20 (Data as at 2 January 2020)

Background context

Serious incidents are defined by NHS England as;

> "…events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare." [4]

There is no definitive list of events/incidents. However, there is a definition in the Serious Incident Framework which sets out the circumstances in which a serious incident must be declared:

Serious incidents are incidents requiring investigation and are defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- serious harm to one or more patients, staff, visitors or members of the public or where outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)
- a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment. IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a larger population
- allegations of abuse
- adverse media coverage or public concern for the organisation or the wider NHS
- one of the core set of *Never Events*[5].

Further information on reporting of SIs is available in on the intranet.

National Update

The NHS Patient Safety Strategy[6] was published in July 2019. This sets out how the NHS will build on two foundations: a **patient safety culture** and a **patient safety system**. Three strategic aims will support the development of both:

[3] Please note the SI figures given in different reports can vary slightly. This report is based on the date the SIs were reported to the CCG via the Department of Health Strategic Executive Information system (StEIS).

[4] NHS England. Serious Incident Framework. March 2015

[5] NHS Improvement. Never Event policy and framework 2018

[6] https://improvement.nhs.uk/resources/patient-safety-strategy/

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

The framework refers to the Patient Safety Incident Response Framework, which will replace the current Serious Incident Framework. The Strategy states that full implementation is anticipated by July 2021.

In the interim, SWYPT has partnered with the Royal College of Psychiatrists to develop the new national serious incident review accreditation network, launched on the 6th January 2020. The network aims to improve the quality of SI reviews to ensure they are conducted for the purpose of learning to prevent recurrence.

Investigations

Investigations are initiated for all serious incidents in the Trust to identify any systems failure or other learning, using the principles of root cause and systems analysis. The Trust also undertakes a range of reviews to identify any themes or underlying reasons for any peaks. Most serious incidents are graded amber or red on the Trust's severity grading matrix, although not all amber/red incidents are classed as serious incidents and reported on the Strategic Executive Information System (StEIS). Some incidents are reported, investigated and later de-logged from StEIS following additional information. Conversely, some incidents are reported as Serious Incidents on StEIS after local investigation.

Headlines

During Quarter 3 2019/20, there were **9 Serious Incidents reported** to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS).

Never Events[7] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were **no 'never event'** incidents reported by SWYPFT in Quarter 3 2019/20. The last Never Event reported by the Trust was in 2010/11. A revised list of Never Events came into effect on 1 February 2018. This is available on the Trust intranet.

Quarter 3 Headlines

- 9 Serious incidents reported
- Serious incidents account for 0.2% of all incidents
- No homicides
- No Never Events

[7] NHS Improvement. Never Event policy and framework 2018

Serious Incident Reporting Analysis

During Quarter 3 2019/20 there have been 9 serious incidents reported on STEIS, as shown in Figure 6 by financial quarter, with comparative data for previous years.

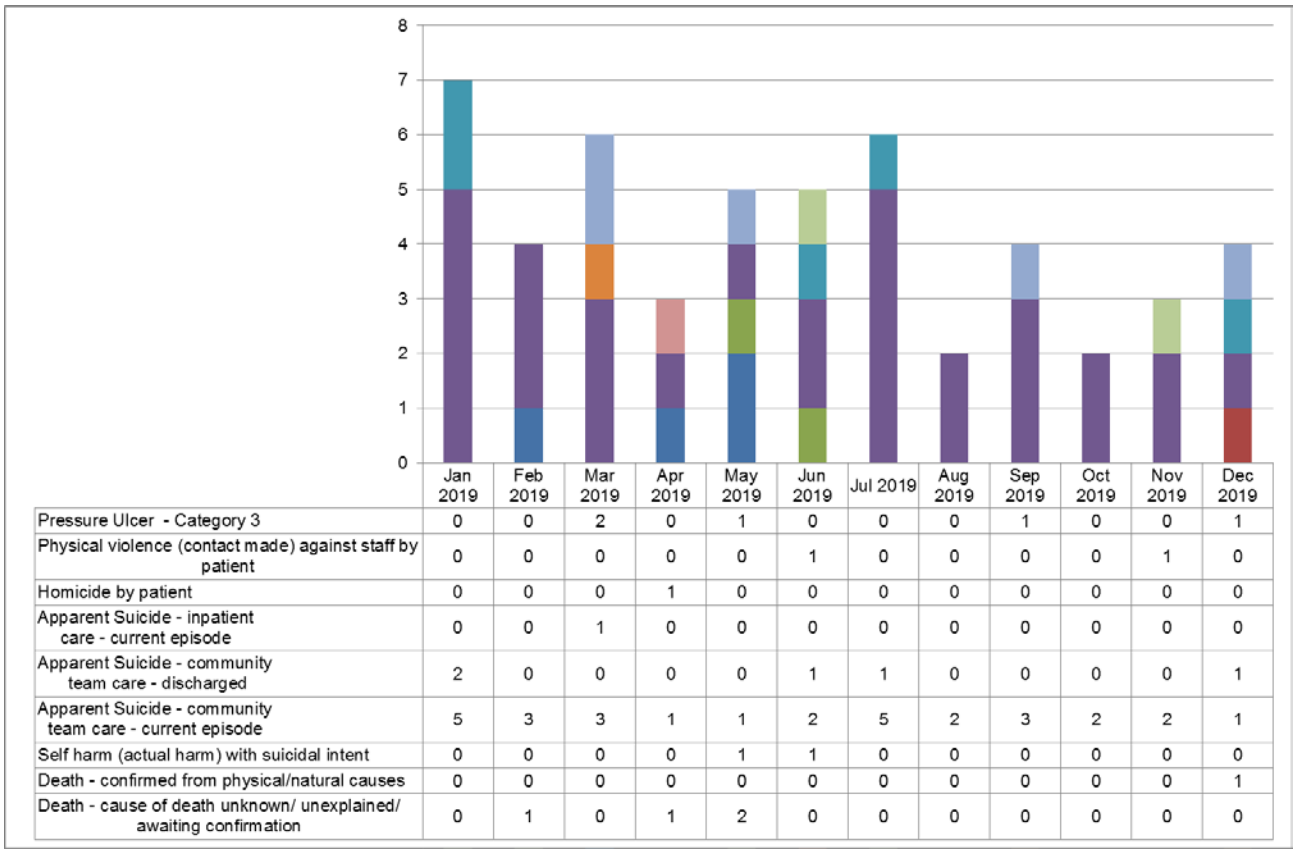
Figure 6 Serious Incidents reported to the Commissioner by financial year and quarter up to 31/12/2019 (2015/16 - 2019/20)

Financial Quarter	15/16	16/17	17/18	18/19	19/20
Quarter 1	18	13	15	8	13*
Quarter 2	23	13	18	9	12*
Quarter 3	15	15	26	10	9
Quarter 4	20	23	12	17	-
Totals	**76**	**64**	**71**	**44**	**34**

*Updated figure from previous reports - three serious incidents reported on StEIS during 2019/20 have since been removed as serious incidents (1 in Q1 and 2 in Q2). These were all homicides by patients, which are being reviewed through safeguarding processes which supersedes the SI process.

Figure 7 shows a breakdown of the 51 serious incidents in a rolling 12 month period (1/1/2019-31/12/2019) by the type of incident and the month reported. The number of SIs reported in any given period of time can vary, and given the relatively small numbers involved and the broad definition of an SI, it can be difficult to identify and understand the reasons for this. However it is important that any underlying trends or concerns are identified through analysis.

Figure 7 Types of All Serious Incidents reported on STEIS in the 12 month period (01/01/2019 – 31/12/2019)



	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
Pressure Ulcer - Category 3	0	0	2	0	1	0	0	0	1	0	0	1
Physical violence (contact made) against staff by patient	0	0	0	0	0	1	0	0	0	0	1	0
Homicide by patient	0	0	0	1	0	0	0	0	0	0	0	0
Apparent Suicide - inpatient care - current episode	0	0	1	0	0	0	0	0	0	0	0	0
Apparent Suicide - community team care - discharged	2	0	0	0	0	1	1	0	0	0	0	1
Apparent Suicide - community team care - current episode	5	3	3	1	1	2	5	2	3	2	2	1
Self harm (actual harm) with suicidal intent	0	0	0	0	1	1	0	0	0	0	0	0
Death - confirmed from physical/natural causes	0	0	0	0	0	0	0	0	0	0	0	1
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	1	0	1	2	0	0	0	0	0	0	0

All serious incidents are subject to a manager's review within 48 hours of reporting. This is to enable any themes/trends /issues to be identified early and as close to services as possible.

Figures 8 and 9 show the SI reported in the quarter (9) by the team type and BDU and incident category.

Figure 8 Serious Incidents reported by team and BDU during Q3 2019/20

Team/BDU	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic	Total
Core Team North - Kirklees	0	0	0	1	0	0	1
Criminal Justice Liaison Team, Barnsley	1	0	0	0	0	0	1
Enhanced Lower Valley Team - Calderdale	0	0	1	0	0	0	1
Enhanced Team West - Wakefield	0	0	0	0	1	0	1
Intensive Home Based Treatment Team (IHBTT) - Wakefield	0	0	0	0	1	0	1
Intensive Home Based Treatment Team (Kirklees)	0	0	0	1	0	0	1
Neighbourhood Team - South (Barnsley)	0	1	0	0	0	0	1
Priestley Ward, Newton Lodge	0	0	0	0	0	1	1
Thornhill Ward (The Bretton Centre)	0	0	0	0	0	1	1
Total	1	1	1	2	2	2	9

Figure 9 Serious Incidents reported by incident category and BDU during Q3 2019/20

Category/BDU	Barnsley Mental Health	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic	Total
Death - confirmed from physical/natural causes	0	0	0	0	0	1	1
Suicide (incl apparent) - community team care - current episode	1	0	1	1	2	0	5
Suicide (incl apparent) - community team care - discharged	0	0	0	1	0	0	1
Physical violence (contact made) against staff by patient	0	0	0	0	0	1	1
Pressure Ulcer - Category 3	0	1	0	0	0	0	1
Total	1	1	1	2	2	2	9

Apparent suicide - National and local demographic comparison

Trust-wide, there were a total of 47 apparent suicides that occurred during the rolling 12 month period between 1 January 2019 to 31 December 2019 (figure 10). This compares with 44 reported during 2018/19* and 58 during 2017/18*. We encourage reporting of apparent suicides for discharged patients where last contact was within the 6 months prior to death.

Figure 10 All Apparent Suicides reported in the last 12 months between 1/1/19 – 31/12/19 by Quarter (date reported) and geographical area

	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	Total
Barnsley	2	1	1	1	5
Calderdale	3	3	3	2	11
Kirklees*	7	3	3	6	19
Wakefield**	4	2	5	1	12
Total	16	9	12	10	47

*includes one apparent suicide reported by Learning Disability Services, Kirklees

**includes one apparent suicide reported by CAMHS Wakefield

The highest method of apparent suicide occurring in this period (Figure 10) related to death by hanging.

Figure 11 Apparent suicides by method reported on STEIS between 01/10/19 – 31/12/19

	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	Total
Hanging - self injury	14	4	6	5	29
Jumping from height	0	3	1	0	4
Other self-injury	0	0	1	2	3
Prescription medication - self poisoning	1	1	1	0	3
Drowning - self injury	0	0	0	2	2
Over the counter medication - self poisoning	0	0	2	0	2
Contact with moving vehicle (car, train) - self injury	1	0	0	0	1
Illicit drug - self poisoning	0	1	0	0	1
Other - self poisoning	0	0	0	1	1
Self-strangulation - self injury	0	0	1	0	1
Total	16	9	12	10	47

The most common method of patient suicide in England[8] is hanging/strangulation (45%), self-poisoning (24%) and jumping/multiple injuries (15%), accounting for 84% of all apparent suicides. The Trust data for the rolling 12 month period is small in number but includes these methods.

The National Confidential Inquiry (NCI)[8] figures **December 2019** indicate that over the period of 2007-2017 there was an average of 4,575 deaths in the general population (England only) that were registered as suicide or 'undetermined'.

* Refreshed data at 15/1/2020 by date reported

[8] National Confidential Inquiry into Suicide and Homicide 2019

Using this data, the NCI stated that the rate of suicide per 100,000 general population for our regions should be approximately 10.4 in the West Yorkshire STP footprint, and 10.3 within South Yorkshire and Bassetlaw.

This information must be viewed with caution, because the Trust does not have access to the actual local suicide numbers in general population data. The data from the National Confidential Inquiry may not reflect trends until two years later.

The NCI report states that on average during 2007-2017, patient suicides accounted for 27% of the general population suicide figures (13,806 deaths i.e. the individual had been in contact with mental health services in the 12 months prior to death). This represents an average of 1,255 patient suicides per year.

Analysis using population size[9] and NCI data[8] shows that a Trust covering Barnsley, Calderdale, Kirklees and Wakefield would expect to see between 33-34 patient deaths by apparent suicide per year. Figure 12 provides an indication of the number of patient suicides by district against predicted levels using the NCI statistics.

Figure 12 Populations of the Trust's Districts and Average Suicide Rates

Area	Population ONS[9] – population estimates Mid 2019	General population suicide rate (NCI) 10.4 (West Yorkshire STP) & 10.3 (South Yorkshire and Bassetlaw) per 100,000 population	Patient suicide rate (27% of general population suicides) (NCI)[6]	Reported apparent suicides (1/1/19-31/12/19)
Barnsley	245,199	24.5	6-7	5
Calderdale	210,082	21.0	5-6	11
Kirklees	438,727	43.9	11-12	19
Wakefield*	345,038	34.5	9-10	12
Trust wide	1,230,730	123.07	33-34	47

The rolling 4 quarter data (Figure 10 and 12) shows that the Trust had 47 apparent suicides of patients/former patients where last contact was in the last 6 months prior to death occurring. This is above the number of apparent suicides we would anticipate based on the National Confidential Inquiry figures (Figure 11) for a population the size of the Trust and patient suicide rate (27%). A higher number in Quarter 4 18/19 will have affected this.

Caution is advised with these comparisons due to the sensitivity of the figures if just one or two more incidents occur, and because the figures are not weighted by characteristics such as age, gender or socio-economic status. Also service provision can differ and some teams (eg police liaison practitioners) routinely report apparent suicides where there has been any contact with the Trust.

The variation in number of suicides may simply be a result of the number of service users seen by the Trust across its services. Further breakdown of this will be included in the Annual apparent suicide report.

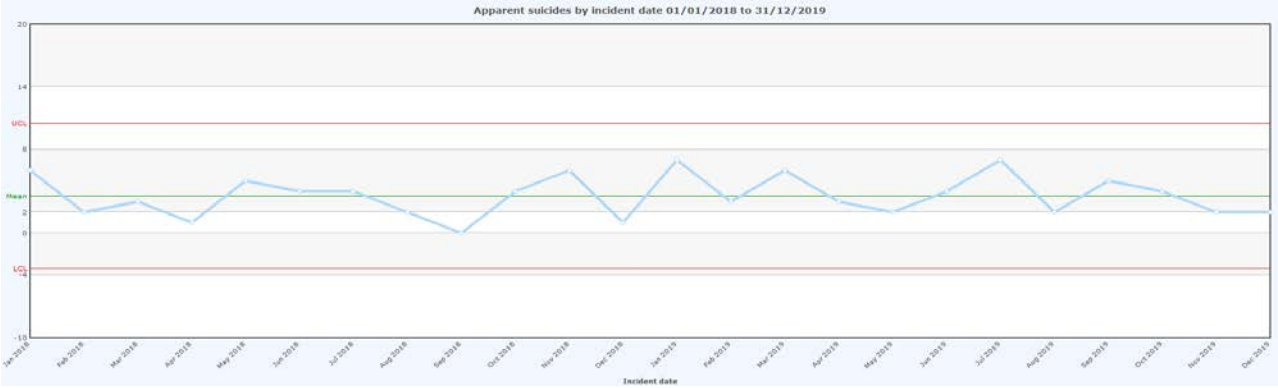
[9] Office of National Statistics.

It must be noted that the figures above are apparent suicides and not confirmed by the Coroner. The timeframes used in this report are based upon when the incident was reported in the Trust. All apparent suicides are reviewed by teams, and in line with the learning from healthcare deaths policy and subject to further review. Deaths will either be serious incident investigations, service level investigations, Mortality Structured Judgement Reviews, first stage case record review or considered through safeguarding processes.

Figure 13 Apparent suicides reported in the Trust by mortality review process

	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	Total
Serious Incident Investigation	12	7	10	5	34
Structure Judgement Review (SJR)	3	2	0	2	7
Service Level Investigation	1	0	1	1	3
Manager's 48 hour review (1st stage case note review)	0	0	1	1	2
Other investigation	0	0	0	1	1
Total	16	9	12	10	47

Figure 14 Apparent suicides reported in the Trust by mortality review process (statistical process chart)



This graph includes all apparent suicides reported on Datix in line with the Learning from Deaths policy. Not all apparent suicides will meet the national definition (see previous definition) for a Serious Incident. This includes deaths that appear to be suicides of service users under the Trust's recent care but have had little or no contact or discharged from services some time before.

Apparent suicide does not indicate the coroner's conclusion. Records will be updated as further information comes to light, e.g. if coroners conclusion is natural causes or confirms suicide. Data may change over time. This graph uses the incident date.

The data from the National Confidential Inquiry may not reflect trends until two years later. The Trust looks at apparent suicides on an annual basis and reports any difference between the national data and that of the Trust. The Trust may on occasions report and investigate deaths that are later removed from the numbers as the death was not found to be due to suicide.

Serious Incident Investigations completed during Quarter 3 2019/20

This section of the report focusses on the 10 serious incident investigation reports that were completed and submitted to the relevant commissioner during Quarter 3 2019/20. Please note this is not the same data as those reported in this period as investigations take a number of months to complete. The term ‘completed’ is used in this section to describe this.

Headlines

Quarter 3 Serious incident investigation headlines

- **10** SI Investigation Reports have been completed
- **8** SI investigations closed by the Commissioners
- **24** SI investigations remain under investigation (as at 09/01/2020)

- From the completed investigations, the top 3 action themes were:
  - Record keeping
  - Care delivery
  - Policy and procedure - in place but not adhered to

From 1 April 2015, the national policy (Serious Incident Framework, NHS England) was updated, and the timescales for completion was revised to complete investigations within 60 working days. While the Trust tries to achieve this, it has the support of commissioners to complete a quality report above a timely report. The Trust requests extensions from commissioners to agree revised dates and the investigators also keep families informed.

Of the 24 investigations that are underway, these are at different stages of progress. Fifteen are currently over the 60 working day timeframe (Figure 14). This higher level of overdue investigations is due to a number of factors.

There was a higher volume of serious incidents reported earlier in the year, coinciding with a reduction in the lead investigator and medical investigator capacity to support. One of the investigations was awaiting the outcome of a criminal investigation before the investigation could be ‘de-logged’ and in two of the investigations the lead investigators have been off work due to sickness and one of the investigations had to be reallocated. To address this, we have used Bank investigators, however as this was the first serious incident investigation for many; this has involved considerable support and coaching from the Patient Safety Support Team.

Some investigations have also been very complex, involving close working with partners such as Acute Trusts and other agencies. Investigators sometimes have difficulty arranging interviews with staff due to shift patterns which adds to delays. Three of these investigations have been completed, but are awaiting approval from Directors. Investigation progress is monitored on a weekly basis through the patient safety investigators meeting, and reported through the weekly clinical risk panel. Close contact is maintained with Commissioners and

the quality and thoroughness of the investigation reports is always seen as the priority rather than meeting the deadline.

To support the lead investigators in the allocation of serious investigations, three additional bank investigators have been recruited and additional members of the workforce have been identified to complete an investigation as part of their continued professional development. We have also commissioned an external investigator to complete three complex investigations and a deep dive into outstanding overdue investigations is being held in February 2020.

Figure 15 Total number of SI investigations ongoing at the end of each quarter 01/01/19 to 31/12/19 compared how many investigations were over 60 working day timescale at that time (at 9/1/2020)

	Quarter 4 2018/19	Quarter 1 2019/20	Quarter 2 2019/20	Quarter 3 2019/20
Serious Incident investigations over 60 working days timeframe	5 (22%)	4 (17%)	5 (16%)	15 (62%)
Total number of ongoing SI investigations	23	24	31	24

SI Action Plans

Each BDU monitors the implementation of their action plans. The Patient Safety Support Team send out information on the current position status based on information completed on Datix each month in the Clinical risk report for Operational Management group report. This is providing real time data more regularly and reducing overdue action plans.

Serious Incident learning and themes

During Quarter 3, the number of investigations completed and sent to the commissioners was 10. There were 29 separate actions made to improve the system or process to prevent recurrence**.**

A standard recommendation to share learning is in common use. This is to support learning being shared across the teams, service, BDU, Trust and wider health economy. These recommendations have been removed from the analysis below.

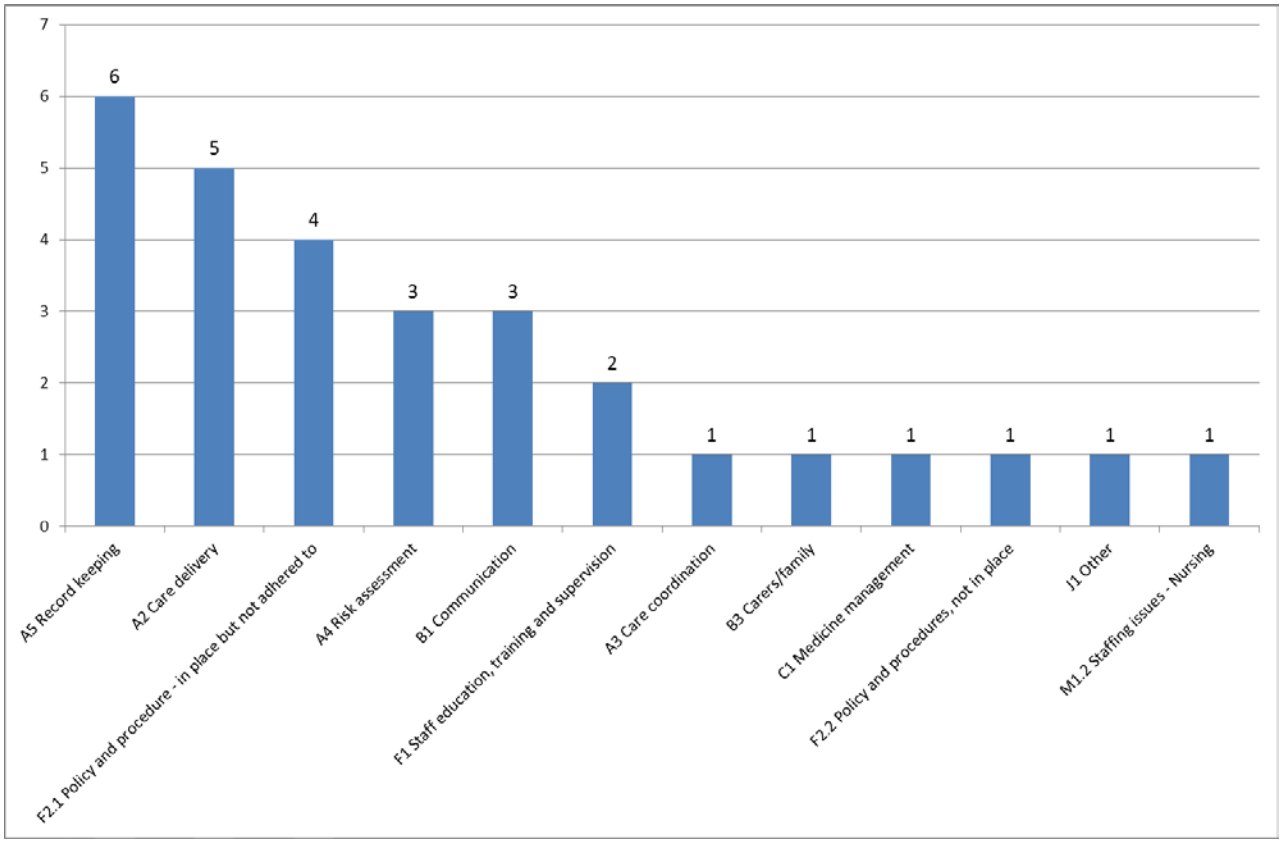
Categorisation of recommendations/actions

In analysing the actions, it isn't always straightforward to identify which category an action should be included in - some don't easily fit into any category, and some could be included under more than one. The analysis undertaken has included each action under the issue/theme that seemed the best match. In an attempt to gain consistency, the theming of actions is undertaken by the Lead Serious Incident Investigators.

Many actions take some time to implement. These are monitored through the operational managers group and BDU governance groups. Work to ensure monitoring and implementation of all Serious Incident action plans continues.

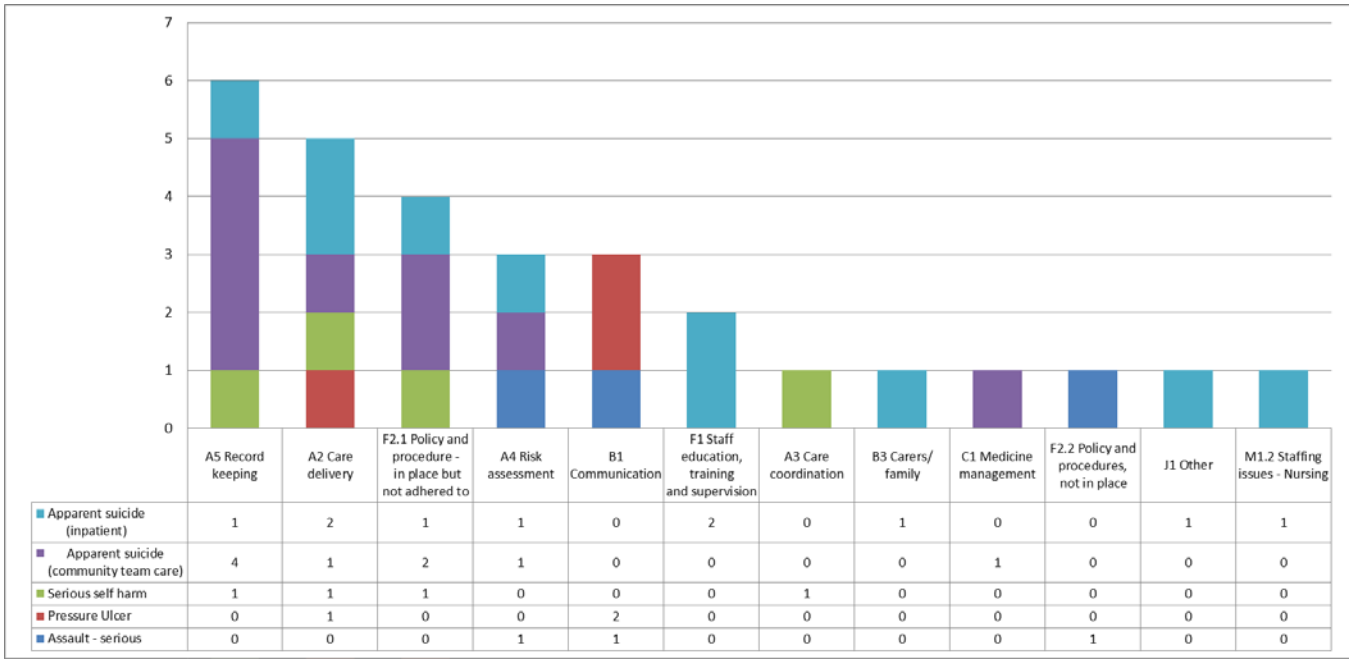
Figure 16 shows the action themes arising from the 10 serious incidents completed and sent to commissioners during Quarter 3.

Figure 16 Quarter 3 2019/20 completed serious incident investigations, by action theme



As shown in Figure 17, suicide including apparent (community team care) incidents had the largest number of actions, which correlates with the number of investigations sent to the commissioners in the quarter.

Figure 147 Comparison of action themes by serious incident type



	A5 Record keeping	A2 Care delivery	F2.1 Policy and procedure - in place but not adhered to	A4 Risk assessment	B1 Communication	F1 Staff education, training and supervision	A3 Care coordination	B3 Carers/ family	C1 Medicine management	F2.2 Policy and procedures, not in place	J1 Other	M1.2 Staffing issues - Nursing
Apparent suicide (inpatient)	1	2	1	1	0	2	0	1	0	0	1	1
Apparent suicide (community team care)	4	1	2	1	0	0	0	0	1	0	0	0
Serious self harm	1	1	1	0	0	0	1	0	0	0	0	0
Pressure Ulcer	0	1	0	0	2	0	0	0	0	0	0	0
Assault - serious	0	0	0	1	1	0	0	0	0	1	0	0

The majority of the actions from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator works closely working with the practice governance coaches and BDUs to present learning from recommendations which is included in 'Our learning journey' reports. A summary suitable for sharing is completed at the end of the investigation process to summarise the learning from an SI investigation. This is shared through Operational Management group and added to the learning library.

Learning within this quarter:-

- A number of individual teams have taken time to share and discuss the learning from particular incidents
- The incidents were shared in the team, service line and BDU

An overview of actions from serious incident investigations completed in Q3, are detailed below:

Record keeping

- The Intensive Home Based Treatment Team to provide assurance that care plans and crisis and contingency plans are recorded in the appropriate section of SystmOne and that these are provided to all service users who receive a period of support from them.
- Changes regarding leave conditions should be recorded contemporaneously and must include informal service users. The practice of leaving these changes to night staff must stop immediately.
- A team response should be included in the actions in a Crisis Care Plan.
- The team should ensure that all service users have a Care Programme Approach Care Plan

- The team should ensure that risk assessments are updated and accurate at the point of referral, when there are significant changes to risk and at least annually
- When service users red, amber, green rating is changed within the IHBTT MDT meeting, the rationale for the grading change should be fully recorded within the electronic record.

Care delivery

- There must be a hard copy of the most recent handover record available on every ward at all times. This should include current leave conditions for all service users.
- Monitor compliance of Waterlow risk assessments during Quarter 4 2019/20 to ensure learning embedded into practice.
- Where there are problems engaging with service users who are on Flexible Assertive Community Treatment this should be raised at the daily Flexible Assertive Community Treatment meeting and the outcome and subsequent plan documented in the service user's notes.
- Wards should not be left without access to routine Clinical Psychology input for extended periods of time. Where it is not possible to recruit temporary staff a system of cross-cover should be implemented to ensure that inpatient service users have access to comprehensive psychological assessments and staff are supported to provide psychologically-minded care.
- Where service users with emotionally unstable personality disorder are experiencing repeated presentations of section 136 assessments, the clinical MDT team should give consideration of a referral to Intensive Home-Based Treatment Team/Crisis Team to decide whether to increase support in the community to try to prevent further section 136 detentions.

Policy and procedure - in place but not adhered to

- The enhanced team needs to provide assurance that all service users under their care who are on Care Programme Approach have a current crisis and contingency plan in place and there is consistent practice across the processes involved in this.
- The Safeguarding Team to update the "information sharing slide" in the mandatory training, to emphasise that All Staff in the Trust may play a role in relation to safeguarding and promoting the welfare of children and through contributing to multi-agency assessments of children and their families.
- A trust-level governance group should formally examine the factors why the existing systems of governance failed to identify or address the significant gaps between the policy and practice of risk assessment, care planning, and the provision and reporting of clinical and management supervision. It should also examine how practicable it is for clinical staff to meet the requirements of the relevant policies and seek to address the gap between 'work as imagined' and 'work as done'. It is essential that this work involves front line clinical staff. The work should also consider how unsafe practices – e.g. the lack of written handover records – were allowed to develop and persist without challenge and develop strategies to prevent recurrence.

Risk assessment

- The service needs to provide assurance that all service users are discharged from the acute ward with a review of existing level two risk assessments having taken place.

  It is acknowledged that the Trust is currently reviewing all risk assessment processes. It is recommended that this review makes reference to in-patient stays of short duration where it is not possible to convene a multi-disciplinary team to discuss and review level two risk assessments.
- Risk management plans should be completed prior to ward transfers and where possible personal behaviour support plans.
- There must be a clinical audit on the ward (and possibly wider) to review the current state of risk assessments including as a minimum:
  • Are they complete?
  • Do they include a risk formulation that meets the requirements of the policy?
  • Have they been reviewed in response to changes in presentation?
  • Have they been updated?
  • Has the assessment been agreed by the Multidisciplinary Team?

  The outcome of the audit must be considered in the appropriate governance group and an action plan implemented to address any issues arising.

Communication

- Outcome of the learning event to include a plan of how the teams can develop a MDT approach to care to ensure joint working and improved communication
- When the transfer/admission of a service user with a violent history occurs, where clinically indicated staff should as soon as possible seek advice from the Reducing Restrictive Practice and Interventions team on how to manage the service user.
- The Patient Safety Strategy BDU action plan to include specific actions around MDT working and a flexible workforce to improve communication and patient experience

Staff education, training and supervision

- The systems of clinical and management supervision on the ward require a review to ensure that both types of supervision meet the requirements of the policy. The review must address the following:

  a) Consideration should be given to implementing a system to book both management and clinical supervision in advance, including effective monitoring, to ensure it occurs regularly and in compliance with the Supervision Policy.

  b) The review must address the over-reliance on informal supervision and ensure that clinical supervision meets the requirements of Section 3.2 of the Supervision of the Clinical Workforce Policy and that Management Supervision meets the requirements of Section 3.1 and specifically includes caseload review in order to maintain standards of care planning, risk assessment and record keeping.

- The Occupational Health Department guidance for managers supporting staff following a critical incident should be reviewed to include advice to be followed immediately on the day of an incident including one-to-one support and for making arrangements for staff affected to go home where appropriate.

Care coordination

- In respect of out of area residents being detained in 136 suites, protocols should contain reference to it being best practice to inform the responsible mental health services when practicable.

Medicine management

- The team should ensure that GP's are aware of who is taking the lead in prescribing psychotropic medication

Policy and procedures, not in place

- The draft Psychiatric Intensive Care Unit SOP should finalised as soon as possible to mirror guidance in the Adult Acute ward SOP.

Other

- The Local Business Continuity Plan should be reviewed jointly with the SystmOne Business Continuity Plan in the light of this report to ensure alignment between what IT and clinical staff regard as system failure and to avoid the risk of gaps between the SystmOne Business Continuity Plan and the Local Operational Business Continuity Plans. This should include clear guidance for clinical staff in the event of any degradation of SystmOne performance that affects their ability to provide safe care.

Staffing issues - Nursing

- The current practice of rostering day shifts and the allocation of bank and agency work on the ward should be reviewed with particular reference to the issues highlighted in the section 'Staffing' with the objective of improving consistency of care and avoiding circumstances where no Registered Nurses on shift were on duty the previous day. It should also take into consideration the wellbeing of staff. This should include reviewing the guidance in the Staff Roster Policy as to how the policies aims should be implemented by Ward Managers.

South West Yorkshire Partnership NHS Foundation Trust

Learning from healthcare deaths Report: Annual Cumulative Report 2019/20 (covering the period 1/4/2019 – 31/12/19)

1. Background context

1.1 Introduction

Scrutiny of healthcare deaths has been high on the government's agenda for some time. In line with the National Quality Board report published in 2017, the Trust has had Learning from Healthcare Deaths policy in place since September 2017 that sets out how we identify, report, investigate and learn from a patient's death. The Trust has been reporting and publishing our data on our website since October 2017.

Most people will be in receipt of care from the NHS at the time of their death and experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, their experience is different and they receive poor quality care for a number of reasons including system failure.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Therefore, it is important that organisations widen the scope of deaths which are reviewed in order to maximise learning.

The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

The Trust has worked collaboratively with other providers in the North of England to develop our approach. The Trust will review/investigate reportable deaths in line with the policy. We aim to work with families/carers of patients who have died as they offer an invaluable source of insight to learn lessons and improve services. 3

1.2 Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and on its Datix system where the death requires reporting.

The Trust's Performance and Information team is also working with local registration of deaths services to ensure data on deaths is accurate and timely.

From 1 October 2017, the Trust introduced our Learning from healthcare deaths – the right thing to do policy which introduced a revised scope for reporting deaths. Staff must report deaths where there are concerns from family, clinical staff or through governance processes and where the Trust is the main provider of care, reporting these deaths on Datix within 24 hours of being informed. The policy was reviewed and updated in January 2020.

Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny the Trust has adopted in line with the National Quality Board guidance:

In scope deaths should be reviewed using one of the 3 levels of scrutiny:		
1	Death Certification	Details of the cause of death as certified by the attending doctor.
2	Case record review	Includes: (1) Managers 48 hour review (2) Structured Judgement Review
3	Investigation	Includes: Service Level Investigation Serious Incident Investigation (reported on STEIS) Other reviews e.g. LeDeR, safeguarding.

1.3 Next Steps

Our work to support learning from deaths continues, and includes:

- Development of processes to support bereaved families and carers.
- Ongoing development of the Clinical Mortality Review Group
- Thematic review and analysis of learning from deaths findings
- Further development of internal processes and consistency in data collection
- Continued training for Structured Judgement Reviewers.

2. Annual Cumulative Dashboard Report 2019/2020 covering the period 1/4/2019 – 31/12/19

Table 1 Summary of 2019/20 Annual Death reporting by financial quarter to 31/12/2019

	2018/19 total	Quarter 1 2019/20	Quarter 2 2019/20	Quarter 3 2019/20	Quarter 4 2019/20	2019/20 total to date
Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death*	2583**	769	679	823		2271
Total number of deaths reported on Datix by staff (by reported date, not date of death)	344	74	77	94		245
Total number of deaths reviewed	344	74	77	94		245
Total Number of deaths which were in scope	274	63	60	81		204
Total Number of deaths reported on Datix that were not in the Trust's scope	37	4	15	10		29
Total Number of reported deaths which were rejected following review, as not reportable or duplicated.	33	7	2	3		12

**Data extracted from Business Intelligence and Datix risk management systems. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems. Dashboard format and content as agreed by Northern Alliance group

* since this figure was run, the data source is now solely from SystmOne, therefore figures will have increased due to improved flow of data. For the purposes of this report and data contained in Quality Accounts, the total for 2018/19 has not been refreshed.

Table 2 Breakdown of the total number of deaths reviewed by service area by financial quarter up to 30/9/2019

Total Number of Deaths reviewed	Mental Health Community	Mental Health Inpatient	General Community	General Community Inpatient	Specialist Services Learning Disability	Specialist Services CAMHS	Forensic Services	Specialist Services ADHD
Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1
63	**45**	**3**	**3**	**0**	**12**	**0**	**0**	**0**
Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2
60	**39**	**4**	**3**	**0**	**14**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3
81	**66**	**5**	**0**	**0**	**9**	**0**	**1**	**0**
Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD
204	**150**	**12**	**6**	**0**	**35**	**0**	**1**	**0**

Table 3: Summary of total number of in scope deaths and Review process (excluding Learning Disability deaths)

Total Number of Deaths in scope	In-Patient Deaths	Deaths Reviewed in line with SI Framework	Deaths reviewed through other investigation processes	Deaths subject to Structured Judgement Review	Deaths where 48 hour review accepted (1st stage case note review)	Deaths Certified
Q1	Q1	Q1	Q1	Q1	Q1	Q1
49	**3**	**9**	**2**	**8**	**7**	**23**
Q2	Q2	Q2	Q2	Q2	Q2	Q2
46	**4**	**11**	**1**	**7**	**15**	**12**
Q3	Q3	Q3	Q3	Q3	Q3	Q3
73	**5**	**6**	**8**	**11**	**14**	**34**
Q4	Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD	YTD
168	**12**	**26**	**11**	**26**	**36**	**69**

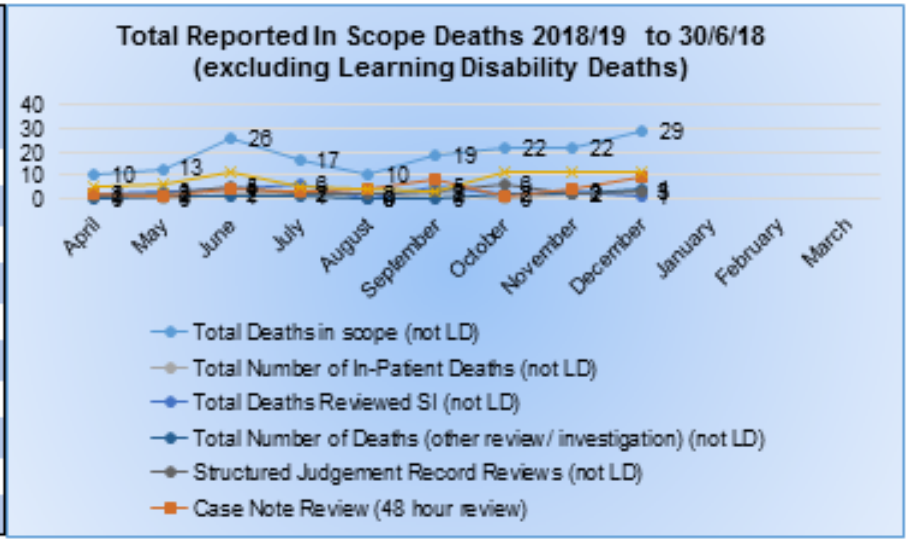
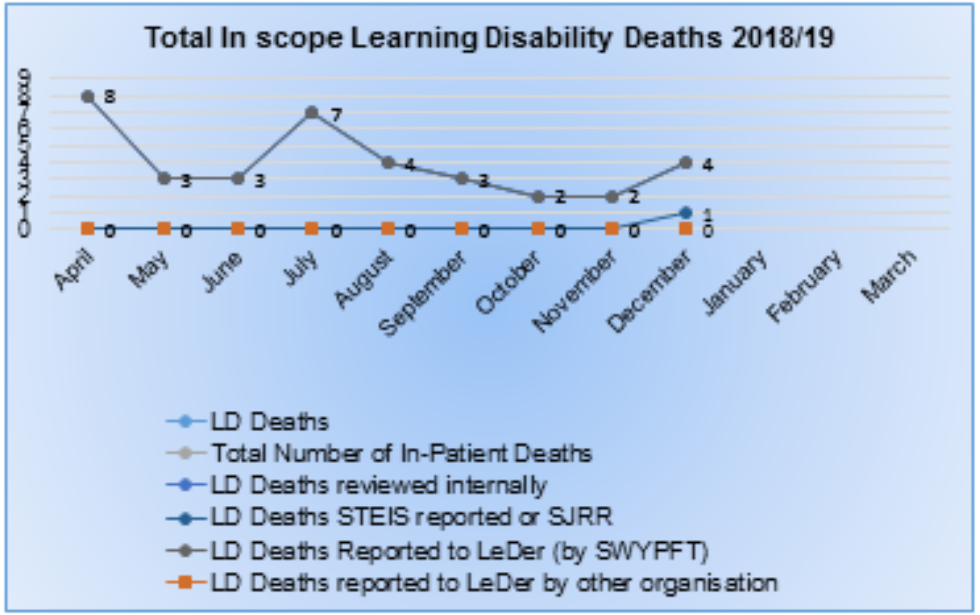


Table 4: Summary of total number of Learning Disability deaths which were in scope

Total Number of Learning Disability Deaths in scope	In-Patient Deaths	Deaths Reviewed internally	Deaths Reviewed as SI or SJR (in addition to LeDer)	Deaths reported through LeDer (By SWYPFT)	Deaths reported through LeDer (By other organisation)
Q1	Q1	Q1	Q1	Q1	Q1
14	**0**	**14**	**0**	**14**	**0**
Q2	Q2	Q2	Q2	Q2	Q2
14	**0**	**14**	**0**	**14**	**0**
Q3	Q3	Q3	Q3	Q3	Q3
8	**0**	**8**	**1**	**8**	**0**
Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD
36	**0**	**36**	**1**	**36**	**0**



3. Learning from Healthcare Death reviews and investigations

This section of the report contains an overview of themes identified from reviews and investigations that have been completed so far (by 13/11/19) for deaths reported between 1/4/17 – 30/9/19. Further learning will be added as these are completed.

The narrative from investigations and reviews that have been completed by 13/11/2019 have been extracted from Datix and grouped by theme for further detailed analysis. Some of this data has been reviewed at the Clinical Mortality Review Group. Learning library summaries are being prepared (as set out in Appendix A) to enable us to share thematic learning and key messages.

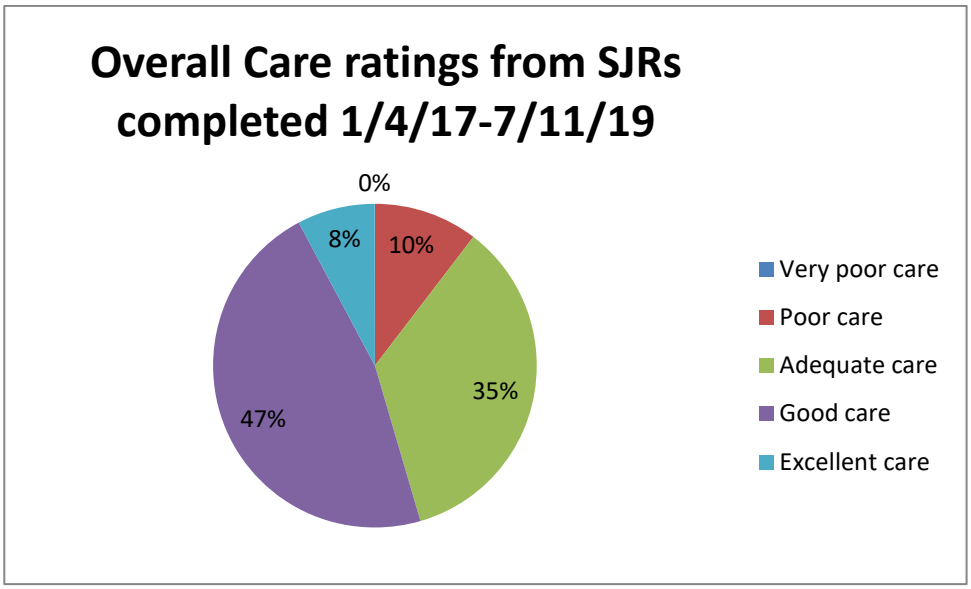
3.1 Learning from Structured Judgement Reviews

This section provides information on deaths reported on Datix between 1 April 2017 and 30 September 2019 which resulted in a Structured Judgement Review. The information in the charts is cumulative over time.

During a Structure Judgement Review, the reviewer assesses each phase of care and records their findings on a template under those headings. The sections below show the ratings for each phase of care.

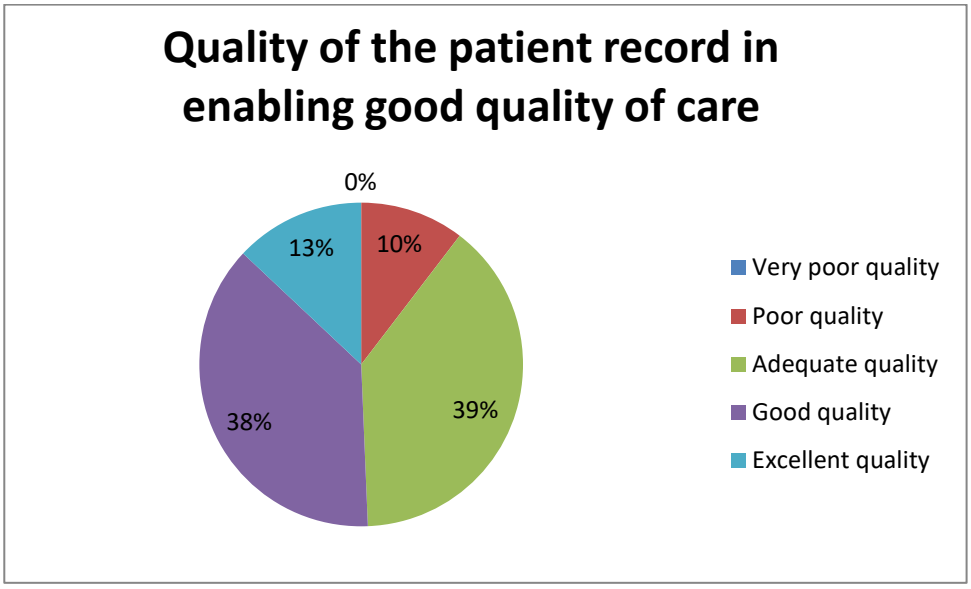
Assessment of Care Overall

55% of the 77 reviews completed to date rated overall care as good or excellent. This compares with the previous position of 56%.



Quality of the patient record in enabling good quality of care to be provided:

51% of the 77 reviews completed were rated the patient record in enabling good quality care as good or excellent. This is the same as reported last year 51%

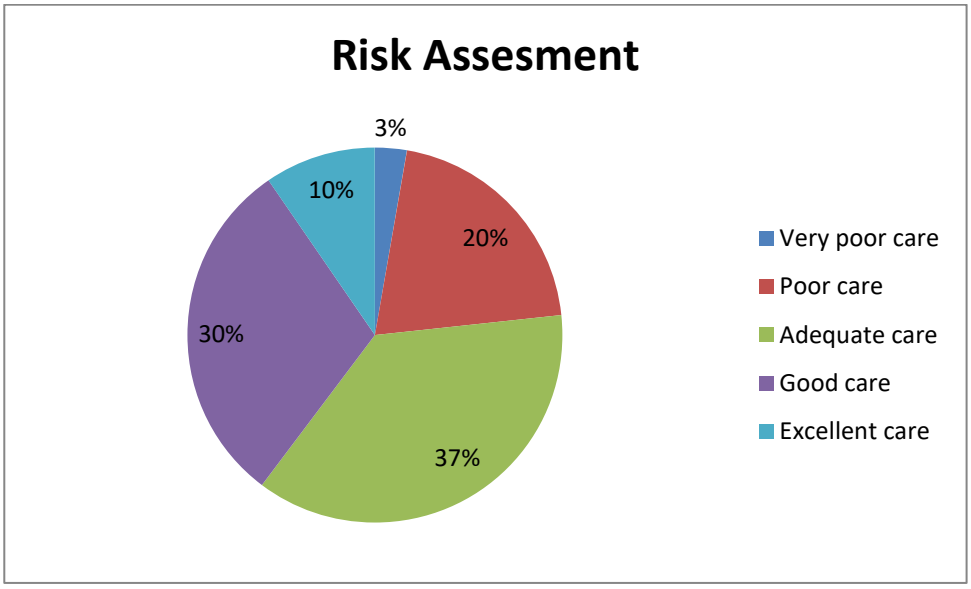


Phases of care

Below is a summary of the ratings given for each phase of care:-

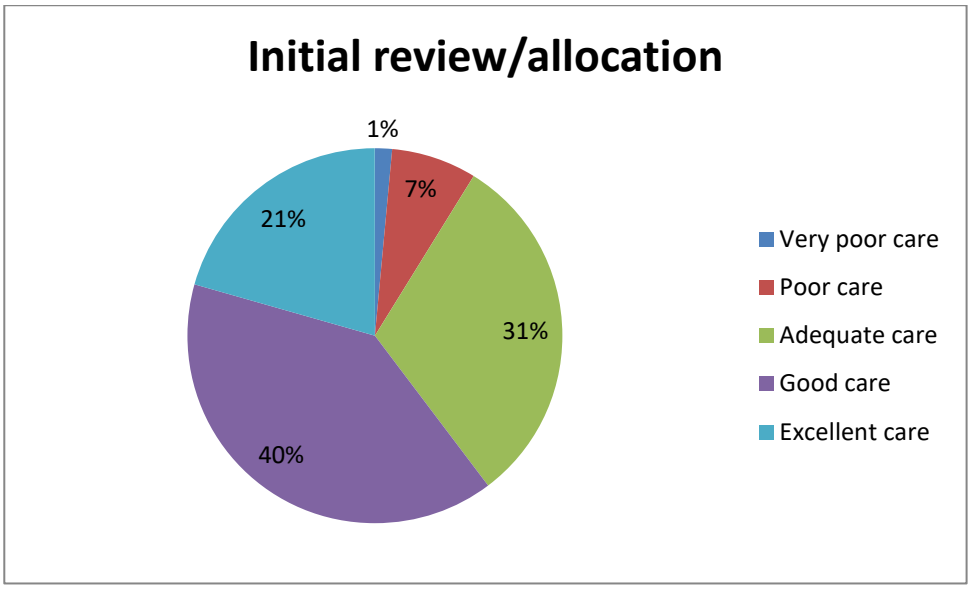
Risk assessment:

40% of the 73 reviews completed rated risk assessment (where this was relevant) as good or excellent. This percentage has increased slightly from the last year (35%)



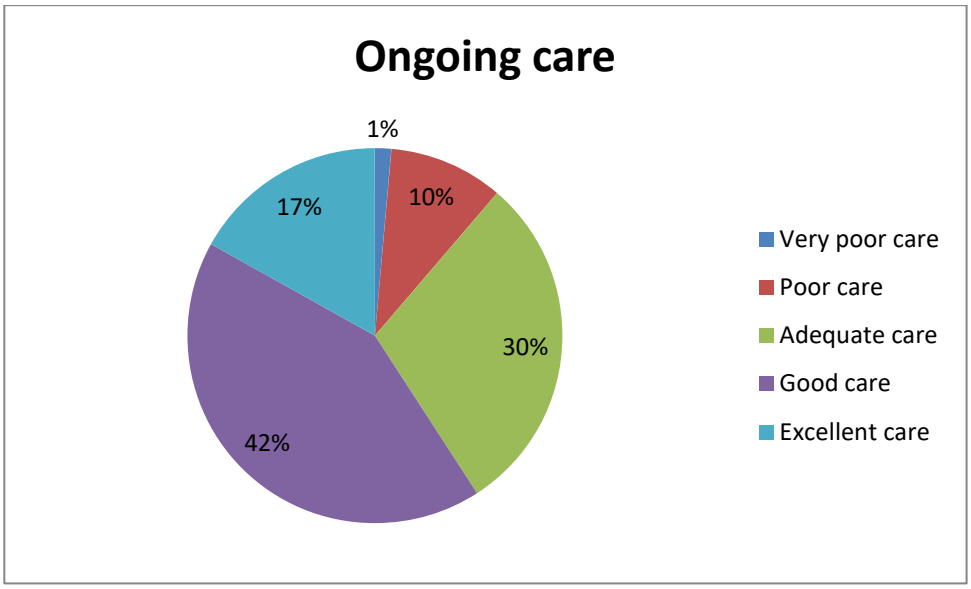
Allocation/Initial Review:

60% of the 68 reviews completed rated the initial review/allocation (where this was relevant) as good or excellent. Improved position on previous year (46%)



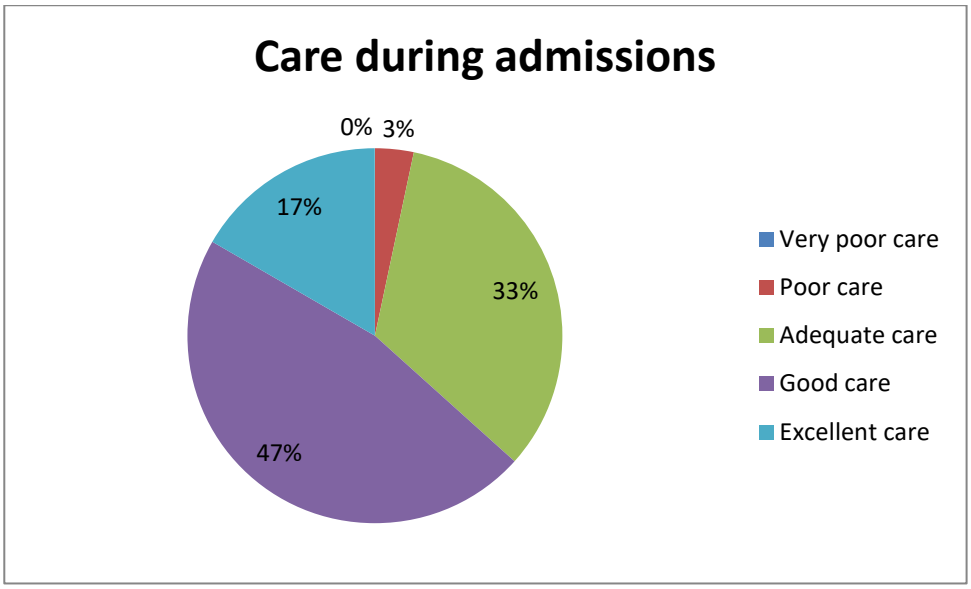
On-going Care:

59% of the 71 reviews completed rated the initial review/allocation (where this was relevant) as good or excellent. Improved on previous year (56%)



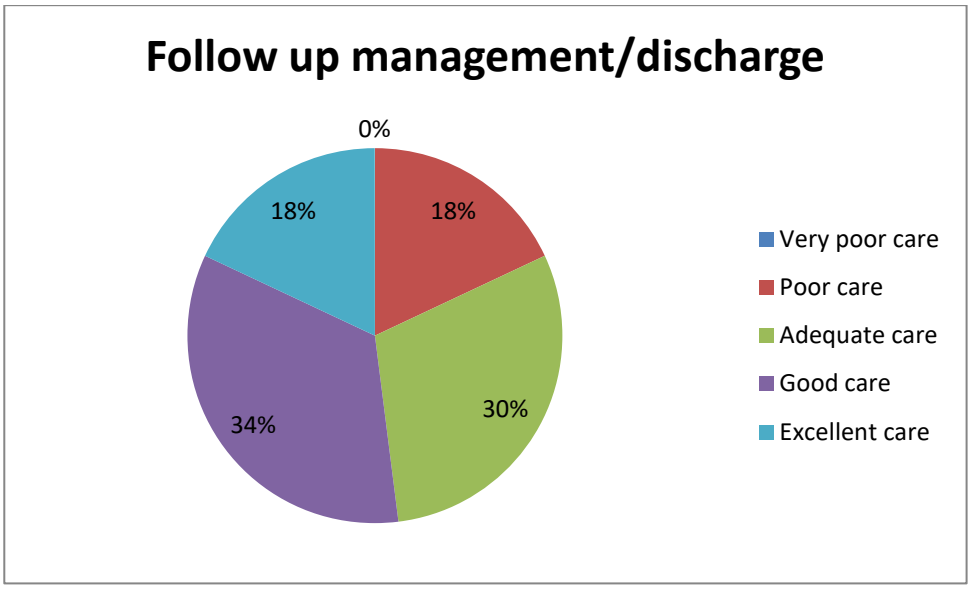
Care During Admissions (where applicable):

63% of the 30 reviews completed rated the Care during admissions (where this was relevant) as good or excellent. Improved on previous year (57%)



Follow-up Management / Discharge:

52% of the 50 reviews completed rated the Follow up management/discharge (where this was relevant) as good or excellent. This percentage has reduced slightly on the last report (56%)



End of Life care

100% of the 4 reviews completed rated End of Life care (where this was relevant) as good or excellent. This has remained consistent.

3.2 Learning from Investigations

3.2.1 Themes from completed Serious Incident investigations

From the Serious Incidents for deaths that were reported on Datix between 1 April 2017 and 30 September 2019 where the investigation has been completed, 56 investigations resulted in recommendations and actions for improvement. The table below sets out the main themes from the resulting actions alongside how many serious incident investigations they related to:

Action theme and descriptor	Number of times theme identified	Number of SI reports where theme appears
Record keeping & documentation	36	23
Communication between staff (same service)	22	20
Risk assessment, management & contingency	21	16
Staff education, training & supervision	17	12
Policy & procedures – in place but not adhered to	16	14
Carers/family – communication, liaison, assessment	15	13
Care pathway – referral, access, discharge, transition between agencies, services & related communications	13	10
Team/service systems, roles & management	11	10
Care delivery - needs assessment, diagnosis, care planning, CPA, care delivery	9	7
P**olicy and procedures,** not in place	8	7
Organisational systems, management issues	8	7
Care coordination	5	4
Other	4	4
Medicine management	3	3
Environment/equipment – security and safety, furniture, medical devices, hardware, ligatures, storage, etc	3	1
Staff attitude, conduct, professional practice	1	1
Information governance - confidentiality breach, information management	1	1
Total themes	**193**	**56**

3.2.2 Service level investigations

Of the 32 service level investigations for deaths reported between 1 April 2017 and 30 September 2019, 25 investigations have been completed (at 13/11/19).

Of the 25 completed investigations, 2 have not yet been updated on Datix. 17 cases had identified care or service delivery issues; some had more than one issue identified. These are themed below:

Record keeping	7
Risk assessment/management	6
Carers/ family	4
Policy and procedure issues	4
Care delivery	3
Care pathway	3
Physical healthcare	3
Staff education, training and supervision	3

Communication	2
Discharge	2
Team/service issues	2
Environment	1
Equipment	1
Safeguarding	1
Medicine management	1

3.2.3 Safeguarding reviews

Between 1 April 2017 and 30 September 2019, there are six deaths that have been/are being reviewed through safeguarding processes. Learning will be updated when this is available.

Three of these cases have some initial findings recorded pending further safeguarding review. One is recorded as being concluded. Themes from these are included below; more than one theme can be added to a record:

Record keeping	1
Environment	1
Risk assessment	1
Physical health	1
Patient Engagement	1

3.2.4 Learning disability reviews

The Mortality Review Group has agreed that for any learning disability deaths, the managers 48 hour review will be completed, and in some cases a Structured Judgement Review will be requested to enable internal learning. This is alongside the LeDeR programme. Learning from any Structured Judgement reviews will be included above. Feedback from the Learning Disability Mortality Review programme (LeDeR) reported to Trust board is available in Appendix B.

4 Thematic Review

The Clinical Mortality Review Group has developed the provisional timetable (Appendix A) to facilitate the ongoing review of thematic data related to the top 10 themes. The volume of data available has vastly increased so a staggered approach to reviewing by theme is now necessary to manage content.

Each theme has or will be reviewed by the group through group-work or task and finish group. The aim is to develop prepared Learning library summaries using the SBAR headings (Situation, Background, Analysis, Recommendation) as the vehicle to share key messages and common learning points related to each theme. In some cases, specialist advisors will be asked to support their development.

The completed SBAR learning summaries will be added to the Learning Library K drive folder, and shared on the Learning Library intranet pages, through the 'Headlines' communication and reported back through Learning from Healthcare Deaths reports and Clinical Mortality Review group.

As further data becomes available, this will be added to the sources of information being used.

Report prepared by

Helen Roberts
Patient Safety Manager
December 2019

Appendix A

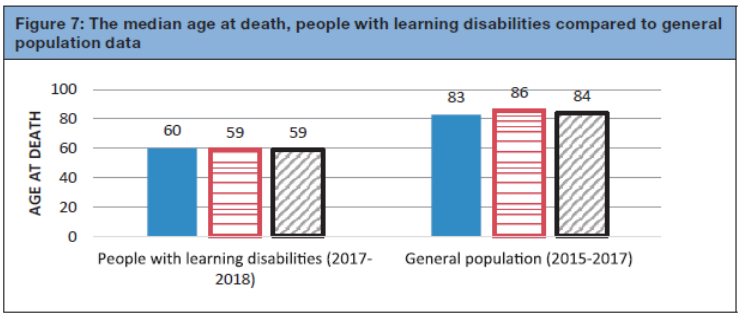
Provisional timetable for reviewing Learning from Deaths - Thematic data (this document will be updated separately)

Theme	**Source of information**	**Review process**	**Financial Quarter**	**Action** *Hyperlinks will be added as content is available*
Record keeping & documentation and information governance	SIs, investigations	Information Governance group	Quarter 1	**Bad news** **Discharge letters** **Consensus status**
Care pathway – referral, access, discharge, transition between agencies, services & related communications	SIs, investigations SJR phases of care – allocation / initial review & follow up	Clinical Mortality Review Group	Quarter 1	
Risk assessment, management & contingency	SIs, investigations SJR phase of care	Clinical Mortality Review Group	Quarter 1	
Care delivery - needs assessment, diagnosis, care planning, Care coordination, CPA, ongoing care	SIs, investigations SJR phases of care – Ongoing Care & Care during admission	Clinical Mortality Review Group	Quarter 2	
Policy & procedures - in place but not adhered to - not in place	SIs, investigations	Clinical Mortality Review Group	Quarter 2	
Staff attitude, conduct, professional practice	SIs, investigations	Clinical Mortality Review Group	Quarter 2	
Carers/family – communication, liaison, assessment	SJR content, SIs, investigations	Clinical Mortality Review Group 18/11/19	Quarter 3	SBARs being prepared around: Information will be shared via Headlines
Other	SIs, investigations	Clinical Mortality Review Group and task and finish group	Quarter 3	SBAR being prepared around choking
Team/service systems, roles & management	SIs, investigations	Clinical Mortality Review Group	Quarter 3	
Organisational systems, management issues	SIs, investigations	Clinical Mortality Review Group	Quarter 3	
Communication between staff (same service)	SIs, investigations	Clinical Mortality Review Group	Quarter 4	
Staff education, training & supervision	SIs, investigations	Clinical Mortality Review Group	Quarter 4	
Medicine management	SIs, investigations	Clinical Mortality Review Group	Quarter 4	

Environment/equipment – security and safety, furniture, medical devices, hardware, ligatures, storage, etc.	SIs, investigations	Clinical Mortality Review Group	Quarter 4	

Appendix B

Feedback from the Learning Disability Mortality Review programme (LeDeR):

Situation	• The LeDeR Programme was set up to provide a robust independent review of deaths of people with learning disabilities to support learning and hopefully help people with learning disabilities to live longer • The most significant challenge has been to provide timely reviews largely driven by four key factors: a) large numbers of deaths being notified before full capacity was in place locally to review them b) the low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review c) trained reviewers having sufficient time away from their other duties to be able to complete a mortality review and d) the process not being formally mandated. • All deaths will have an initial review – if further learning felt useful a multi-agency review will be conducted
Background	• It is well documented that People with Learning Disabilities have poorer health than the general population resulting in earlier death (15-20 years earlier) • From 1st July 2016 to 31st December 2018, 4,302 deaths were notified to the LeDeR programme. This was a massive increased in reporting from the last report. These figures are understood to be approximately 86% of the estimated deaths of people with learning disabilities. • Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes: o Children aged 4-17 (42% of deaths reported were from a BAME group) o Adults aged 18-24 (26% of deaths reported were from a BAME group) o Adults 25+ (7% of deaths reported were from a BAME group) • 25% of people from BAME groups had profound and multiple LD – TWICE the proportion of those from White British (11%) • 93% (590 people from a BAME group) had at least 1 long term condition in addition to the Learning Disability • The most common causes of death across all groups were Pneumonia (25%), Aspiration Pneumonia (16%), Sepsis (7%), Dementia (6&), Ischemic heart disease (6%), Epilepsy (5%). • Where gaps in service were reported those individuals more frequently died from Sepsis • A third of reviews identified good practice in the areas of strong effective multi-agency working, person centred care and end of life care. • The box below demonstrates the difference in age of death for people with Learning Disability as opposed to the general population  • Since reporting via notifications commenced on the 1st November 2016 **SWYPFT have reported 97 Deaths of people with learning disabilities via Datix** (End June 2019) • In SWYPFT we currently have 3 trained reviewers and a further 2 reviewers being trained in the near future.

Actions for the Trust	• In the forthcoming year the LeDeR programme will focus on actions that are being taken locally and sharing examples of good practice to affect service improvement (SWYPFT now links this work to the Mortality Group) • Health Action plans are formulated with people with learning disabilities where accessible format is required by learning disability service and these are shared accordingly and shared between services • There should be a named person (Care Co-ordinator) to help professionals work together (SWYPFT have either CPA Coordinator or Lead Professional) • Reasonable adjustments should be recorded on individual records • Learning Disability Awareness Training should be provided to all those who support people with learning disabilities – SWYPFT have developed a briefing paper to go to the Education & Training Governance Group that addresses this issue. • People need to understand more about the problems with infections in people with learning disabilities (pneumonia & sepsis in particular and constipation) - SWYPFT have commissioned an Advanced Practitioner in Respiratory Care post which can support the reduction in reported deaths due to respiratory issues • There should be much more of a focus on the use of the Mental Capacity Act • A strategic approach is required to training reviewers – Reviewer training is available via e-learning
Recommendations for the Trust	• SWYPFT need to continue to support the review process and more reviewers will be required • SWYPFT will consider how reasonable adjustments are evidenced in records • The community learning disability team will continue to support the development of health action plans in an accessible format to support people with learning disabilities to maintain and improve their health through better understanding of conditions • The Trust will develop a system for learning from reviews to enable service improvement to occur and a lead for the Trust should be considered – still required • The Trust need to consider Information Sharing agreements with Partners – Systmone will be helpful in terms of sharing information with GP's • Action plan to be developed, monitored and delivered by the Local Area Contact which Reviewers feed into and attend support forums. The CCG in each area is responsible for collating the learning.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020
Confidential agenda item 7.2

Title:	**West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships update**
Paper prepared by:	Director of strategy Director provider development
Purpose:	The purpose of this paper is to provide the Trust Board: 1. With an update on the development of the West Yorkshire and Harrogate Health and Care Partnership; and 2. Local Integrated Care Partnership developments.
Mission/values:	The development of joined up care through place-based plans is central to the **Trust's strategy**. As such it is supportive of our mission, particularly to **help people to live well in their communities.** **The way in which the Trust approaches strategy and strategic developments must be in accordance with our values**. The approach is in line with our values - **being relevant today and ready for tomorrow**. This report aims to assist the Trust Board in shaping and agreeing the strategic direction and support for collaborative developments that support the Trust's strategic ambitions.
Any background papers/ previously considered by:	Strategic discussions and updates on place based plans have taken place regularly at Trust Board including an update to January Trust Board.
Executive summary:	The Trust's Strategy outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP): **West Yorkshire and Harrogate Health and Care Partnership:** The paper outlines key developments including the partnerships 5 year plan, increasing the diversity of the workforce and the Partnership response to COVID-19 pandemic. The paper also provides an update on key programmes of work that we are partners in or leading. We continue to work with partners to develop and deliver joined up care and transform services and support. The paper provides an update that includes notable developments including the impact of the current pandemic on place based partnership work, including; ➢ Kirklees ➢ Calderdale ➢ Wakefield

	Risk Appetite The development of strategic partnerships and the development and delivery of place-based plans is in line with the Trust's risk appetite supporting the development of integrated, joined up care and services that are sustainable. Risks to the Trust's services in each place will need to be reviewed and managed as the partnerships develop to ensure that they do not have a negative impact upon services, clinical and financial flows.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the updates on the development of Integrated Care Partnerships and collaborations including:** ➢ **West Yorkshire and Harrogate Health and Care Partnership** ➢ **Wakefield** ➢ **Calderdale** ➢ **Kirklees** ➢ **Receive the minutes of relevant partnership boards.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - update

Trust Board 31 March 2020

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) focusing on developments that are of importance or relevance to the Trust. The paper will also include a brief update on key developments in local places that the Trust provides services.

2. Background

Led by the Trust's Chief Executive, Rob Webster, West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs). It brings together all health and care organisations in six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

The West Yorkshire and Harrogate Health and Care Partnership emphasises the importance of place-based plans where the majority of the work happens in each of the six places (Bradford, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These build on existing partnerships, relationships and health and wellbeing strategies.

Collaboration is emphasised at West Yorkshire and Harrogate (WY&H) level when it is better to provide services over a larger footprint; there is benefit in doing the work once and where 'wicked' problems can be solved collaboratively.

3. Update – Progress West Yorkshire and Harrogate Health and Care Partnership

3.1 System Oversight and Assurance Group (SOAG)

The primary objectives of this group include oversight of progress for all the West Yorkshire and Harrogate priority programmes and system performance. Key points from the meeting in March include the following:

Partnership response to COVID19 - The work of the WY&H Health and Care Partnership will change significantly in response to the COVID-19 incident. There are well established arrangements at system level through the West Yorkshire Local Resilience Forum and in places. ***(These are set out in a more detailed paper that is a separate agenda item - Covid Response)*** The WY&H Partnership will not duplicate these arrangements or create additional oversight or reporting mechanisms. However the relationships and ways of working that are now established across the partnership may be able to add value through releasing capacity from priority programmes, accelerating the work of some programmes and through facilitating mutual aid arrangements.

The large majority of existing programme priorities will stop or slow down. Work is taking place across mental health providers about the arrangements for mutual support, liaison and oversight as well as transformation priorities that may emerge. It is likely that the partnership team will be refocused to support this work. **The Trust will continue to work with partners on developing an approach to mutual aid and sharing best practice and opportunities to collectively use our resources to respond to guidance once where this makes sense**.

4. ICS Five Year Strategy and Plan

The strategy and plan has been co-produced with significant input from stakeholders and partners. (**The draft strategy has previously been discussed at Trust Board** and the ICS Partnership Board). The document incorporates the updated priorities from each programme and builds on the existing work of the partnership. A suite of information products have also been produced to support the communication of the Plan. The plan and supporting materials are available on the partnership website. **The Trust as a key partner has contributed to the plan. The Trust's contribution to the plan and alignment of the plan to the Trust strategy was discussed at previous Board meetings.**

5. Diverse Workforce and Leadership

The ICS five year strategy sets out an ambition to increase the diversity of leadership across all organisations, and improve the experiences of staff from British, Asian and Minority Ethnic (BAME) communities. The ICS Leadership team engaged in a conversation about an inclusive workforce as part of its celebration of Black History Month last October. This was followed by an event that was held in January, with over 30 people in attendance from partner organisations including chairs of Black Minority Ethnic Staff Networks (BMESN) from across the partnership. The event was led by Fatima Khan Shah member of the core ICS team and programme lead for carers. The Trust CEO, and Cherill Watterston, Chair of the Trust BMESN, were speakers at the event, with Cherill sharing her leadership journey. The CEO challenged the group to be ambitious in their vision and bold in defining the actions they felt were needed to turn the dial on a more equal and diverse workforce. Recommendations from the event have been discussed and approved at the System Leadership Group and the Partnership Board in March. **The Trust is key partner in this emerging network and programme of work. The Trust has made some progress on this agenda with a more diverse Board, established networks and improvements in some of the Workforce Race Equality (WRES) standards. However we still have more to do to, and will be able to work with others across the partnership to continue to develop a more equal health and care system for staff, service users, carers and communities. The paper which details the recommendations has been discussed at the Trust Equality and Inclusion forum.**

6. West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Committees in Common

The committee continues to meet and drive forward the agreed transformation areas across the system in line with the national improvements set out in the NHS Long Term Plan.

6.1 West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative update

Progress is being made against all programmes as reported through the Trust Integrated Performance Report and through the Committees in Common for mental health, learning disability and autism providers. Key developments to note include:

Specialist Community Forensic Team Pilot Wave 2 Selection: The Trust submitted a bid on behalf of the West Yorkshire Forensic Provider Collaborative for Wave 2 selection. This bid was successful and is being mobilised. Regular meetings are taking place with NHS England representatives to review the implementation plan and service delivery. The Trust is actively participating in a national learning set in respect of the national roll out of specialist community forensic teams, and applying learning to our own team's operation as appropriate.

West Yorkshire Provider Collaboratives:

Leeds & York Partnership NHS Foundation Trust (LYPFT), as a Lead Provider Collaborative on the NHS England 'fast track', submitted a final business case to NHS England for approval on 29 November 2019 for the Adult Eating Disorder Collaborative. The Trust (along with

LYPFT as lead provider, and the other two partners Bradford District Care Trust [BDCT] and Tees Esk and Wear Valleys NHS Foundation Trust [TEWV]) was a signature to a Partnership Agreement in fulfilment of the Lead Provider Collaborative functions. The business case successfully completed the NHS England Gateway process, and the Provider Collaborative will move to a full contract from 1 April 2020.

The LYPFT Director of Finance (DoF) will be the lead for the commissioning responsibilities of the Provider Collaborative (PC), and the LYPFT Chief Operating Officer (COO) will be accountable for delivery of services across the PC. The PC governance structure includes a programme board which will report into the LYPFT Trust Board, thus ensuring non-executive director oversight in the lead provider.

The PC Commissioning Team will report to the WY&H Specialised Mental Health, Learning Disabilities & Autism (MH, LD & A) Programme Board, and will provide assurance to LYPFT Trust Board that commissioning activities are being overseen. The future commissioning structure arrangements (termed 'Steady State Commissioning') and principles for all the WY&H Lead Provider Collaboratives have been reviewed, and proposed staffing capacity for commissioning and lead provider development next year have been identified across all three LPCs. A joint bid was made through the ICS for Transformation funding moneys to fund this capacity should funding become available for 2020/21. **The Trust's commissioning responsibilities as Lead Provider for the Forensics Lead Provider Collaborative (from April 2021) will be discharged through the Steady State Commissioning arrangements within WY&H, and we are therefore proactively engaged in the work on ensuring that the Forensic LPC (and the other two LPCs) has sufficient commissioning and lead provider staffing capacity to fulfil its functions.**

Confirmation has been received that Harrogate will be moving from West Yorkshire to Humber Coast and Vale STP. The implications of this are currently being worked through, particularly in respect of patient flow in the LPCs.

Learning Disabilities ATU - The service option proposal for the Learning Disabilities ATU was presented and discussed at the West Yorkshire Joint Overview Scrutiny Committee (OSC) on 18 February 2020. The Joint OSC supported the recommendation to progress through a process of engagement on the proposed two site model, which has already been supported by our CiC and joint committee of CCGS. This means that the proposal will not be going through statutory consultation and therefore there is no requirement to set up a mandatory JOSC.

7. Local Integrated Care Partnerships - key developments

A number of the places in which the Trust provides services are part of the WY&H HCP. These include Kirklees, Calderdale and Wakefield. Barnsley is part of the South Yorkshire and Bassetlaw Integrated Care System (ICS) that the Trust is a partner within. Notable developments include the following:

7.1 Calderdale

We continue to work with our partners in developing a joint response to manging the current COVID-19 pandemic. The Council has also developed a ten point plan that sets out Calderdale's response. We are refocusing partnership work on increasing physical activity to support people at home by developing resources and support through Creative Minds and recovery colleges. The Alliance development work is being reviewed and likely to be paused. Calderdale CCG are in the process of changing provider (we do not provide this element of the contracted services) for the delivery of IAPT services in Calderdale. A verbal update will be provided in relation to this.

7.2 The Wakefield Integrated Care Partnership and Mental Health Alliance

The Wakefield partnership has continued to progress the integration agenda through the Integrated Care Partnership (ICP).

The Mental Health Alliance has completed the work on the Alliance Plan for 2020/21, which includes developing and agreeing the investment priorities for 2020/21. The Plan was presented and supported at both the Wakefield ICP Board meeting on 25 February 2020, and the Wakefield CCG Governing Body meeting on 10 March 2020. The investment priorities for 2020/21 were 'signed off'. The Alliance's April meeting will focus on reviewing partners' service contingency plans in context of Covid 19, identifying pressure points and how we might collectively address those. It will also review how we can support the third Sector in supporting mental well-being in the District.

The Children and Young People's (C&YP) plan for 2019-22 was 'signed off' on 5 November 2019 at the Children & Young Peoples' Partnership Board meeting, and emotional health and wellbeing is one of the four key priorities in the C&YP Plan. The Trust has a key role in supporting this priority area through the provision of CAMHS services in Wakefield. The Director of Provider Development (along with the CCG Director of Commissioning) is Board joint SRO for this priority. The Plan was launched at an event involving children and young people at South Elmsall on 2 March 2020. The event was interactive and included an outstanding performance from the Wakefield Children in Care Choir.

7.3 Kirklees

System leaders have continued to meet and the Trust is a key partner in shaping the developments of integrated care across Kirklees. The Trust is leading the development of proposals to strengthen mental health and well-being through a partnership approach across Kirklees through the development of an Alliance. The mental health alliance formally met for the first time in March and agreed membership and TOR. The emerging themes from the stakeholder workshop and the service user and carer workshop were also discussed. Due to the current context this work has now formally been paused in order to refocus capacity on a joined up response to manage the current pandemic.

Recommendations

- **Trust Board is asked to receive and note the update on the development of Integrated Care Systems and collaborations:**
    - **West Yorkshire and Harrogate Health and Care Partnership**
    - **Calderdale**
    - **Wakefield**
    - **Kirklees**
- **Receive the minutes of relevant partnership boards.**

Appendix - Links to relevant partnership meetings and papers

1. West Yorkshire & Harrogate Health & Care Partnership Board -
2. West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive - https://www.wyhpartnership.co.uk/blog
3. West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group - https://www.wyhpartnership.co.uk/blog
4. Calderdale Health and Wellbeing Board - https://www.calderdale.gov.uk/council/councillors/councilmeetings/index.jsp
5. Kirklees Health and Wellbeing Board - https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

6. Wakefield Health and Wellbeing Board - http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

West Yorkshire and Harrogate
Health and Care Partnership

TO: Members of the WY&H System Leadership Executive Group
(sent via email)

Friday, 27 March 2020

Dear Colleagues

Our partnership response and role on COVID-19

Further to my letter of 13 March 2020, I am writing to provide you an update of the work we are taking forward at WY&H level to support the COVID-19 response.

I believe there are four broad tasks that we are engaged in, and partnership efforts should be focused on supporting our response on them:

1. Exponentially increasing critical care capacity to meet the demands of Covid-19.
2. Caring for our share of the 30,000 people discharged from general and acute beds nationally at short notice.
3. Building coordinated support for our share of the 1.4 million people being shielded at home for 12 weeks.
4. Delivering business continuity and safe services in the face of reduced staffing from sickness, self-isolation and shielding.

Every sector, every place and every organisation has a role to play in delivering these tasks. You will all be engaged in well-established arrangements at system level, through the West Yorkshire Resilience Forum, and at local level, with Councils, NHS organisations and other partners working together in each place to co-ordinate our response on COVID-19. There is, however, clear benefit in using the infrastructure, relationships and ways of working we have established through the WY&H Partnership in supporting the response. We also have access to staff with the capacity and skills to work in different ways as required by the system throughout the pandemic.

To co-ordinate our efforts I have moved to the following weekly arrangements:

I have convened weekly virtual meetings of a small group of **sector leads** within the WY&H Partnership. This includes Jo Webster [CCGs], Julian Hartley [WYAAT], Tom Riordan [LAs], Robin Tuddenham [LRF Chair], Sara Munro [Mental Health] plus Sarah Muckle (DPH representative), Richard Parry (DAS representative) and Richard Vautrey (LMC representative). The group is supported by Anthony Kealy and Ian Holmes.

This provides us with the means to work at pace and bring focus to our collective efforts. We will use the group to:

- Ensure we join up messages received for a regular integrated system-wide response
- Identify specific tasks against the four themes that could be co-ordinated at WY&H level using WY&H programme team capacity

- Where appropriate agree a position to feed into other fora, such as the Local Resilience Forum, SOAG and national network discussions
- Identify hotspots across WY&H and arrangements for mutual aid / support
- Ensure that sector level work is shared and coordinated.

The key messages from these weekly meetings will be communicated to you every week. Anthony Kealy and Robin Tuddenham will ensure connectivity with the West Yorkshire Local Resilience Forum.

In addition to this NHSE/I is coordinating a weekly **Strategic Health Co-ordination Group** meeting of emergency planners from key partners to look at national work and what needs escalating to the relevant forums. The group is made up of representatives across health organisations in WY&H. The actions from this meeting will feed into this sector leads meeting to ensure we have the insight needed to coordinate action.

The **West Yorkshire and Harrogate Programmes** have also undertaken a stop, continue, and accelerate of activities. Through this exercise around two thirds of our capacity will be refocused towards COVID-19 activities. This is already underway.

The remaining staff (around 20) will be used to support activities directed by the sector leads group. The immediate tasks that were agreed yesterday from freed up capacity are as follows:

- Support the co-ordination of Independent Sector capacity, working closely with NHSE and WYAAT
- Support WYAAT in developing the exponential increase in critical care capacity
- Support Yorkshire Ambulance Service on discharge, reconfiguration and patient transport issues
- Identify and disseminate good practice on discharge to community and community support for people shielded at home through integrated models and primary care networks
- Identify common actions that could be taken to support the home care and the care home market in this context.

The detailed analysis of the programmes and their focus will be discussed and agreed at the WY&H SOAG Meeting on Monday 30 March 2020. The way we engage and communicate with all of you through these times will also be agreed. All of this will use our principles of WY&H working at scale, working to share good practice and working to tackle wicked issues.

I trust you find this update helpful. I will write to you all again following SOAG. In the meantime, take care of yourselves and keep going. The work I see around me is truly astonishing and the leadership on display gives me confidence we will get through this together.

Rob Webster
Chief Executive South West Yorkshire Partnership NHS Foundation Trust
Chief Executive Lead, West Yorkshire and Harrogate Health and Care Partnership

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020

Confidential agenda item 7.3 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	8 October 2019 (Meetings scheduled for 26 November 2019 and 23 January 2020 cancelled – further meeting scheduled for 23 April 2020)
Member	Chief Executive / Director of Strategy
Items discussed	➢ Barnsley Children & Young Peoples Plan 2019-2022 ➢ Barnsley Safeguarding Children Board Annual Report ➢ Barnsley Safeguarding Adults Board Annual Report ➢ Health and Wellbeing Board Review ➢ Joint Strategic Needs Assessment ➢ Better Care Fund 2019/20 Submission ➢ Advancing our health: prevention in the 2020s – consultation document ➢ South Yorkshire and Bassetlaw Integrated Care System 5 Year Plan
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	20 February 2020
Non-Voting Member	Medical Director / Director of Nursing & Quality

Items discussed	➢ Calderdale Cares:
	  ○ Locality Perspective Lower Valley
	  ○ Calderdale Cares Engagement and Communications Approach
	➢ Health and Wellbeing Strategy – Life Course Updates:
	  ○ Developing Well
	  ○ Ageing Well
	➢ Adults Safeguarding Annual Report
	➢ Motor Neurone Disease Charter
	➢ Forward plan 2019/20

Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=27436

Kirklees Health and Wellbeing Board

Date	30 January 2020 (next meeting 26 March 2020)
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	➢ Update on the Primary Care Networks Development Programme ➢ Tackling Violence in Kirklees ➢ WY&H Care Partnership Unpaid Carers Programme/Kirklees Carers Strategy ➢ Stronger together – Working for a safe and healthy Kirklees – Kirklees Inter-Board Partnership Protocol ➢ Kirklees Safeguarding Adults Board Annual Report 2018 - 2019
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Wakefield Health and Wellbeing Board

Date	19 March 2020 (next meeting provisionally scheduled for 11 June 2020)
Member	Chief Executive / Director of Provider Development
Items discussed	➢ Health & Wellbeing Board Action Log ➢ West Yorkshire and Harrogate Memorandum of Understanding ➢ Focussed Discussion – Health Inequalities with a focus on Place ➢ Health Inequalities ➢ Joint Strategic Needs Assessment Overview ➢ Expert witness from Career's Cabin, Castleford ➢ Citizens Advice Bureau – reducing health inequality through support and advocacy ➢ Reducing Inequality – Knottingley Case Study ➢ Next Steps for the Health and Wellbeing Board ➢ Public Health Annual Report 2019 ➢ Third Sector Strategy ➢ Connecting Care Executive Minutes
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	11 October 2019 (meeting scheduled for 13 March 2020 cancelled)
Member	Chief Executive
Items discussed	➢ Public Health Update ➢ Priorities for joint working for local authorities: Complex Lives ➢ Developing the ICS focus on the Voluntary and Community Sector ➢ New arrangements for CPB ➢ Developing the South Yorkshire and Bassetlaw 5 Year Strategy 2019 – 2024 ➢ ICS Finance Update ➢ ICS Highlight Report ➢ Sheffield City Region team on the Health Led Employment Trial
Minutes	Approved Minutes of previous meetings are available at: https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings

West Yorkshire & Harrogate Health & Care Partnership Board

Date	3 March 2020
Member	Chief Executive
Items discussed	➢ Update from the WY&H Partnership CEO Lead ➢ Improving Health and Wellbeing by connecting people with local resources, groups and individuals ➢ WY&H Improving Population Health programme ➢ Operational Planning for 2020/2021 ➢ Achieving our ambition to increase the diversity of our leadership ➢ Looking out for our neighbours Community Campaign
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 31 March 2020
Confidential agenda item 8.1

Title:	**Review and update of the Trust Constitution, including Standing Orders**
Paper prepared by:	Director of Finance and Resources
Purpose:	The purpose of this report is to update the Board on amendments and areas for further consideration agreed by the Members' Council on 31 January 2020.
Mission / values:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Any background papers / previously considered by:	The Trust Constitution is based on the NHS Foundation Trust Model Core Constitution (2013). The last amendments to the Trust Constitution were approved by the Trust Board on 31 January 2017 and Members' Council on 3 February 2017. A review of the Constitution has taken place including discussion on proposed amendments at the Governor workshop on 9 December 2019 and Trust Board strategic session on 17 December 2019. Suggested amendments and areas for further consideration were discussed at the Members' Council meeting on the 31 January 2020.
Executive summary:	**Background** The Trust is required to have a Constitution in place that sets out: ➢ how it is accountable to local people ➢ who can become a member ➢ the role of the Members' Council ➢ how Trust Board and the Members' Council are structured ➢ how Trust Board works with the Members' Council ➢ how the Chair and Non-Executive Directors are appointed ➢ how public and staff governors are elected. **Amendments to the Constitution (including Standing Orders)** ➢ Minor amendment include: - Reference to the expectation that all committees will conduct their business in accordance with the Nolan Principles. - Addition of the Equality and Inclusion Committee. - Addition of the Finance, Investment and Performance Committee. - Update to the name of the Workforce and Remuneration Committee. - Addition of the West Yorkshire Mental Health Services

	Collaborative Committees in Common. - Clarification that the Charitable Funds Committee is a committee of the Corporate Trustee. - Clarification that the Nominations Committee is a committee of the Members' Council. ➢ Change to the public constituency for the 'Rest of South and West Yorkshire' to the 'Rest of Yorkshire & the Humber' to: - Reflect the work the Trust is involved with across Yorkshire. - Represent forensic services that are provided to the whole of Yorkshire by the Trust. - Open up membership to anyone living in Yorkshire. ➢ Removal of automatic membership for staff in line with General Data Protection Regulations (GDPR) and inclusion of statement that staff will be asked if they would like to become a member on appointment. ➢ Inclusion and development of a Deputy Lead Governor role. ➢ Change to the term of office for governors and Non-Executive Directors to be a maximum of nine years in total. ➢ Inclusion of a statement to confirm that staff currently employed by the Trust cannot be a Non-Executive Director for the Trust. ➢ Inclusion of a statement to confirm that a Non-Executive Director can continue in their role for the remainder of their term if they move out of the Yorkshire & the Humber area and are no longer a member of the Trust, so far as it is practical to do so. ➢ Inclusion of a statement regarding the use of recording devices for meetings. **Areas for further consideration** ➢ Review of the Code of Conduct for governors, including consideration of the following: - Specific grounds for suspension if the Code of conduct is not met - Use of a simple majority for all votes to maintain consistency - In the event that a vote is tied, the deciding vote would lie with the Lead Governor, or Deputy Lead Governor in their absence - Strengthen the section relating to confidentiality - Clarify the use of social media, in line with Trust policy. ➢ Governor constituencies, including consideration of the following: - Reviewing the number of public governors

	- Reviewing the number of appointed governors - The option to co-opt, including principles and how / who would decide on co-option. **Next steps** ➢ The Corporate Governance team is completing an exercise to compare the current Code of Conduct for governors with those from other Foundation Trusts. ➢ The areas outlined above relating to the Code of Conduct for governors will be strengthened; ensuring appropriate advice is sought in relation to the section on suspension. ➢ The Corporate Governance team is completing an exercise to compare the numbers of governors in the public and appointed seats of other Foundation Trusts, and will see appropriate advice around the option to co-opt. The outcome of the above will then be presented to the Members' Council for approval. It is noted that there will be a delay in considering the areas outlined above and reporting to the Members' Council due to the national situation relating to Covid-19. **Risk appetite** The delivery of the Trust's Constitution supports the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to RECEIVE the update.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020
Confidential agenda item 8.2

Title:	**Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)**
Paper prepared by:	Director of Finance & Resources
Purpose:	To enable Trust Board to approve the Policy on Policies, a core policy for the Trust and reserved for Trust Board consideration and approval.
Mission/values:	Policies and procedures covering core Trust systems and processes are a key part of the Trust's governance arrangements, supporting the Trust to achieve its mission and adhere to its values.
Any background papers/ previously considered by:	The policy was approved by Trust Board in July 2011, October 2012 (as part of the changes recommended to achieve NHS LARMS level I), July 2014, January 2017 and January 2019. Clinical leads, Human Resources, Staff side, and Equality & Engagement were consulted in the development of the policy. The revised policy has been reviewed and supported by the Executive Management Team for approval by Trust Board.
Executive summary:	**Background** The purpose of the Policy on Policies is: ➢ to describe the approach to development and approval of policies and procedural documents ➢ to provide a standard template for policy documents ➢ to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure ➢ to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance ➢ to describe the process for version control to ensure people have access and are operating to the most current version ➢ to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements. The current Policy has been reviewed to ensure it remains fit for purpose, with minor amendments made to reflect the current review and approval process, and formatting of the document to ensure it is also consistent with the policy template. Also note, the Internal Auditors conducted a policy monitoring benchmarking review in October 2019, which identified 1 medium and 1 low recommendation in relation to compliance with the Policy on Policies. These have been addressed in line with the updates to the policy.

	Risk Appetite The Policy on Policies supports the Trust in its endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the update to the policy.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Document name:	**Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)**
Document type:	Policy
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	Version 11 February 2020
Next review:	February 2023
Approved by:	Executive Management Team 6 February 2020 prior to Trust Board 31 March 2020
Developed by:	Director of Finance & Resources Company Secretary
Director leads:	Director of Finance & Resources
Contact for advice:	Company Secretary Corporate Governance Manager

Contents

13.1 Appendix A - Style and format template for policies and procedural documents (Policy Template)
- TEMPLATE for Appendix - Equality Impact Assessment Tool
- TEMPLATE for Appendix - Checklist for the Review and Approval of Procedural Document
- TEMPLATE for Appendix - Version Control Sheet

13.2 Appendix Bi - Proforma for approval of policies by the Executive Management Team (EMT)

13.3 Appendix Bii - Proforma for extension of policies by the Executive Management Team (EMT)

13.4 Appendix C - Equality Impact Assessment

13.5 Appendix D - Checklist for the review and approval

13.6 Appendix E - Version control sheet

Policy for the development, approval and dissemination of policy and procedural documents

1. Introduction

Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust.

A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies and procedures in use are current and reflect an organisational approach.

2. Purpose

The purpose of this document is:

- to describe the approach to development and approval of policies and procedural documents.
- to provide a standard format and content for policy and procedure documents.
- to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure.
- to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance.
- to describe the process for version control to ensure people have access to – and are operating to – the most current version.
- to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.

3. Definitions

- A **POLICY** is a high level statement. Each policy should specify its purpose and may also include a procedure setting out how the policy will be achieved. A policy enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.

- A **PROCEDURE** is often incorporated into a policy or can be a 'standalone' document. Procedures are the practical way in which a policy is translated into action. They explicitly outline how to accomplish a task or activity, giving detailed instructions. A procedure often allocates specific roles that specific individual must undertake.

4. Principles

The fundamental action points of this policy are to ensure all policies are developed and updated using a consistent approach, ensuring such documents are regularly reviewed to reflect current guidance, and following their approval that policies are disseminated so that staff are aware of their responsibilities.

5. Duties

It is the policy of the Trust that all policy documents and procedure documents will:

- have an identified Director lead
- have a designated contact for advice
- identify who is responsible for taking what action.

The following duties apply to this policy.

5.1 Trust Board

Trust Board is responsible for approving the policy for the approval, dissemination and implementation of policies and procedures as outlined in this document.

Policies that require Trust Board approval are outlined in the Trust's Scheme of Delegation. These include policies which are likely to be of major strategic or political significance, such as those relating to the appointment, remuneration and dismissal of staff, policies relating to the management of financial or clinical risk and policies for management of complaints and claims. Approval may also be delegated by the Trust Board for approval by a committee through their Terms of Reference and the Scheme of Delegation.

5.2 Executive Management Team (EMT)

The Executive Management Team (EMT) will approve all other policies (however, see 4.3 below). The EMT will be responsible for ensuring the policy document has been developed according to this policy.

5.3 Directors

Each policy will have an appointed lead Director. The lead Director lead is responsible for the development of new policies and timely review of policies in accordance with this policy.

The lead Director will be responsible for engaging relevant stakeholders in the development of the policy and ensuring appropriate arrangements are in place for managing any resource implications, including dissemination and training and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation.

It is the responsibility of the lead Director for a policy to ensure that the document is appropriately consulted on during the development process by key stakeholders (see section 6.2.2) and to agree the most appropriate way to undertake such consultation.

Multi agency policies will have a lead Director who will be responsible for ensuring the policy has gone through the necessary approval process.

Some policies are delegated to committee for approval as detailed in the Trust's Scheme of Delegation. In the case of policies relating to medicines management, with the exception of the overarching medicines management policy and the medicines code, approval is delegated to the Drugs and Therapeutics sub-committee of the Clinical Governance and Clinical Safety Committee and it is the responsibility of the lead Director to ensure that these policies adhere to this policy. Other policies

that are specific or relevant to local clinical arrangements can be approved locally by appropriate mechanisms within Business Delivery Units (BDUs); however, where there are implications across the Trust or a policy will have an impact on resources, staffing, Trust strategy, reputation, etc., approval remains reserved for the EMT. Directors should seek the advice of the Company Secretary or the Corporate Governance Manager if in doubt.

Procedures and guidance notes may be developed and issued by the lead Director using the principles included in this document. The lead Director is responsible for engaging relevant stakeholders in developing the procedure or guidance note, communicating the procedure and ensuring its implementation.

5.4 Director of Finance & Resources
The Director of Finance & Resources supported by the Company Secretary will, on behalf of Trust Board, ensure this Policy is implemented and that documents are controlled in accordance with non-clinical records management requirements.

5.5 Business Delivery Units (BDUs) and Trust Action Groups (TAGs)
Directors may engage BDUs (including the Operational Management Group (OMG)) and TAGs in developing and implementing policies or procedural documents. They have no authority to approve policies.

5.6 Specialist staff
Specialist staff have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures. Specialist staff include areas such as Safeguarding, Infection Prevention and Control, and Equality & Engagement Development Managers.

5.7 Service managers
Service managers have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures.

5.8 Staff
All staff need to be aware of policies and how they impact on their practice. All new policies approved by Trust Board, its committees and / or EMT are communicated through the staff briefing and via the intranet. Staff have an individual responsibility to seek out this information.

5.9. Duties for this policy
The Trust Board is responsible for approving this policy.

The lead Director is the Director of Finance & Resources.

All staff who write policies need to be aware of this policy.

The Company Secretary, supported by the Corporate Governance Manager, is responsible for overseeing the administration of this policy. This includes ensuring policies for approval are included in the relevant Trust Board or EMT agenda in a timely way, maintaining a corporate record of all current and past policy and

procedure documents, and notifying lead Directors when a policy or procedure is due for review.

6. Process of developing, approving and reviewing policies

6.1 Style and format

All policies and procedures should be written in a style that is clear, concise and unambiguous. Titles should be kept simple to assist easy identification of the document.

Policy and procedural documents should follow Trust Branding Guidance. The standard font is Arial 12 point. Uppercase and underlining should be avoided except in headings. Page numbers should be used.

A template showing the structure and mandatory sections to be included is provided in appendix A.

Acronyms and technical language should be explained or a glossary included.

A checklist is also provided under Appendix A (see template for appendix C) to be completed and submitted to the EMT, committee or Trust Board at the time of final approval to ensure the policy includes all required contents.

6.2 Development process

6.2.1 Identification of need

The need for a new policy or procedure may be prompted by a change in national legislation, policy or guidance or it may be identified within the Trust either as a result of learning from experience, such as complaints or incidents, or as a result of a risk being identified by a specialist advisor or TAG. New policies may also be required as a result of the development of a new service or new way of working.

The first step should be to establish whether a new policy or procedure is required or whether the requirement can be met by amending an existing policy or procedure.

The aim should be to keep the number of policies to a minimum. The lead Director should be able to provide a clear justification for the development of any new policy.

This policy has been developed to minimise risks associated with policies and procedures being written without appropriate authority or consideration of the impact of the policy and to prevent inconsistent application of policies as a result of failure to effectively communicate or disseminate a policy or procedure. No other document already in existence in the Trust covers this subject.

6.2.2 Stakeholder involvement

Consultation with relevant stakeholders secures 'buy in' and provides an opportunity to identify and eliminate potential barriers to implementation.

The lead Director is responsible for ensuring relevant stakeholders have been consulted during the development of the policy. The following identifies some of the individuals or groups who might be consulted with. This is not an exhaustive list. Consideration should be given to digitally-enabled care.

Stakeholder	**Level of involvement**
Executive Management Team (EMT)	Approval – (may also be involved at the outset in confirming the requirement for a new policy or agreeing the development process)
Directors	Initiation, lead, development, receipt, circulation
Business Delivery Units (BDUs) (including the Operational Management Group (OMG))	Development, consultation, dissemination, implementation, monitoring
Specialist advisors	Development (including EIA), consultation, dissemination, implementation
Service user and carers	Development, consultation
Professional groups and leaders	Development, consultation, dissemination, implementation
Trust Action Groups (TAGs)	Development, consultation, dissemination, implementation
Staff side	Development, consultation, dissemination
Trust learning networks	Consultation
Local Authorities	Development, consultation
Police	Development, consultation
Other NHS Trusts	Development, consultation
University	Consultation

For this document, the clinical leads, Human Resources, staff side, and the EMT were consulted. The Trust Board agreed when developing the Scheme of Delegation that responsibility for determining policy approval arrangements should be a decision reserved to the Trust Board.

6.2.3. Undertaking Equality Impact Assessments

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer.

All new policies and procedures should be subject to an Equality Impact Assessment (EIA). For revised policies an update of the EIA needs to be undertaken. A tool to support this process is included at appendix B to this document.

As part of stakeholder involvement, Equality & Engagement Managers should be involved in the development or review of a policy to ensure all equality and diversity requirements are included in the policy as well as in the EIA. If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

6.3. Approval and ratification process

Procedures and guidance notes should have a lead Director identified and may be approved and issued directly by the lead Director.

Policies for approval that have not been identified as requiring Trust Board approval should be submitted by the lead Director to the EMT. For clinical policies, these should first be reviewed by the Clinical Policy Group prior to being submitted to EMT. The checklist at Appendix A (TEMPLATE for Appendix - Checklist for the Review and Approval of Procedural Document) should be completed by the lead Director. When submitted to EMT for approval, policies should be submitted with a completed proforma (see template at Appendix Bi) and will be subject to peer review by another Director.

Policies where authority to approve is reserved to the Trust Board should be submitted to the Trust Board by the lead Director after they have been discussed by the EMT.

6.4. Process for review

At the time of approval, all policies should have a clearly defined review date. This may be brought forward if earlier review is required, for example because of an identified risk or change in national policy.

The EMT receive the Policy Register monthly for lead Director to note when policies are due for review.

The lead Director will check the policy. If no amendment is required, this should be reported to the EMT or Trust Board for ratification along with an updated EIA by the review date. Policies should be submitted to EMT with a completed proforma for approval of policies (see template at Appendix Bi).

If the policy requires amendments, this should be done in consultation and the EIA updated prior to presenting the revised policy to the EMT with a completed proforma for approval (see template at Appendix Bi) or Trust Board.

An EIA must be completed for all policies that have not previously been subject to EIA. For revised policies an update of the EIA needs to be undertaken.

It should be noted that, for services that came to the Trust as part of transformation, there may be a number of policies that, over time, will need to be aligned. Existing policies will continue to be followed until this work takes place. Each appointed lead Director for a policy will need to ensure that reviews include all existing policies that have been produced by previous organisations and that new / updated polices are clear which policies they replace.

Should the review of a policy be delayed, a request for extension should be presented to EMT by submitting a completed proforma (see template at Appendix Bii).

6.5. Version control

All policies and procedures must have the version number, date of issue and the review date clearly marked on the front cover and as a footnote.

Draft policies should be marked v1 draft, v2 draft etc during the consultation phase. Once approved the document becomes Version 1. Each time the policy or procedure is updated the version number must be changed.

The introduction to the Policy should make it clear whether a document replaces or supersedes a previous document, including the title(s) of any superseded or replaced documents.

6.6. Dissemination and implementation arrangements (including training)

Once approved, the Corporate Governance Manager (for corporate policies) and Quality Improvement & Assurance Team (QIAT) (for clinical policies) will be responsible for ensuring the updated version is added to the Document Store on the intranet and is included in The Headlines weekly communication to staff.

The Corporate Governance Manager (for corporate policies) and Quality Improvement & Assurance Team (QIAT) (for clinical policies) will also be responsible for ensuring the document being replaced is removed from the Document Store and that an electronic copy, clearly marked with version details, is retained as a corporate record (archive).

Directors are responsible for ensuring that staff within their area of responsibility are aware of new or amended policies and procedures related to their work.

If local teams download and keep a paper version of procedural documents, the responsible manager must identify someone within the team who is responsible for updating the paper version when a policy change is communicated via the staff brief.

All policies and procedures must identify the arrangements for implementation, including:

- Any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training.
- Any resource requirements, including staff, and how these will be met.
- Support available to assist implementation.
- Arrangements for ensuring the policy or procedure is being followed.
- Monitoring and audit arrangements.

6.7 Document control and archiving

Current policies and procedures will be available on the intranet in read only format.

For historic policies and procedures, a central electronic read only version will be kept as a corporate record (archive) in a designated shared folder to which all staff can request access.

Documents will be retained in accordance with requirements for retention of non-clinical records.

6.8 Monitoring compliance with the policy

All policies and procedure must identify the arrangements that are in place for ensuring and monitoring compliance. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission (CQC) standards, NHS Resolution frameworks and Monitor (or successor organisation) compliance.

Methods may include:

- Monitoring and analysis of incidents, performance reports and training records.
- Audit.
- Checklists.
- Monitoring of delivery of actions plans through TAGS or BDUs.

The document should identify the methods that will be used to ensure timely and efficient implementation.

For this policy implementation:

- is the responsibility of the lead Director for individual policies to ensure that this policy is followed in the development and presentation of individual policies
- is monitored through presentation to EMT and / or Trust Board, evidenced by the minutes of meetings where policies are approved, or the appropriate ratifying body, again evidenced by the minutes of meetings where policies are approved
- is monitored by the ratifying body through the policies checklist
- is assured through occasional audit by the Trust's internal auditors.

7. Equality Impact Assessment

An Equality Impact Assessment has been completed with no negative impacts identified (Appendix B).

8. Dissemination and implementation arrangements (including training)

This dissemination and implementation of this policy will be conducted in accordance with the processes outlined under section 6.6.

Support to assist the development of other policies is available by contacting the Corporate Governance Manager (for corporate policies) and Quality Improvement & Assurance Team (QIAT) (for clinical policies).

9. Process for monitoring compliance and effectiveness

Compliance and effectiveness of this policy is reviewed through the approval of all other policies to ensure they comply with the requirements of this policy. Other methods may include review as part of Care Quality Commission (CQC) inspections and audit by the Trust's internal auditors.

10. Review and revision arrangements

A review and revision of this policy should take place at least every three years or if required earlier due to national guidance.

11. References Associated documents and supporting references

This document has been developed in line with guidance issued by the NHS Resolution and with reference to model documents used in other trusts.

12. Associated documents

This policy should be read in conjunction with

- the Trust Branding Policy
- the Records Management Strategy, Non-Clinical Records Management Policy and non-clinical records retention and disposal schedule.

Appendix A

Style and format template for policies and procedural documents (Policy Template)

Document name:	**Name of the policy**
Document type:	Policy
What does this policy replace?	New policy / Updated version
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	Version No. Month Year
Next review:	Month Year
Approved by:	Executive Management Team
Developed by:	Job title
Director leads:	Job title
Contact for advice:	Job title

Contents

1. Introduction

This section should include a brief explanation of the reason for the policy.

2. Purpose and scope of the policy

This section should include why the policy needed, the rationale for development, what will it cover and an outline of the objectives and intended outcomes.

3. Definitions

This section should include a list and / or description of the meaning of terms used in the context of the policy or procedure.

4. Principles

This section should include the fundamental action points of the policy or procedure to be adopted.

5. Duties

This section should include the following:

- who is responsible for developing and implementing the policy
- who in the organisation is required to do what
- who is responsible for communicating the policy
- who is responsible for consultation with stakeholders
- who is responsible for approving the policy/procedure

6. Equality Impact Assessment

New or updated Equality Impact Assessment to be completed (Appendix A).

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer. All new policies and procedures should be subject to an Equality Impact Assessment (EIA). For revised policies an update of the EIA needs to be undertaken.

If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

7. Dissemination and implementation arrangements (including training)

This section should describe the methods that will be used to ensure timely and efficient dissemination and implementation arrangements including training. This should include:

- any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training;
- any resource requirements, including staff, and how these will be met; and
- support available to assist implementation;

Directors are responsible for ensuring that staff within their area of responsibility are aware of new or amended policies and procedures related to their work and the change is communicated in The Headlines. If local teams download and keep a paper version of documents, the responsible manager must identify someone within the team who is responsible for updating the paper version.

8. Process for monitoring compliance and effectiveness

This section should identify the arrangements for compliance and effectiveness, responsibility for conducting any audit, review or monitoring, the methodology to be used for audit, review or monitoring, its frequency, the process for reviewing the results and monitoring of key performance indicators. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission (CQC) standards, and Monitor / NHS Improvement compliance. Methods may include:

- monitoring and analysis of incidents, performance reports and training records
- audit by the Trust's internal auditors
- checklists
- monitoring of delivery of actions plans through TAGs or BDUs.

9. Review and revision arrangements

This section should identify the arrangements for the review and revision of the policy. If an update to a policy has taken place it should describe the process undertaken.

10. References

This section should list any other documents referenced within the policy.

11. Associated documents

This section should list any other documents to be read in association with the policy. This could include other policies, procedures and guidance documents.

12. Appendices

As a minimum all policies should include completed versions of the following:

- Equality Impact Assessment (see appendix A);
- Checklist for the Review and Approval of Procedural Document (see appendix B);
- Version control sheet (see appendix C).

TEMPLATE for Appendix - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment:

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	Name of the document that you are Equality Impact Assessing		
2	Describe the overall aim of your document and context? Who will benefit from this policy/procedure/strategy?		
3	Who is the overall lead for this assessment?		
4	Who else was involved in conducting this assessment?		
5	Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy? What did you find out and how have you used this information?		
6	What equality data have you used to inform this equality impact assessment?		
7	What does this data say?		
8	Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:	Yes/No	Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.
8.1	Race		
8.2	Disability		
8.3	Gender		

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.4	**Age**		
8.5	**Sexual orientation**		
8.6	**Religion or belief**		
8.7	**Transgender**		
8.8	**Maternity & Pregnancy**		
8.9	**Marriage & Civil partnerships**		
8.10	**Carers*Our Trust requirement***		
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		
9c	**Promotes good relations between different equality groups;**		
9d	**Public Sector Equality Duty – "Due Regard"**		
10	**Have you developed an Action Plan arising from this assessment?**		
11	**Assessment/Action Plan approved by**		**Signed:** **Date:** **Title:**
12	***Once approved, you must forward a copy of this Assessment/Action Plan to Equality & Engagement Managers - Aboo Bhana (Aboobaker.Bhana@swyt.nhs.uk) and Zahida Mallard (Zahida.Mallard@swyt.nhs.uk)***		

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	Please note that the EIA is a public document and will be published on the web. **Failing to complete an EIA could expose the Trust to future legal challenge.**	

If you have identified a potential discriminatory impact of this policy, please refer it to the Equality & Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Equality & Engagement Managers.

TEMPLATE for Appendix - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
	Is it clear in the introduction whether this document replaces or supersedes a previous document?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are supporting documents referenced?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint Human Resources/staff side committee (or equivalent)		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?		
	Is there a plan to review or audit compliance with the document?		
10.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?		

TEMPLATE for Appendix - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes

Appendix Bi

South West Yorkshire Partnership NHS Foundation Trust

PROFORMA FOR APPROVAL OF POLICIES BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

The following should be completed to support submission of policies for approval to EMT.

Policy name	
EMT date	
Purpose of the policy	
What has changed and why?	
What policy(ies) does it replace or update, if any?	
Confirm that the policy has been developed / updated in accordance with the 'Policy for the development, approval and dissemination of policy and procedural documents' (Policy on Policies). Refer to the intranet page: http://nww.swyt.nhs.uk/Pages/Policies-and-procedures.aspx	e.g. correct Trust logo, font is Arial 12pt, stakeholder consultation completed (see below), EIA completed / updated (see below), checklist for the review and approval of procedural document completed, version control appendix updated
Provide evidence of consultation with appropriate stakeholders (who, how and when). For clinical policies this must include the Clinical Policies and Procedures Group.	
Provide the date that the Equality Impact Assessment (EIA) was completed / updated in consultation with an Equality & Engagement Manager. Refer to the intranet page: http://nww.swyt.nhs.uk/equality-impact-assessments/Pages/default.aspx	
Identify any risks	

Are there any implications for: • **Finance** • **Governance** • **Training** • **Other**	

Appendix Bii

South West Yorkshire Partnership NHS Foundation Trust

PROFORMA FOR EXTENSION OF POLICIES BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

The following should be completed to support submission of policies for extension to EMT.

Policy name	
EMT date	
Purpose of the Policy	
Reason for extension?	
Length of extension required?	
How will you manage the risk	
Identify any risks	

Appendix C - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment: 9 January 2020

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Policy for the development, approval and dissemination of policy and procedural documents
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		The overall aim of the policy is to describe the Trust's approach to the development and approval of policies and procedural documents. All staff
3	**Who is the overall lead for this assessment?**		Director of Finance & Resources
4	**Who else was involved in conducting this assessment?**		Company Secretary Corporate Governance Manager
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		Clinical Leads, Human Resources, Staff side, and the Executive Management Team were consulted on the ~~d~~evelopment of the policy. N/A
6	**What equality data have you used to inform this equality impact assessment?**		This policy impacts on everyone therefore no equality data required.
7	**What does this data say?**		N/A
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**Yes/No**	**Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.**
8.1	**Race**	No	N/A
8.2	**Disability**	No	N/A
8.3	**Gender**	No	N/A
8.4	**Age**	No	N/A

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.5	**Sexual orientation**	No	N/A
8.6	**Religion or belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		This policy aims to standardise the approach to policy development, approval and dissemination and requires adoption of the Equality Impact Assessment throughout the organisation.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		As above.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		As above.
9c	**Promotes good relations between different equality groups;**		As above.
9d	**Public Sector Equality Duty – "Due Regard"**		As above.
10	**Have you developed an Action Plan arising from this assessment?**		N/A
11	**Assessment/Action Plan approved by**		**Signed:** Mark Brooks **Date:** 9 January 2020 **Title:** Director of Finance & Resources
12	***Once approved, you must forward a copy of this Assessment/Action Plan to Equality & Engagement Managers - Aboo Bhana (Aboobaker.Bhana@swyt.nhs.uk) and Zahida Mallard (Zahida.Mallard@swyt.nhs.uk)*** **Please note that the EIA is a public**		

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	document and will be published on the web. **Failing to complete an EIA could expose the Trust to future legal challenge.**	

If you have identified a potential discriminatory impact of this policy, please refer it to the Equality & Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Equality & Engagement Development Managers.

Appendix D - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent)	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix E - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	June 2008	Director of Corporate Development	Final	Final version approved by Trust Board
2	March 2009	Director of Corporate Development		Changes made to ensure clarity on superseded or replaced documents and to reflect change in guidance for 2009/10
3	March 2010	Integrated Governance Manager	Final draft	Changes made following review and subsequent recommendations made during NHS LARMS review
4	Decemb er 2010	Integrated Governance Manager	Final	Inclusion of Equality Impact Assessment
5	July 2011	Integrated Governance Manager	Final	Changes made to accommodate comments made during NHS LARMS review and transfer of services from NHS Barnsley
6	October 2012	Integrated Governance Manager	Final draft	Changes made to meet requirements of NHS LARMS
7	October 2013	Integrated Governance Manager	Final	Revised equality impact assessment added (approved by lead Director 3 October 2013)
8	July 2014	Integrated Governance Manager	Final	Review by Lead Director; agreed no changes required. Approval of review date extension for further two years
9	January 2017	Integrated Governance Manager	Final	Reviewed with minor amendments and approved by Trust Board.
10	January 2019	Company Secretary Corporate Governance Manager	Final	Reviewed with minor amendments. Approved by EMT and Trust Board.
11	January 2020	Company Secretary	Draft	Reviewed with minor amendments. To be approved by EMT and Trust Board.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 31 March 2020
Confidential agenda item 8.3

Title:	**Standards of Conduct in Public Service Policy (conflicts of interest)**
Paper prepared by:	Director of Finance and Resources Director of Human Resources, Organisational Development and Estates
Purpose:	To inform the Trust Board of updates to the Trust's standards of conduct in public service policy and to gain approval for it. The previous update in 2017 was based on guidance provided by NHS England at that time and as such is in line with that guidance.
Mission/values:	The NHS as a whole spends a large amount of public money and therefore it is vital that this is done in the best interest of the population served. The Trust's Standards of Conduct in Public Service Policy, which is supported by NHS England's guidance, is designed to ensure that all staff are clear about the importance that decisions are seen to be arrived at without undue influence. This policy supports all the Trust's values but in particular the commitment to be honest, open and transparent.
Any background papers/ previously considered by:	Update to the previous Standards of Business Conduct which forms part of all staff contracts of employment. The update has been reviewed by the Executive Management Team on 5 March 2020.
Executive summary:	The Trust's Standards of Conduct in Public Service Policy sets outs clear expectations and responsibilities of staff whilst at work and in summary these are: Staff of the Trust are expected to: ➢ Ensure that the interest of patients remains paramount at all times. ➢ Be impartial and honest in the conduct of their official business. ➢ Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money. Staff have a responsibility not to: ➢ Abuse their official position for personal gain or to benefit their family or friends. ➢ Accept bribes. ➢ Seek to advantage or further private business or other interests, in the course of their official duties. NHS England guidance on managing conflict of interests: ➢ Introduced common principles and rules for managing conflicts of interest. ➢ Provided simple advice to staff and organisations about what to do in common situations. ➢ Supported good judgement about how interests should be approached and managed. NHS England's guidance defines a conflict of interest as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring

	taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Categories of interests are set out as: ➢ **Financial Interests**: Where an individual may get direct financial benefit from the consequences of a decision they are involved in making. ➢ **Non-Financial Professional Interests**: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career. ➢ **Non-Financial Personal Interests**: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career. ➢ **Indirect Interests**: Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making. The guidance and Policy details principles, rules and the declaration process for the following areas: ➢ Gifts ➢ Hospitality ➢ Outside Employment ➢ Shareholding and other ownership interests ➢ Patents ➢ Loyalty interests ➢ Donations ➢ Sponsored events ➢ Sponsored research ➢ Sponsored posts ➢ Clinical private practice Note, there are separate conflict of interest policies for the Trust Board (*Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality and Members' Council*) and Members' Council (*Members' Council declaration and register of interests, gifts and hospitality*) which support the specific requirements of Directors and Governors within the Trust's Constitution, the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and Monitor's Code of Governance for Foundation Trust. Updates to the policy include: • Clear reference to the Nolan principles • Clear reference to the fact the policy also applies to non-executive directors • Clear reference to the fact declarations of interest are required to be published on the Trust's website • Reference to the fact governors are required to sign the code of conduct for governors on appointment

	Risk appetite As the Trust's Standards of Conduct in Public Service Policy is compliant with the NHS England guidance there is no change to any identified risks and it remains consistent with the agreed risk tolerance.
Recommendation:	**Trust Board is asked to APPROVE the updated policy which is aligned with the guidance issued by NHS England on managing conflicts of interest.**
Private session:	Not applicable.

Document name:	Standards of Conduct in Public Service Policy (including managing conflicts of interest)
Document type:	Policy
What does this Policy replace?	Update of previous version
Staff group to whom it applies:	All staff
Distribution:	Trust Wide
How to access:	Intranet
Issue date:	March 2020
Next review:	March 2023
Approved by:	Trust Board 31 March 2020
Developed by:	HR Business Manager Deputy Director of Finance
Director leads:	Director of Finance and Resources Director of HR, OD and Estates
Contact for advice:	Corporate Governance Team

Contents

1 Policy Summary

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our service users / patients for the decisions we take.

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf. • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent. • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • **NOT** misuse your position to further your own interests or those close to you. • **NOT** be influenced, or give the impression that you have been influenced by outside interests. • **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money.	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Identify a team or individual with responsibility for: o Keeping this policy under review to ensure they are in line with the guidance. o Providing advice, training and support for staff on how interests should be managed. o Maintaining register(s) of interests. o Auditing this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

2 Introduction

South West Yorkshire Partnership NHS Foundation Trust (the 'Trust'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our service users / patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise. (See Section 4 for the definition of conflict of interests)

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As a Trust and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

In terms of standards of integrity the Trust, and this policy, follow the Nolan principles of public office.

- Selflessness – act solely in terms of the public interest.
- Integrity – avoid placing in suituations where decisions could be inappropriately influenced.
- Objectivity – make decisions impartially, fairly and using the best evidence without discrimination or bias.
- Accountability – be open to public scrutiny.
- Openness – decisions taken in an open and transparent manner.
- Honesty.
- Leadership – everyone should exhibit these principles in their own behaviour, promote and support the principle and challenge poor behaviour wherever it occurs.

This policy replaces Standards of Conduct in Public Service Policy (October 2017). The structure follows the national model policy and incorporates Trust specific elements. All staff (See section 6) must follow the principles set out in the policy.

All staff are responsible for ensuring that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

3 Purpose

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules.
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests.

The core principles underpinned by this policy include that staff are expected to:

- Ensure the interest of patients remains paramount at all times.
- Be impartial and honest in the conduct of their official business.
- Use public funds entrusted to them to the best advantage of the services, always ensuring value for money.

It is the responsibility of staff to ensure that they do NOT:

- Abuse their official position for personal gain or to benefit their family or friends.
- Accept bribes.
- Seek to advantage or further private business or other interests in the course of their official duties.

This policy should be considered alongside these other Trust policies:

- Standing Financial Instructions (SFIs).
- Anti-Fraud, Bribery and Corruption Policy.
- Whistleblowing Policy.

4 Key terms

A ‘conflict of interest’ is:

> “A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests.
- Potential – there is the possibility of a material conflict between one or more interests in the future.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 Interests

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.

- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect interests:**
  Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

6 Staff

At the Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees.
- All prospective employees – who are part-way through recruitment.
- Non-Executive Directors.
- Bank staff.
- Contractors and sub-contractors.
- Agency staff.
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust).
- Volunteers.
- Governors (Governors are also required to sign the 'code of conduct for governors' on appointment to the Members' Council which requires all governors to adhere to Trust policies and procedures).

[1] This may be a financial gain, or avoidance of a loss.
[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

This policy applies to all staff and it is the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. Staff need to be aware that it is both a serious criminal offence (Bribery Act 2010, the Theft Act 1968 and the Fraud Act 2006) and disciplinary matter to corruptly receive or give any fee, loan, gift, reward or other advantage in return for doing (or not doing) anything or showing favour (or disfavour) to any person or organisation.

It is the responsibility of managers within the Trust to ensure that the policy is brought to the attention of all staff.

Staff need to ensure that they consider any potential conflict of interests arising from the development of the Integrated Care Systems and the different organisations which operate within them. In each case the policies and procedures of the host organisation will take precedent but declarations should be made to all parties.

Staff on secondment will also need to comply with the policy of their host organisation and make declarations to both the Trust and their host organisation.

7 Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this Trust are:

- Trust Directors.
- Trust Board members.
- Senior Managers with responsibility for commissioning of services and /or the purchasing of goods and services.

The Trust is required to publish declarations of interest for decision making staff annually. This report is available on the Trust website:

https://www.southwestyorkshire.nhs.uk/contact-us/freedom-of-information/registers-and-documents/

Note, there are separate Declaration of Interest policies for the Trust Directors, Trust Board members, and governors of the Members' Council.

8 Identification, declaration and review of interests

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the Trust.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

A declaration of interest(s) form is available at Appendix D.

Declarations should be made to the Trust Company Secretary.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

8.2 Proactive review of interests

We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return.

9 Records and publication

9.1 Maintenance

The Trust will maintain a single Register of Interest.

All declared interests will be promptly transferred to the register by the Company Secretary, at least monthly.

9.2 Wider transparency initiatives

The Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

- Speaking at and chairing meetings.
- Training services.
- Advisory board meetings.
- Fees and expenses paid to healthcare professionals.

- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK.
- Donations, grants and benefits in kind provided to healthcare organisations.

Further information about the scheme can be found on the ABPI website:

http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

10 Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making.
- removing staff from the whole decision making process.
- removing staff responsibility for an entire area of work.
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

11 Management of interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts.These should be politely but firmly declined.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be politely but firmly declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6[3] in total, and need not be declared.

[3] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts of a low intrinsic value such as chocolates or flowers can be accepted but must be declared.
- If a gift is accepted a Declaration of Interest form (Appendix D) should be completed.
- Any gift accepted should be accepted on behalf of the Trust and other related Charities.

11.1.1 What should be declared

- Staff name and their role with the Trust.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. (It would be normal and reasonable for hospitality to be provided).
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval, by a General Manager or equivalent, must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75[4] - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the Trust itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be

[4] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

recorded on the Trust's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:

- offers of business class or first class travel and accommodation (including domestic travel).
- offers of foreign travel and accommodation.

11.2.1 What should be declared

- Staff name and their role with the Trust.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.3 Outside Employment

Employees of the Trust are advised not to engage in outside employment, which may conflict with their NHS work, or be detrimental to it.

Outside employment could include working in a private clinic / hospital, registered nursing or residential care home. Other areas may include consultancy work, or involvement in running of a voluntary sector organisation (even in a voluntary capacity).

- Staff must declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff are required to seek prior approval from the Trust to engage in outside employment.

11.3.1 What should be declared

- Staff name and their role with the Trust.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust.

- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

11.4.1 What should be declared

- Staff name and their role with the Trust.
- Nature of the shareholdings / other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the Trust.
- Staff should seek prior permission from the Trust before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the Trust's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.5.1 What should be declared

- Staff name and their role with the Trust.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.

- Are aware that their Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

11.6.1 What should be declared

- Staff name and their role with the Trust.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.7 Donations

- Donations made by suppliers or bodies seeking to do business with the Trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust, or is being pursued on behalf of the Trust's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the Trust if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the Trust's own. Approval must be received from the Director of Finance and the Director of Human Resources.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared

- The Trust will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in a clear benefit to the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

- At the Trust's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the Trust involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the Trust through the Declaration of Interest form.

11.8.1 What should be declared

- The Trust will maintain records regarding sponsored events in line with the above principles and rules. This must include:
  - Purpose of Sponsorship.
  - Names of companies involved.
  - Sponsorship value.

11.9 Sponsored research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the Trust, and / or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the Trust through the Declaration of Interest form.

11.9.1 What should be declared

- The Trust will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
  - Their name and their role with the Trust.
  - Nature of their involvement in the sponsored research.
  - Relevant dates.
  - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.10 Sponsored posts

- External sponsorship of a post requires prior approval from the Trust.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.10.1 What should be declared

- The Trust will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

11.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and / or any new private practice when it arises[5] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions / time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their Trust before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[6]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

[5] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

[6] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

11.11.1 What should be declared

- Staff name and their role with the Trust.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

12 Management of interests – advice in specific contexts

12.1 Strategic decision making groups

In common with other NHS bodies the Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the Trust's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the Trust should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

By participating in tendering exercises prospective suppliers should also be in agreement with, and adhere to, the Trust's Supplier Code of Conduct. A copy of which is included within the tender documentation. Any supplier not wishing to comply with this term should provide details of their objections which will be duly noted and considered within the contract award process.

13 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

13.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to:

- Line Manager .
- Deputy Director of Finance.
- Human Resource Business Partner.
- Company Secretary.
- Local Counter Fraud Specialist.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the Trust's Whistleblowing Policy available on the Intranet document store: (http://nww.swyt.nhs.uk/docs/Documents/Forms/AZ.aspx)

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so the what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

13.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR / employment law / contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and / or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

13.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Trust Executive Management Team (EMT) and reported, at least annually, to the Trust Audit Committee.

14 Bribery

Bribery is defined as “an inducement or reward offered, promised or provided to gain personal, commercial, regulatory or contractual advantage”. Bribery can also be described as corruption, the offering or acceptance of inducements, gifts, favours, payment or benefit-in-kind which may influence the action of a person.

All employees have a personal responsibility to protect the Trust from bribery and corruption and not engage in any form of bribery, in the UK or abroad.

Please refer to the Trust’s Anti-Fraud, Bribery and Corruption Policy.

15 Counter Fraud measures

As noted in section 3, staff are expected not to use their position to gain advantage. The organisation is keen to prevent fraud and encourages staff with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. In accordance with the Trust’s Anti-Fraud, Bribery and Corruption Policy and also the Trust’s Whistleblowing Policy, staff should inform the nominated Local Counter Fraud Specialist (LCFS) or the Trust’s Director of Finance, unless the Director of Finance or LCFS is implicated. If that is the case, they should report it to the Chair or Chief Executive, who will decide on the action to be taken.

Employees can also call the NHS Fraud and Corruption Reporting Line on free phone 0800 028 40 60. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

16 Review

This policy will be reviewed bi-annually unless an earlier review is required. This will be led by the Human Resources Business Partner in conjunction with the Deputy Director of Finance and Company Secretary.

17 Associated documentation

Trust's Anti-Fraud, Bribery and Corruption Policy
Bribery Act 2010
Theft Act 1968
Fraud Act 2006
Freedom of Information Act 2000
ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
ABHI Code of Business Practice
NHS Code of Conduct and Accountability (July 2004)

Appendix A - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment: 1st September 2019

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Standards of Conduct in Public Service Policy
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		To ensure that employees adhere to the expected standards of business conduct required of NHS staff and that there is an appropriate means of declaring legitimate interests All staff and the Trust
3	**Who is the overall lead for this assessment?**		Human Resources, OD and Facilites Director of Finance
4	**Who else was involved in conducting this assessment?**		Human Resources Integrated Governance Manager Deputy Director of Finance Staff Side
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		Staff Side
6	**What equality data have you used to inform this equality impact assessment?**		Reviewed data in the equality workforce monitoring report
7	**What does this data say?**		Data of numbers of staff in different equality groups
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**Yes/No**	
8.1	**Race**	No	This policy applies equally to all groups of staff
8.2	**Disability**	No	This policy applies equally to all groups of staff
8.3	**Gender**	No	This policy applies equally to all groups of staff

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.4	**Age**	No	This policy applies equally to all groups of staff
8.5	**Sexual orientation**	No	This policy applies equally to all groups of staff
8.6	**Religion or belief**	No	This policy applies equally to all groups of staff
8.7	**Transgender**	No	This policy applies equally to all groups of staff
8.8	**Maternity & Pregnancy**	No	This policy applies equally to all groups of staff
8.9	**Marriage & Civil partnerships**	No	This policy applies equally to all groups of staff
8.10	**Carers*Our Trust requirement***	No	This policy does not apply to carers
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		This policy applies equally to all staff.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		Declarations of interests will be reviewed to ensure that appropriate advice/support is provided to different staff groups.
9c	**Promotes good relations between different equality groups;**		This policy applies equally to all staff.
9d	**Public Sector Equality Duty – "Due Regard"**		This policy applies equally to all staff.
10	**Have you developed an Action Plan arising from this assessment?**		N/A
11	**Assessment/Action Plan approved by**		**Signed:** A Hambling, HR Business Manager Rob Adamson Deputy Director of Finance **Date: 1st September 2019**
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the partnerships team:*** **partnerships@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on the web.** **Failing to complete an EIA could**		

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	expose the Trust to future legal challenge.	

If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Finance and Dirctor of Human Resources with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Huamn Resources Equality and Engagement Development Managers.

Appendix B - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	Clear policy which enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	No	
	Are people involved in the development identified?	Yes	Utilise national policy framework but HR, finance and governance involved prior to Staffside and Members review
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	Applies to all staff
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	Will be subject to discussion and agreement with staff side
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix C - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1.0	Aug 03	James Corson	Superseded	
2.0	May 12	James Corson	Superseded	An extensive rewrite and change of title. It incorporates elements of the Barnsley PCT policy and reference to the Bribery Act and the revised CIPS professional Code. It also now makes reference to the Code of conduct for NHS Managers. This single procedure now replaces all the previous disciplinary documents for the forerunner organisations: Barnsley, Calderdale and Wakefield PCT's
2.0a	Apr 13	James Corson	Superseded	Links embedded in the document updated
2.0b	Dec 13	James Corson	Superseded	Addition of further information on Fraud/bribery/corruption following a Focussed Quality Assessment
2.0c	Feb 15	James Corson	Superseded	Further clarification of when staff can engage in outside employment. See para 5.8
3	3/10/17	HR Business Manager / Deputy Director of Finance	Superseded	Updated in accordance with national guidance.
	25/07/18	Company Secretary	Superseded	Reference added to bribery and counter fraud.
4	Sept 19	Company Secretary Deputy Director of Finance HR Business Manager	Current	Minor updating. Reference to staff working across Integrated Care Systems/secondments.

Appendix D - Declaration Form

IN STRICT CONFIDENCE - INTERESTS DECLARATION FORM		
Name and Base		
Job Title		
Description of Interest		
Relevant dates	From:	To:
The information submitted will be held by South West Yorkshire NHS Foundation Trust ('the Trust') for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that South West Yorkshire NHS Foundation Trust holds. I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to South West Yorkshire NHS Foundation Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result. I **do / do not** give my consent for this information to published on registers that South West Yorkshire NHS Foundation Trust holds. If consent is not given please give reasons.		
Signed:	**Date:**	
Comments of Line Manager and/or Head of Service (as appropriate)		
Signed:	**Date:**	
Action required, if any:		
• **Copy to Personal File**	• **Original to Register of Interests File**	

PLEASE RETURN THIS FORM TO: Company Secretary, Block 8, Fieldhead, Wakefield

GUIDANCE NOTES FOR COMPLETION OF INTERESTS DECLARATION FORM

Name and Base Insert your name and location

Job Title Insert your position/role in relation to the Trust

Description of Interest: Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc). That is, the information provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest.

Types of interest:

Financial interests - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making

Non-financial professional interests - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career

Non-financial personal interests - This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career

Indirect interests - This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

A benefit may arise from both a gain or avoidance of a loss.

Further comments:

Detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action.

Relevant Dates: Detail here when the interest arose and, if relevant, when it ceased.

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Trust Board 31 March 2020
Confidential agenda item 8.4

Title:	Involving people strategy update
Paper prepared by:	Marketing, communications, engagement and inclusion lead Director of Nursing and Quality Director of Strategy
Purpose:	The purpose of the paper is to provide an update on the approach to managing the refresh of the Communication, Engagement and Involvement Strategy 2016-2019.
Mission / values:	The Involving People Strategy (formerly Communication, Engagement and Involvement Strategy) refresh will need to demonstrate a responsive approach to strengthen our approach to inclusion and in meeting our statutory legal obligations. The strategy will act as an enabler to the Trust Strategy. The approach will support our mission to **help people reach their potential to live well in their communities** and is in line with our Trust values, in particular **putting people first and in the centre** The strategy will ensure we improve health and wellbeing by involving people to co-design the services they use. We will ensure that what people tell us will improve quality and experience shapes change and transformation. By developing a systematic approach to involving people the strategy will improve the use of our resources, making us **relevant today and ready for tomorrow, with an engaged workforce reflective of our communities.**
Any background papers / previously considered by:	The existing Communication, Engagement and Involvement Strategy had previously been agreed by the Trust Board in 2016. The strategy is due to expire in December 2019. The new strategy will incorporate the functions of marketing, communications, engagement, equality and inclusion, and more recently membership. The approach was agreed at the November Trust Board. The biggest current impact on the development of a strategy is the timeline. The stakeholder perception survey has been delayed in light of COVID19.The team are also refocussing resources to ensure communications are strengthened during this time.
Executive summary:	This paper provides an update on the proposed approach, process and timescales to refresh the Involving People Strategy.
Recommendation:	**The Trust board is asked to:** ➢ **RECEIVE an update on the proposed approach and provide additional comments and feedback** ➢ **ACKNOWLEDGE the current climate which will impact on delivering the strategy in previously agreed timescale** ➢ **COMMENT on and AGREE a new timeline**
Private session:	Not applicable

Trust Board
31 March 2020

Involving People Strategy refresh update

1. Introduction

The purpose of the paper is to describe an update on progress of the Involving People Strategy refresh. This paper sets out the

- Progress made to identify the requirements of the strategy
- Progress made to create the right conditions for a new strategy
- Update on engagement activity
- How the strategy will align with other strategies
- Timeline for delivery

The Trust Board are asked to consider the content of the paper, accept the update and discuss and comment on the recommendations.

2. Strategy requirements

The strategy refresh will provide the Trust with an opportunity to strengthen its commitment to developing a more inclusive and integrated approach to involving people. The strategy will align the functions of marketing, communications, engagement and equality.

In addition the strategy will now align membership as an integral part of the strategy and as with other areas a website page will be created to support this work.

3. Progress made to create the right conditions for a new strategy

The progress made to developing a new strategy is as follows:

- **Map** The team have already started to map the existing approaches in each of the localities and services. Mapping on an excel spreadsheet will ensure that the Trust can identify established mechanisms and build on existing relationships. The mapping will cover three cohorts:

- Person at the centre: How do we involve individuals, what mechanisms are in place? This would include involvement in care and treatment and functions such as complaints and patient experience.
- People at the centre: How do we involve people who have a shared or common interest. This would include service user, carer, family and friends groups, staff groups, governors and members.
- Communities at the centre: How do we involve communities at a place based, locality or neighbourhood level? And who are our stakeholders?

- **A plan to gather views from external stakeholders** and build on previous insight is now in place. The content of the original insight report will be reflected in the strategy, with additional insight gathered to support this work.

- **To identify our approach to evaluation** we are asking people to tell us how we will know if we have got the approach right. The Trust will identify measures based on the feedback we receive. We have asked people to tell us 'how will you know when we have got this right'. This feedback will help to co-create a stakeholder driven set of measures and tools.

- **To develop a process and approach which will help the Trust meet its legal obligations.** A process for using a checklist at the beginning of a programme of work is now in place. This includes a dedicated inbox. The checklist is on the intranet. Training on this approach has now been identified as part of the Trust learning needs analysis and plans are to start to deliver this training in quarter 1.

- The Trust still needs to explore the **governance for engagement** and formal consultation. The requirements will be to sign off plans and reports so they can be published.

- Work to design the '**Get Involved' section of the website** has started and will be further informed by the requirements of the 'Accessible Information Standard', the Trust value to be open and transparent and the findings from engagement on the strategy. Work will continue post strategy sign off with stakeholders to ensure the website is refreshed collaboratively. The website will have an involving people front page with the strategy attached as an easy read document. There will be links to pages dedicated to the functions set out below. All pages will have an action plan published on the page:

  - Marketing and communication (covering the accessible information standard and guidelines for requesting and using an interpreter)
  - Involvement (how to get involved (including staff networks), reports from all involvement activity, you said we did section, calendar of up and coming activity, policy for reimbursement of expenses, legal obligations and our governance explained)

- Equality and inclusion (this will be divided into workforce and public and legal obligations and governance explained – public and workforce pages will set out the specific duties with publications included)
- Membership (this will describe the role of members – further work to identify what else will be included will be co-designed with members council)

- The findings from engagement will help the Trust **identify objectives for each of the functions**. These objectives will be driven by the actions set out in each individual annual action plan.

4. Update on engagement activity

A delivery plan for involving people in the strategy has been developed. The plan identified a range of stakeholders and communities with whom the Trust should engage. The methods and approaches used to deliver engagement are:

- Using what we already know – this includes the recent staff and membership survey and the insight survey for stakeholders
- A postcard (50 received to date)
- An online survey (survey completion currently is at 197)
- A paper survey
- Peer led community conversations (32 taking place of between 8-12 people)
- Attendance at meetings (5 so far)
- Specific focus groups (5 planned)
- Artwork – currently working alongside NHS England and NHS Improvement to incorporate a piece of art with people who have a learning disability in conjunction with 'Creative Minds'.

Conversations started in January and will continue until mid-March. The strategy will be one product created from the conversations. The other items to be co-created will be specific action plans and a website designed with stakeholders in mind.

All engagement activity is being equality monitored so the Trust can ensure it reaches a diverse range of views and specifically considered the needs of all protected groups.

5. Feedback from conversations: one or two strategies

Following a number of dialogues with different people it was brought to the attention of the Equality and Inclusion Committee by the chair that a Trust member had expressed concern that we won't have a specific strategy for equality. This was supported by other members (not all) of the committee, including the engagement and equality managers.

The committee requested that Trust Board revisit the decision to have one strategy. The reasons given were:

- To ensure auditors such as CQC can see the strategy published
- To not lose the momentum on this agenda
- To ensure the agenda remains visible

It is worth noting that this concern has not been expressed as yet in any of the public feedback I have reviewed, with most people welcoming a simplified strategy and supporting action plans for each area.

If a single strategy is preferred, one option could be to rename the strategy and there are some suggestions below:

- Involving People: *our approach to equality, diversity, involvement and inclusion*
- Equality, diversity, involvement and inclusion strategy
- Person at the centre: *our approach to equality, diversity, involvement and inclusion*

If the Trust make a decision to support two strategies then 'Involving people' will still be used for the marketing, communication, engagement, membership and inclusion strategy

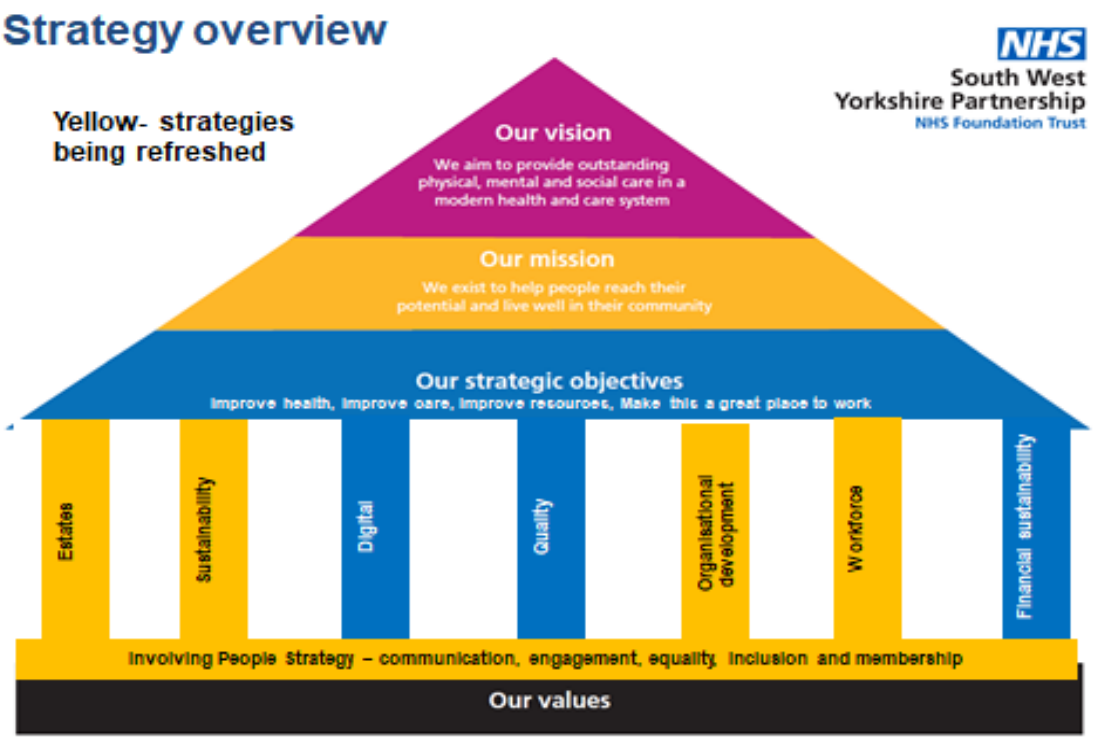
Each strategy will still have an accompanying action plan. The current difference between both strategies is only legislation, and objectives.

6. Proposed approach to align with other strategies

The proposed approach is to align the strategy with other strategies using a narrative and link to ensure that stakeholders can see the alignment. As the Involving people strategy supports the delivery of all the Trust values and relates directly to people it will drive other strategies. The key strategies currently being refreshed are:

- The workforce strategy
- The sustainability strategy
- The estates strategy

As the involving people strategy describes the relationship services should have with people, including how the Trust will inform, communicate and involve people, it is important that the Trust do not lose the requirements set out under law. This legislation still needs to drive how the Trust operates. The Involving people strategy will underpin the work of the Trust. A diagram to explain the proposed approach is set out below:



High level timeline

The timeline for developing a strategy refresh is set out below. Due to the current climate there are now changes to the existing timeline which are noted in the status column. The reasons for this are set out below:

- The biggest current impact on the timeline is the stakeholder perception survey which has been delayed in light of COVID19
- The team are also refocussing resources to ensure communications are strengthened during this time
- The Trust may not be in a position to fully consider the strategy refresh in light of other internal pressures relating to COVID19

The RAG is included in the status and describes that the development to date has been on track with the agreed timescales.

Process	**Action**	**Timeline**	**Status (RAG)**
Mapping	Identify the current mechanisms in place	November/December 2019	
Developing a draft document	Develop a framework for a document which includes all the must do elements.	January 2020	
Developing a draft strategy	Share the draft document through a number of forums and network to co-design additional content and use views gathered to inform an EQIA.	January - February 2020	On hold now until May 2020
Developing a draft strategy	Share a further draft of the strategy with stakeholders for final comments and considerations	June 2020	Timescale changed
Share a final draft with Trust Board	Present a final draft strategy and present the process delivered to design the strategy and describe the next steps.	July 2020	Timescale changed
Publication	Finalise the strategy and update the website ready for publication	July 2020	Timescale changed
Integrated action plan	Develop an integrated action plan to support the delivery of the strategy.	August 2020	Timescale changed

7. Recommendations

It is recommended that the Trust Board:

- Accept the content of the paper
- Endorse the approach to engagement
- Support the changes to the timeline
- Make a decision on a preferred option for one or two strategies

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Trust Board 31 March 2020
Confidential agenda item 9.1

Title:	**Delivering same sex accommodation declaration of compliance**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To approve the annual declaration following the scrutiny and support from the Clinical governance and clinical safety committee.
Mission/values:	We must support people to fulfil their potential and live well in their community. This includes safeguarding the privacy and dignity of service users when they are often at their most vulnerable.
Any background papers/ previously considered by:	Clinical governance and clinical safety committee reviews the compliance statement on an annual basis. Any exception reports regarding same sex accommodation are reported to the Clinical Governance and Clinical Safety Committee by the Director of Nursing and Quality.
Executive summary:	**Background** This paper is intended to assure the Trust Board of the organisation's level of compliance with the national standard in respect of delivering same sex accommodation. The declaration of compliance, which will appear on the Trust's website, is shown below. The Trust is expected to make a declaration to commissioners by 31 March 2020 to confirm the Trust's position regarding compliance with the mixed sex accommodation standard. The statement of compliance is then required to be posted on the Trust website. The guidance in relation to mixed sex accommodation expects Trusts to provide the following accommodation. Single Sex accommodation can be provided in: ➢ single sex wards (the whole ward is occupied by men or women but not both) ➢ single rooms with adjacent single sex toilet and washing facilities ➢ single sex accommodation within mixed wards (bays or rooms that accommodate either men or women, not both) with designated single sex toilet and washing facilities preferably within or adjacent to the bay or room. In addition, service users should not need to pass through accommodation or toilet / washing facilities used by the opposite sex to gain access to their own. During 2019 NHS England and NHS Improvement have produced some revised guidance on the current same-sex accommodation policy. The guidance has led to some changes in reporting from January 2020, including the requirement for a declaration so this is the

	last year this is required. Governance and scrutiny around delivering same sex accommodation takes place ➢ The 2019 audit of incidents reported take place in line with the incident reporting policy. ➢ A quarterly report is submitted to the Clinical Governance Group. ➢ A more detailed audit was conducted on areas based on risk these included: o New buildings o Based on incidents o Feedback – e.g. CQC The main conclusions are: ➢ There were no recorded breaches of mixed sex accommodation policy in 2019. ➢ As the Trust continues to increase its single sex accommodation, the number of mixed sex accommodation related incidents decreases. ➢ The number of mixed sex accommodation incidents recorded on Datix fell from 23 in 2016 to 11 in 2017, 9 in 2018 and 4 in 2019. Preventative measures were put in place to safeguard safety and dignity and no harm occurred; therefore there were no breaches. ➢ The results show high level of compliance with best practice standards. The standards the teams are unable to declare full compliance is similar to previous years:- o Staff gender mix on wards can affect ability to provide same sex key worker, this is mainly shortage of males o Nurse call system being available in all toilets. ➢ When CQC undertook core service inspection visits and our well led review between May and June 2019, there were no CQC comments regarding any mixed sex accommodation issues. They said the acute wards for working age adults and PICU's should continue to monitor CAMHS admissions on to the wards; and make sure staff have the skills and experience to be able to care for under 18 year olds. The under 18s admissions incident reports are included in the quarterly reports. **The Clinical Governance & Clinical Safety Committee supported the following recommendations:** ➢ To continue to explore opportunities through the transformation agenda for wards to be designated single sex and to continue to improve the availability of en-suite accommodation in all units. ➢ To continue considering ways to avoid allocating bedrooms in areas designated for the opposite sex.

	➢ To examine ward nurse on call system for toilets. ➢ To support the compliance declaration and recommend approval to the board. **Risk Appetite** A mixed sex accommodation breach could potentially be a clinical risk as well as a compliance risk. Through the flexibility within the Trust's accommodation the risk is mitigated in line with the Trust's risk appetite. However, it may be deemed safer to breach mixed sex accommodation on an individual basis than not to admit in a clinical emergency and actions would be put in place to manage the individual risk.
Recommendation:	**Trust Board is asked to approve the compliance declaration.**
Private session:	Not applicable.

Delivering same sex accommodation and Bed Management Incidents Annual Report

1. Executive Summary

South West Yorkshire Partnership NHS Foundation Trust provides a variety of services to a diverse population across the geographical localities and is committed to achieving the Trust's 'Mission and Values'.

Our mission

- We help people reach their potential and live well in their community

Our values

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

Trust inpatient services are provided in Calderdale, Kirklees, Wakefield and Barnsley. As part of clinical governance a priority area is ensuring the Trust meets the requirements for Eliminating Mixed Sex Accommodation (EMSA).

This report is based on information from 1 January 2018 to 31 December 2019.

The main conclusions are:

- The Trust can be assured it continues to meet the requirements of EMSA.
- There were no recorded EMSA breaches in 2019.
- As the Trust continues to increase its single sex accommodation, the number of EMSA related incidents decreases.

Calendar year	2016	2017	2018	2019
Number of reported incidents	23	11	9	4

- In 2019 EMSA four potential incidents were reported on four separate wards. These incidents involved either a female being admitted onto a male ward or vice versa. All were due to emergency admissions and did not meet national reporting requirements. Mitigation actions took place in all cases to protect privacy and dignity.

- Other bed management issues are reviewed including admission of under 18s

- National guidance is scanned for implications for EMSA. NHS England and NHS Improvement have produced some revised guidance on the current same-sex accommodation policy. The guidance will require some changes in reporting from January 2020 and all planning and communication to implement this has taken place.

- The results show high level of compliance with best practice standards. The standards the teams are unable to declare full compliance is similar:-
  - Staff gender mix on wards can affect ability to provide same sex key worker, this is mainly shortage of males.
  - Nurse call system being available in all toilets.

2. Main Report

During 2019 the governance of EMSA included:

- Ongoing performance reporting and review of incidents reported taking place in line with the incident reporting policy.
- A quarterly report is submitted to the Clinical Governance Group.
- The EMSA policy has been updated.
- The best practice standard audit has been conducted on areas based on risk, these included:
  - New buildings
  - Based on incidents
  - Feedback – e.g. Healthwatch, CQC

2.1 Incidents of potential breaches by team and month

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Walton PICU	1	0	0	0	0	0	0	0	0	0	0	0	1
Crofton ward, Wakefield	0	0	0	0	0	0	0	0	0	1	0	0	1
Ward 18, Kirklees	0	0	0	0	0	1	0	0	0	0	0	0	1
Beechdale, Calderdale	0	0	0	0	0	0	0	1	0	0	0	0	1
Total	1	0	0	0	0	1	0	1	0	0	0	0	4

- The table above shows the potential breaches reported by services. Two incidents involved female service users being admitted as an emergency onto a corridor occupied by males.

Another incident involved a similar scenario when the service user was returning from leave but had no bed due to an emergency. The other incident was due to a male service user being admitted to a female pod because of the lack of any alternative bed other than in London.

Where such an incident occurs, mitigating action includes:

- Increased observation
- Updated risk assessment and monitoring
- Review of care plan

2.2 Best practice standard audit results

A best practice standard audit was undertaken on:

- Crofton ward
- Ward 18
- The Poplars
- Beechdale ward
- Walton PICU
- Beamshaw ward

These wards were chosen against the criteria identified during the review.

Standards and results

Standard	2019	Comments
Service users are accommodated in single rooms, single sex bed bays, separate corridors, pods or en-suite single rooms	**83%**	One female service user had to be admitted as an emergency and was on a corridor occupied by male service users
Is a lounge available for sole use of female service users (new question for 2017)	**100%**	Available or not applicable as male only ward.
Bedroom doors are fitted with observation peephole or panel window and these can be operated by members of staff	**100%**	
Consultations take place in a private room	**83%**	Ward 18 staff said this is not always possible due to the space available on the ward and because of service user preference
Toilets and bathroom doors are lockable from the inside and fitted with fail safe entry mechanisms which can only be opened by staff	**100%**	Ensuite toilets do not have locks but the main door locks
Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department	**100%**	
Bedroom doors are lockable from the inside with fail safe entry mechanisms to ensure service user safety	**83%**	On ward 18 none of the bedroom doors are lockable from the inside
Bedroom doors are fitted with an observation peephole or panel window which can only be operated by members of	**100%**	

staff		
Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department.	**100%**	
Male and female toilets and washing facilities are clearly labelled male or female	**100%**	
Clear information is provided for service users, relatives and carers on the arrangements made and the standards they should expect to ensure their privacy and dignity is maintained	**100%**	
Staff carrying out physical examinations are the same gender as the service user or if not are accompanied by a chaperone of that gender	**67%**	Beamshaw and The Poplars this sometimes happens
Staff using planned restraint are the same gender as the service user or if not are accompanied by a chaperone of that gender	**33%**	Not always able to accommodate due to gender of staff on duty.
Toilets have nurse call systems to ensure safety	**67%**	Walton and ward 18 do not have call bells in toilet areas
Where toilets do not have nurse-call systems the service user is risk assessed	**100%**	
Service users are asked if they have a preference regarding same sex key worker	**50%**	The Poplars, Beamshaw and Crofton said this is sometimes done.
Bedroom doors have observation mechanisms to ensure service user safety	**100%**	
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex this incident is reported in accordance with the Trusts reporting procedure (through Datix)	**100%**	
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex appropriate safeguarding measures such as enhanced observation are applied	**100%**	

The ward staff completed the survey on survey monkey and it was collated by the Quality, Improvement and Assurance Team (QIAT).

The above table shows the results and comments made. The results show a high level of compliance with the standards.

The standards the teams are unable to declare full compliance at 100% is similar:-

- Staff gender mix on wards can affect ability to provide same sex key worker and physical examinations and restraint being undertaken by the same sex gender. This is mainly due to the shortage of male staff.
- On two wards there is no nurse call system available in toilet areas.

Both of these issues are part of wider plans within the Trust.

2.3 Summary of results - Trust Board

	Trust Board Self-Assessment		
	The Trust does not have any mixed sex accommodation so the standards are judged to be met as determined in previous audits. Commentary given is related to maintaining good practice in regard to Trust Board information		
	Mechanisms are in place to provide the Board of Directors with regular information on the views of service users	**met**	The board receives regular reports providing service user feedback which capture any views expressed about mixed sex accommodation
	The Board receives regular reports on the Trust's progress in eliminating mixed sex accommodation	**met**	The board receives information in the quarterly quality reports where any EMSA breaches would be highlighted. There is also the annual EMSA statement from the lead Director
	The Board receives information from patient complaints and incidents, categorised on the basis of mixed sex accommodation issues. These should also include abuse and sexual safety issues	**met**	• The Board receives regular customer services reports including information on complaints broken down into themes which would capture mixed sex accommodation concerns. • The quarterly compliance report which goes to Executive Management Team specifies incidents which have occurred relating to people accommodated on other gender ward areas and associated safeguarding processes (increased observation levels etc.)
	The Board reviews and amends policies on mixed sex accommodation in light of experience, incidents and changes to the service	**met**	• There is an EMSA policy. • Trust uses national guidance to inform practice. Trust Board would respond and require practice change if breaches were to occur
	The Board sets annual measurable targets for improvement	**N/A**	This is not applicable as the Trust has declared that mixed sex accommodation has been eliminated in all SWYPFT inpatient areas.
	The Trust considers the elimination of mixed sex accommodation in any refurbishment or new-build capital development schemes	**met**	This is an integral part of the planning procedure
	The Trust provides training to support the elimination of mixed sex accommodation & promote the protection of privacy & dignity	**met**	Not specifically, however safeguarding training links to protection of privacy and dignity

During 2019 there have been no reported EMSA breaches. The Trust is, therefore, in a position to declare EMSA compliance as follows.

"Every service user has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The South West Yorkshire Partnership NHS Foundation Trust is committed to providing every service user with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

"We confirm that mixed sex accommodation has been eliminated in our organisation. Service Users that are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed. Sharing of sleeping accommodation with the opposite sex will never occur. Occupancy by a service user within a single bedroom that is adjacent or near to bedrooms occupied by members of the opposite sex will only occur based on clinical need. If this occurs the service user will be moved to a bedroom block occupied by members of the same sex as soon as possible. On all mixed gender wards there are women only lounges or rooms which can be designated as such."

3. Other bed management incidents

During the year there have been 43 other bed management issues not linked to single sex accommodation but incidents that may have an impact on the quality of care. The table below breaks these down by BDU and sub category. Pressure on bed availability was an issue within quarters 1 and 2 when three patients slept on mattresses in interview rooms. One male had to sleep overnight in a lounge and a number had to sleep in inappropriate wards e.g. older peoples ward or PICU. Some patients were unable to be admitted from acute trusts. In quarter 3 there has been one incident of a patient being admitted directly to PICU. During quarter 4 there were 5 bed management issues reported. One incident was linked to transport for a person returning to the Trust in his area of residence which was outside the Trust geography, two people were admitted with no bed available; one had to sleep on a sofa and the other had a bed by night time. The remaining two incidents were individual being nursed in PICU for longer than required as no bed was available in local area.

3.1 Other bed management incidents by BDU and sub category

	Acute patient admitted into PICU bed	Admitted to ward - no bed available	Bed Management - Other	High risk leave bed used for admission	Lack of / delayed availability of beds (high dependency / intensive care)	Person detainable (MHA) - No bed available, not able to admit	Return From Leave - No Bed	Total
Barnsley Mental Health	0	0	7	0	0	0	0	7
Calderdale	0	3	1	0	0	0	0	4
Kirklees	0	2	2	0	0	0	0	4
Wakefield	16	4	1	0	0	1	0	22
Forensic Service	0	0	0	0	0	0	0	0
Specialist Services	0	0	0	0	0	0	0	0
Total	16	9	11	0	0	1	0	37

Under 18 admissions

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Barnsley Mental Health	0	0	0	0	1	0	0	0	0	0	0	0	1
Barnsley General Community Services	0	0	0	0	1	0	0	0	0	0	0	0	1
Calderdale	0	0	1	0	0	0	0	1	0	0	0	1	3
Kirklees	0	1	0	0	2	0	0	0	0	0	0	0	3
Wakefield	0	1	0	0	0	0	0	0	0	1	1	0	3
Specialist Services	0	0	0	1	0	0	0	0	0	0	0	0	1
Total	0	2	1	1	4	0	0	1	0	1	1	1	12

This year to date there has been 12 incidents reported in relation to under 18 admissions. These incidents related to 10 individuals.

4. National and local feedback

4.1 Delivering same-sex accommodation revised guidance

NHS England and NHS Improvement have produced some revised guidance on the current same-sex accommodation policy. The guidance will require some changes in reporting from January 2020.

4.2 CQC activity

When CQC undertook core service inspection visits and our well led review between May and June 2019, they said the acute wards for working age adults and PICU's should continue to monitor CAMHS admissions on to the wards; and make sure staff have the skills and experience to be able to care for under 18 year olds. There were no other CQC comments regarding any EMSA issues.

CQC undertook a Mental Health Act visit to Beechdale on 6 September 2019. They found that the room designated as a female-only lounge was in fact an activity room used by all service users and was kept locked. The room designated as an activity/therapeutic room was being used as storage. There was a male toilet located on the 'admission pod.' This pod could be designated as either male or female and at the time of the CQC MHA visit was designated for females. However, male service users continued to access this male toilet during the day.

Following the CQC visit a number of actions have been taken to mitigate any risks. The female lounge area is now kept unlocked and an alternative activity area is being used. Interchangeable signage has also been introduced to ensure that the 'admission pod' will remain only one gender at any given time.

4.3 Estates updates

From the OPS Transformation Project, work is still ongoing and all estates option will consider EMSA requirements.

The Chantry Unit has now closed and has been re-located to a new build named Crofton ward which is EMSA compliant.

National association of psychiatric intensive care and low secure units

Design guidance was published in 2017. In 2018 an assessment of all of the Trust's PICU units against this guidance was completed. Assessments were undertaken by a member of the Estates and Facilities Team alongside a senior clinical lead from the unit, a Ward Manager, General Manager or Practice Governance Coach. All of this work has now been completed.

5. Compliance monitoring

The Clinical Governance and Clinical Safety Committee receive assurance through the Director of Nursing and Quality about the Trust's compliance with eliminating mixed sex accommodation. Any potential areas of risk are considered at clinical governance group meetings. During 2018, the clinical governance group has monitored all reported instances where service users have had to sleep in a single room on a corridor or pod designated for the opposite sex. From January to December 2017, there were 9 such instances reported on Datix compared with 11 for the same time period in 2018. The 2018 EMSA Best Practice Guidance Audit indicates that the Trust continues to perform well against best practice standards. The clinical governance group will

implement action against any areas where improvements can be made. Provision of high quality facilities that meet the privacy and dignity of service users is a prime consideration when any changes to the Trust estate are made. The trust increased the numbers of single sex wards during 2018. Going forward, transformation projects will work with commissioners to look for opportunities to create new, and improve current single sex environments.

6. Actions planned for calendar year 2020

- The NHS England and NHS Improvement 'Delivering same-sex accommodation revised guidance' will come into place from January 2020. Trust staff will change the way they report incidents as a result of the new guidance. This is detailed in the updated and approved policy and will enable clearer national and local reporting.
- Continue to monitor incidents and take action as required.
- To take quarterly reports to the Clinical Governance Group.
- MSA is considered in quality monitoring visits.
- Estates and planning are considered as part of estates planning.

Appendix A

Best practice standard Questions

Standards
Service users are accommodated in single rooms, single sex bed bays, separate corridors, pods or ensuite single rooms
Is a lounge available for sole use of female service users (new question for 2017)
Bedroom doors are fitted with observation peephole or panel window and these can be operated by members of staff
Consultations take place in a private room
Toilets and bathroom doors are lockable from the inside and fitted with fail safe entry mechanisms which can only be opened by staff
Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department
Bedroom doors are lockable from the inside with fail safe entry mechanisms to ensure service user safety
Bedroom doors are fitted with an observation peephole or panel window which can only be operated by members of staff
Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department.
Male and female toilets and washing facilities are clearly labelled male and female
Clear information is provided for service users, relatives and carers on the arrangements made and the standards they should expect to ensure their privacy and dignity is maintained
Staff carrying out physical examinations are the same gender as the service user or if not are accompanied by a chaperone of that gender
Staff using planned restraint are the same gender as the service user or if not are accompanied by a chaperone of that gender
Toilets have nurse call systems to ensure safety
Where toilets do not have nurse-call systems the service user is risk assessed
Service users are asked if they have a preference regarding same sex key worker
Bedroom doors have observation mechanisms to ensure service user safety
Male and Female toilets and washing facilities are clearly labelled male or female
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex this incident is reported in accordance with the Trusts reporting procedure (through Datix)
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex appropriate safeguarding measures such as enhanced observation are applied

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 31 March 2020
Confidential agenda item 9.2

Title:	**Data Security & Protection Toolkit**
Paper prepared by:	Director of Finance & Resources
Purpose:	To provide approve the submission of the Data Security and Protection Toolkit (DSPT)
Mission / values / objectives:	All Trust objectives.
Any background papers / previously considered by:	• An annual report to the Trust Board • Internal audit will be reviewed at the April Audit committee
Executive summary:	• The Data Security and Protection Toolkit (DSPT) was launched in April 2018, replacing the Information Governance Toolkit (IGT). • The DSPT requires organisations to achieve a status of 'standards met'. • The data security standards are clustered under three leadership obligations, to enable peer support and cascade lessons learned. These are 1) People: Ensure staff are equipped to handle data respectfully and safely, according to the Caldicott Principles 2) Process: Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses 3) Technology: Ensure technology is secure and up to date. • Evidence for the submission has been collated by the Information Governance Manager and reviewed by Associate Director of Corporate Governance and the Senior Information Responsible Officer (SIRO). • For the purpose of the current DSPT assessment, the data security standards are broken down into 40 assertions, which are further divided into 116 mandatory evidence items. • The draft submission and evidence has been reviewed by internal audit. Significant assurance has been provided. • Of the five recommendations raised by internal audit, four have implementation dates after 31 March 2020. Internal Audit has confirmed that the associated evidence items can be marked as complete as the recommendations relate to evidentiary gaps rather than what is happening in practice. • The final recommendation relates to training needs analysis for staff in key data security and protection roles. The recommendation is low risk as internal audit acknowledged that these staff complete appropriate training in practice but it needs to be formally defined. It will be completed prior to the submission of

	the DSPT and is being reviewed by the SIRO on 30 March 2020. • In light of the Covid-19 pandemic trusts have been given the option of deferring the submission to 30 September 2020. Given the fact the work is complete the Trust plans to submit in line with original timescales. • The evidence to date is such that the Trust can submit a return that meets the standards.
Recommendation:	**It is recommended that the Board NOTES the work undertaken in completing the DSPT self-assessment and that which is ongoing to ensure all mandatory standards are met for submission.** **It is recommended that the Trust submits a DSPT that is compliant with the standards.**
Private session:	Not applicable

Data Security & Protection Toolkit 2019/20

1. Introduction

The Data Security and Protection Toolkit (DSPT) was launched in April 2018, replacing the Information Governance Toolkit (IGT).

The DSPT allows organisations to self-assess their performance against the ten data security standards recommended by Dame Fiona Caldicott, the National Data Guardian, as part of her review of Data Security in July 2017. In order to ensure this self-assessment is considered and evidenced the final assessment submission is subject to review by internal audit. Internal audit were invited to an interim advisory visit, 3 months prior to the final review, to assist the Trust with action planning to achieve full compliance as well as ensuring the self-assessment is but on robust and evidenced grounds

The standards are clustered under three leadership obligations to enable peer support and cascade lessons learned:

- Leadership obligation 1: People
  Ensure staff are equipped to handle data respectfully and safely, according to the Caldicott Principles.

  Data Security Standard 1: Confidential, person-identifiable data
  All staff ensure personal, confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

  Data Security Standard 2: Staff responsibilities
  All staff understand their responsibilities under the National Data Guardian's Data Security Standards including their obligation to handle data responsibly and their personal accountability for deliberate or avoidable breaches.

  Data Security Standard 3: Training
  All staff complete appropriate annual data security and protection training and pass a mandatory test.

- Leadership obligation 2: Process
  Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses.

  Data Security Standard 4: Data access management
  Personal, confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal, confidential data on IT systems can be attributed to individuals.

  Data Security Standard 5: Process reviews

Processes are reviewed at least annually to identify and improve processes that have caused breaches or near misses, or, which have forced staff to use workarounds that compromise data security.

Data Security Standard 6: Incident responses
Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or near miss, with a report made to senior management within 12 hours of detection.

Data Security Standard 7: Continuity planning
A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum with a report to senior management.

- Leadership obligation 3: Technology
  Ensure technology is secure and up to date.

  Data Security Standard 8: Unsupported systems
  No unsupported operating systems, software or internet browsers are used within the IT estate.

  Data Security Standard 9: IT security
  A strategy is in place for protecting IT systems from cyber threats, which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.

  Data Security Standard 10: Accountable suppliers
  IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

For the purpose of the current DSPT assessment, the data security standards are broken down into 40 assertions, which are further divided into 116 mandatory evidence items. In 2018/19 there were only 100 mandatory evidence items: new items have been added largely in support of the incident responses and IT security standards.

Internal audit made an interim, advisory visit to review evidence for 29 assertions in December 2019 and conducted the final review in February 2020.

A baseline submission was made in October 2019 to assess the current position. In response to the Covid-19 outbreak NHS Digital has made the decision to extend the deadline for the final submission to 30 September 2020. However given the large volume of work that has been completed on this process already, the Trusts expects to make its final submission by 31 March 2020 as originally planned and required.

It should be noted that, whilst it has been approved for use by NHS Digital, the DSPT has been a beta release since its release and is subject to ongoing review and development.

2. Internal audit reviews

The interim visit summary report was issued on 4 December 2019. 29 evidence items were reviewed and the position was as follows:

- 6 verified
- 14 required further evidence
- 9 to be revisited at the final review

The draft final report was issued on 6 March 2020, and the summary findings are as follows:

Audit opinion: **significant assurance**

Governance: the Trust has effective arrangements in place including appropriately qualified and experienced officers in key roles and an established committee, the Improving Clinical Information Group (ICIG), with a clear remit, membership and lines of reporting.

To confirm, the key roles include:

- Director of Finance & Resources/ Senior Information Risk Owner (SIRO)
- Director of Nursing & Quality/ Caldicott Guardian
- Deputy Head of IT & Systems Development/ Cyber Security Lead
- Information Governance Manager/ Data Protection Officer
- Information Security Manager provided under contract by Daisy IT

In addition, the ICIG lines of reporting include updates to the Clinical Governance & Safety Committee and, by exception, to the Audit Committee, plus issues identified for escalation to EMT via a briefing paper.

Validity of the DSPT assessment: the evidence provided was sufficient and appropriate to support the responses to the assertions and the Trust's proposal that a status of 'all standards met' will be achieved was supported, based on the evidence reviewed. However, two medium-risk and three low-risk recommendations were raised.

Wider risk exposures: none were identified.

3. Action Plan

Of the five recommendations raised by internal audit, four have implementation dates after 31 March 2020. Prior to NHS Digital's confirmation that the deadline for the final assessment submission had been extended, internal audit confirmed that the associated evidence items could be marked as complete as the recommendations relate to evidentiary gaps rather than what is happening in practice.

One recommendation must be completed before the final submission, and this relates to training needs analysis for staff in key data security and protection roles. Previously, training needs for specialist staff were included in the relevant policy and were heavily reliant on e-learning packages provided by NHS Digital as part of the former IG Toolkit. However, when the IG Toolkit was decommissioned, only the mandatory information governance training was re-issued via e-learning. Other training has since been delivered by alternative methods and is largely incorporated into local induction plans, e.g. for health records staff. The audit

recommendation is low risk as internal audit acknowledged that these staff complete appropriate training in practice but it needs to be formally defined. Once approval from the SIRO has been received the assertion will be marked as complete.

It is worth noting that 98% of staff have completed their annual mandatory information governance training as at 13 March 2020.

Aside from the evidence items in scope of the audit, all other evidence items are complete, with the exception of those relating to the Trust's annual penetration test. The testing commenced on 16 March 2020 but was unable to be completed due to the need of the tester to self-isolate. Work is scheduled to resume on 1 April 2020, however, the previous test was completed on 29 March 2019 so the Trust currently meets the standard.

4. Conclusion and Recommendation

The Trust has made significant progress in its completion of the DSPT and will have evidence of full compliance with all mandatory standards by the end of March 2020. The final review of evidence including the updated actions is being conducted by the SIRO on Monday 30th March.

It is recommended that the Trust submits the final assessment of the DSPT.

It is recommended that the Board notes the work undertaken to date and that which is ongoing to ensure all mandatory standards are met.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020

Confidential agenda item 9.3 – Assurance from Nominations Committee

Nominations Committee

Date	6 March 2020
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Process for reappointment of Non-Executive Director (KQ) ➢ Process for appointment of Lead Governor and Deputy Lead Governor ➢ Non-Executive Director Recruitment
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 9 January 2020 to follow.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020

Confidential agenda item 10 – Assurance from Trust Board committees

Clinical Governance & Clinical Safety Committee

Date	11 February 2020
Presented by	Charlotte Dyson, Deputy Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Transformation - Care closer to home ➢ CQC improvement plan ➢ Waiting lists, link with FIP (Chris Jones) ➢ CAMHS ➢ Nurse Revalidation ➢ Clinical Supervision update o Complaints audit
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 5 November 2019 attached.

Equality & Inclusion Committee

Date	3 March 2020
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ RACE Forward focus ➢ Equality Impact Assessment - strong focus ➢ Development of Performance Dashboard ➢ Staff networks – audit done – disability access / rainbow badges, reciprocal mentoring ➢ Strategy development
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 10 December 2019 attached. Minutes of the Committee meeting held on 3 March 2020 to follow.

Finance, Investment & Performance Committee

Date	27 February 2020 and 24 March 2020
Presented by	Chris Jones, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	➢ Good performance in month and against our plan ➢ Overall assessment of the risk of the Trust not achieving the control total is significantly low ➢ Further recurrent CIPs need to be identified to support financial sustainability ➢ FIP will consider in depth LD indicators and then CAMHS at future committee meetings ➢ FIP will loo at the content of IPR and risk assess data quality as it is developed ➢ MH Benchmarking report to return to FIP. MB/RW to agree where this goes for action in terms of OMG/EMT
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 23 January 2020 and 27 February 2020 (to follow)

Mental Health Act Committee

Date	10 March 2020
Presented by	Kate Quail, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	➢ Code of Practice Group progress ➢ Great QI work ➢ Improved Ethnicity reporting ➢ Improved CQC Action Plan frequency of actions ➢ Pilot on uncontested Hospital Managers renewals and extension hearings ➢ IHI work driven through improved QI
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 12 November 2019 (to follow).

West Yorkshire Mental Health Services Collaborative Committees in Common

Date	21 January 2020
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Verbal update.
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 21 January 2020 attached.

Workforce & Remuneration Committee

Date	11 February 2020
Presented by	Sam Young, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	➢ Focus on Forensics – The Committee welcomed Sue Threadgold to the meeting and heard the actions that had been taken to make the Forensic Service a great place to work. ➢ Equality Pay Audits – The Committee received Equality Pay Audits covering gender, ethnicity and disability and will be reviewing the action plan at the next meeting. ➢ Prototype Integrated Performance Report – The Committee received a prototype Workforce Performance Report to consider how we report into future Committee meetings. ➢ Risk Register – The Committee agreed a collective workforce risk which the Executive Management Team will include on the next update of the Risk Register.
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 7 November 2019 attached.

Note, assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 5 November 2019
Meeting room 1, Block 7, Fieldhead, Wakefield

Present:	Angela Monaghan (AM)	Chair of the Trust
	Charlotte Dyson (CD)	Deputy Chair (Chair of the Committee)
	Tim Breedon (TB)	Director of Nursing and Quality (Lead Director)
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Kate Quail (KQ)	Non- Executive Director
	Dr Subha Thiyagesh (SThi)	Medical Director
Apologies:	Sue Barton (SB)	Deputy Director of Strategy & Change
In attendance:	Carol Harris (CH)	Director of Operations
	Mike Doyle (MD)	Deputy Director of Nursing & Quality
	Sarah Harrison (SH)	PA to Director of Nursing and Quality (author)
	Dave Ramsay (DR)	Deputy Director of Operations (item 14)
	Yvonne French (YF)	Assistant Director Legal Services

CG/19/126 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. Apologies were noted as above. The Committee noted the people attending to cover items on the agenda, as shown above.

CG/19/127 Declaration of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2019 or subsequently.

CG/19/128 Minutes of previous meeting held on 10 September 2019 (agenda item 3)

Minutes of the previous meeting were agreed.

It was RESOLVED to APPROVE the minutes of the meeting held on 10 September 2019.

CG/19/129 Matters Arising (agenda item 4)

The Committee reviewed the actions from the meeting held on 10 September 2019 and the action log was updated as appropriate.

- CG/19/94 The Committee discussed the clinical audit action plan. It was noted that the clinical audit report is now included in the clinical risk report which is discussed in OMG and EMT.
- CG/19/95 RISK ID 1151- AD confirmed that the risk will be considered in the WRC meeting.
- CG/19/99 – CQC Inpatient and Community Surveys. MD noted that Quality Improvement & Assurance Team (QIAT) are considering an alternative approach. We are establishing whether the CQC community survey is mandated participation as we have to report on it in the quality account. The inpatient survey is voluntary and options are being explored.
- CG/19/99 –CQC Inpatient and Community Surveys – Volunteers. AM queried the governance of our volunteers within services and CH also enquired on the route for volunteer assurance. The committee agreed that there is a potential gap to be explored. CH to discuss with Salma Yasmeen.

Action: Carol Harris

CG/19/130 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)

The ORR was last reported to the Trust Board on 29 October 2019 and there were no new risks aligned to the Clinical Governance & Clinical Safety Committee.

There are no 15+ risks reported to the Trust Board and aligned to the Clinical Governance and Clinical Safety Committee. The risks below 15 aligned to the Clinical Governance and Clinical Safety Committee were reviewed and discussed, with a particular focus on the following.

RISK ID 905 – Safer Staffing
RISK ID 1424 - Serious Incidents
RISK ID 1368 – CAMHS

The Committee noted that they adequately reflected the findings within the CQC report and had been accepted by Trust Board

It was RESOLVED to NOTE that the items on the ORR relevant to the CGCS have been considered and the Committee satisfied themselves that they are assured that the current risk level, although above risk appetite given the current environment is appropriate.

CG/19/131 Quality Accounts (agenda item 6)

Tim Breedon (TB) informed the Committee that we are on target to deliver the accounts as per the agreed timetable. TB also noted that a key meeting with the Members Council Quality Group will be taking place on the 14 November to identify the local indicators. TB highlighted the importance of ensuring that any local indicator is measurable and noted the

close liaison with Deloitte. Consideration of quality priorities will commence December 2019.

It was RESOLVED to NOTE the positive progress on the production of the Quality Account.

CG/19/132 Planned / Unannounced Visits Annual Report (agenda item 7)

TB reminded the Committee that the primary purpose of the 2018/2019 visits was to undertake a review of services that were given "must do" or "should do" actions from the previous CQC visit in March 2018. The visits were also undertaken to teams in anticipation of future visits by the CQC. The visits summary showed a mixed picture with many improvements demonstrated but some issues outstanding as shown in the report. Clearly the outstanding issues were subject to significant action to ensure completion within the agreed timescale. It is important to consider the report in the context of the recent CQC inspection and align our understanding with that of the regulator and although further work is required, our positions generally align.

TB then signaled a change in the approach for this years visits as they will now be planned and announced. The quality monitoring visit pilot programme for 2019/2020 will be carried out during November and December 2019. It is proposed this year's quality monitoring visit programme will be more closely aligned to quality improvement whilst still providing assurance. The increase in emphasis on quality improvement is aimed at making sure improvements are not only evident but also sustained over time.

The quality monitoring visits will be taking place across a variety of our inpatient and community services and we have taken learning from the Stoke Rehab services which achieved outstanding from the CQC.

13 visits have been planned using quality improvement methodology which will provide assurance and sustainability using quality scheme standards.

Kate Quail (KQ) raised a query regarding last years quality monitoring visit (QMV) as to how we capture some of the issues which arose out of the report. MD informed that the extra ordinary interim report related to these issues.

Charlotte Dyson (CD) raised the question of leadership and quality impact which requires the whole team to be engaged in the process including middle managers and wanted assurance that this is being embedded. TB advised that this is addressed under the well led domain and MD confirmed that this is featured in the visits.

AM noted the focus of the new approach and questioned the need to consider other issues that are raised eg PLACE or confidential information. TB confirmed that the key lines of enquiry will include consideration of immediate concerns and this will be built into the visits.

AM queried the invites for governors and NEDs to take part in the visits. There is a query raised regarding the confusion of the different roles. AM feels NEDS are being not included as the dates to attend have not been received. TB confirmed that NEDs are welcome on the visits and agreed to look at the dates and times and circulate to NEDs

Action: Mike Doyle

AM queried if all visits happened last year as some were cancelled and rearranged and MD noted all visits did take place.

The Committee RECEIVED the quality monitoring visit report and to NOTED progress of the process.

CG/19/133 Transformation & Priority Programmes Update (agenda item 8)

TB gave a brief overview to the Committee and noted the good work and significant progress on the priority programmes of change. Following agreement at EMT timeout, work is taking place on the revision of priorities, commencing with a resource planning exercise scheduled to be presented to EMT on 7th November. A presentation was shared with Trust Board and Extended EMT on the 5 year plan and information on what this means for the Trust and how the priority programmes are contributing to the longer time plan..

The Committee agreed that they would like to see the CRS Optimisation progress summary included in the February meeting report this should include SystmOne optimisaton summary and Care Closer to home.

Action: Sharon Carter

The Committee also requested and update on the priority programmes be brought back after discussion at EMT regarding (IPR)

Action: Sharon Carter

The Committee RECEIVED the quarterly update report on progress of priority programmes.

CG/19/134 Care Quality Commission Action Plan (agenda item 9)

9.1 Care Quality Commission Improvement Plan

MD highlighted the position to the Committee and noted that there has been a collaboratively developed improvement plan to address all concerns raised. For the MUST DO actions there are common themes that impact on our overall rating for the safety domain. There will be more focus on using quality improvement methods to address these concerns. The remainder of the plan, i.e. SHOULD DO actions are being addressed via both quality improvement methods and by taking specific action/s to complete the task. MD informed this report is familiar but more of a QI approach is included.

In line with the vision we set out in our Quality Strategy we will use the Model for Improvement to address themes identified in the CQC inspection report (2019) which not only impacts on our requires improvement rating for safety but address issues included in serious incident reports, fitness to practice cases and CQC MHA inspections.
These areas are:

- Risk assessment,
- Care planning,
- Record keeping
- Safe medicines.
- Reducing violence against staff
- Always Events: Dignity and respect

It was noted that the required improvement on caring has hit staff hard and the process for dealing with this is outlined within the report. Closer monitoring and hot spotting has already commenced through OMG.

CD raised an overall question on how do we continue to get the assurance and that it is actually taking place and being embedded. TB highlighted that the planned milestone reporting could help regarding and acknowledge that the transition from traditional action planning to QI style will present a reporting challenge initially. MD noted a progress report against the improvement plans will be coming back along with RAG ratings to a future CGCS meeting.

AM queried as to whether we have the right people in the right places with the QI training to ensure we get the right level of improvement. MD informed the Committee that we have different levels of people trained at different levels of intensity and appropriate people will be linked to relevant improvement activities.

Action Tim Breedon

Committee noted that the language of the title "Action Plan" didn't seem quite appropriate and requested "Improvement Plan" as the context could be confusing.

The Committee agreed that they supported the revised approach and noted the revised reporting arrangement.

The Committee RECEIVED and COMMENTED on the CQC improvement plan, NOTED the areas of risk, and supported the revised approach.

9.2 Mental Health Act Visits

Nothing to receive, Mental Health Act Committee meeting is taking place next week.

CG/19/135 Trust achievements (agenda item 10)

The Committee noted the significant number of Trust achievements across all areas of the organisation and also the importance of sharing our achievements externally. Committee discussed thanking staff by sending letters / cards as a result of the Trust achievements.

The Committee RECEIVED and NOTED the update.

CG/19/136 *Patient Experience Update* (agenda item 11)

Paper not required as now included in the IPR and annual report as received in September 2019

CG/19/137 Issues arising from Performance report (agenda item 12)

TB informed that there were no issues to highlight from the Performance report following Board discussion. CD raised a query regarding clinical supervision and whether CGCS needs further assurance. TB informed that more information would be available in the next IPR. AM noted it was an areas or concern. Alan Davis (AD) confirmed the mandatory training report will be reported into the next WFRC.

CG/19/138 Update on topical, legal and regulatory risks (agenda item 13)

TB briefed the Committee on the following:-

NHS Providers Briefing – TB highlighted the following to the Committee:-

- Health Service Safety Investigations Bill – Potential impact on the organisation
- Adult social care reforms
- CQC state of health & social care – interesting to note that the report aligns well with our view of the system.
-

CG/19/139 Child and adolescent mental health services - update (agenda item 14)

CAMHS

Forensics

Dave Ramsay (DR) gave an overview of the report to the Committee. DR confirmed that the report is now joint report which includes Wetherby YOI and Adel Beck CAMHS.
Dr informed the Committee that he had received positive feedback from the Commissioners regarding Claire Strachan and her new role which is a positive move towards change.

DR informed the Committee that harmful sexual behaviour (HSB) will still be managed through Forensic because of specialist nature of intervention.

DR noted that increasing the two CAMHS services will see benefits from joint working. AM queried whether we saw the benefits of this joint working before this occurred. DR informed that we could see the benefits however it was something that NHSE requested. SThi noted some of the benefits have been opportunistic but noted no issues before this had been requested by NHSE and that Claire Strachan is helping manage this. CH noted that this is also an additional post. CH notes that this also aligned with other children services.

Service model. The formal agreement of the leadership and clinical (specifically medical) model remains outstanding**.** Robust arrangements are now in place and it is expected a related paper be submitted to NHSE by 14 November 2019 for approval.

Performance report. A framework has been agreed for routine activity reporting with the intention of establishing more explicit targets/KPI's. DR noted the complexity around performance monitoring and the difficulties.

The Committee questioned if we had a timescale of when they could feel more confident. CH noted that we are working closely with NHSE to achieve lifting the performance notice. CH informed the Committee that there will be a meeting held on the 22 November with NHSE to discuss medical leadership notice. There is a model in place to present to NHSE and then a better steer will be known.

AM asked DR regarding the 207 KPI's for integrated care plans and queried the figures. DR to add in the next report and add narrative.

Action: Dave Ramsay

Barnsley

DR informed the Committee that Barnsley are over their financial envelope and going forward will have significant performance elements. TB informed the Committee that the decision tree re CAMHS is to be discussed in EMT 7 November.

Waiting lists initiatives

There has been a significant improvement in waiting times in Barnsley and Wakefield which is as a result of the service improvement work that has taken place

Transition
Difficulties at transition continue to be centred on the often fundamental difference in the nature of the child-adult service offers and access criteria. This can particularly impact on more complex cases e.g. eating disorders and ADHD/ASD. It is of note in this regard that the Barnsley procurement references the development of a 0-25 service reach and a similar strategic approach is being discussed within Wakefield.

Barnsley 0-25
AM raised the query as to whether we should be looking ages 16-25 and not 17 ½ and queried when the last transfer of care policy was reviewed. AM noted the transition feels out dated and feels a review is needed against current guidance. Trust wide transition meeting is being looked at with SThi, TB, Marios Adamou and DR. AM would also like to be invited to the meeting.

Action: Dr S Thiyagesh

AM highlighted to the Committee that a recent service user storey on ASC and ADHD at Trust Board was very successful.

The Committee RECEIVED and commented on the updated report and NOTED the next steps identified.

CG/19/140 Quality Impact Assessment review (agenda item 15)

TB gave a brief overview to the Committee noting that there was nothing new to highlight.
AM queried the next steps needed for new services. TB advised that new services are picked up through the contractual change process and then highlighted via OMG for QIA review.

It was RESOLVED to RECEIVE and NOTE the update.

CG/19/141 Serious Incidents Quarterly Report Q2 19/20 (agenda item 16)

MD updated the Committee on the Q2 serious incent report. Detailed Quarterly reports have been produced and shared with each BDU. All managers have access to Datix dashboards to interrogate data further.

- Q2 had 3487 incidents; slightly lower than the previous quarter (3511).
- 86% of incidents are graded as “low” or “no harm” showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs). AM queried whether 86% does indicate a positive reporting culture as national reporting shows 98% of low or no harm incidents as the average. TB noted the need to review against benchmarking figures.

Action: Mike Doyle

- “Physical aggression/threat (no physical contact): by patient” 345 incidents (10%) remains as the most reported category.
- “Violence and Aggression” continues to be the highest reported incident type (29% (1015) of all incidents reported in the quarter, consistent with the previous quarter). Staff

have reported that this can be linked to individual service users but also say some incidents are linked to the trust's current smoking policy.
- 10 serious incident investigations have been submitted to the Commissioner during the quarter and 17 previous serious incidents have been closed by Commissioners.

Learning from healthcare deaths

- There was a requirement for Trusts to report and publish data from Quarter 3 2017/18 onwards. When approved, our reports are made available on our website.
- Our report provides figures on deaths and the number that have been reviewed.
- From April 2017 to September 2017 the Trust started reviewing all deaths reported on Datix using an incremental approach.
- The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
    - Death Certification
    - Case record review, including Structured Judgment Review. The managers 48 hour review on Datix is also classed as a first stage case record review.
    - Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding.

AM noted that the report headlines show an decrease in the moderate and severe incidents however the number reported into the IPR are showing an increase. TB explained that this may be due to the time lag on incident report close down and will review the Q2 report and IPR report alignment.

MD informed the Committee that location plays a part in higher numbers recorded and that Kirklees for example is a larger area so will be higher. This will be reported into the IPR next year.

AM noted that on page 212 of the report regarding IHBBT and queried if this relates to the issue regarding discharge letters (issues discussed in Members Council) MD informed that information has been discussed with a governor that is in hand.

The **Committee agreed the following:-**
The report remains of good quality and well structured.

- Robust systems are in place to report and investigate incidents.
- The further explanation of the increase in moderate / severe incidents and deaths shown in the IPR and the alignment with this report provided the Committee with additional assurance around potential increasing trend. This issue will be addressed in future quarterly reports.
- Further explanation of the difference between the number of incidents reported in the Q2 report and the data shown in the National Reporting Learning System (NRLS)
-

The Committee REVIEWED the quarterly report on incident management and COMMENTED on areas for further review for action.

CG/19/42 Safer Staffing Report (agenda item 17)

TB informed the Committee that this is a routine report which includes both safer staffing and workforce.

In future we will be reporting our fill rates for acute mental health wards against the new establishment staff numbers for acute mental health acute wards. Initial review reveals that overall capacity of actual v planned staffing remains above 100% when new establishment staff numbers used.

Shortfall of registered nurses has resulted in the use of existing HCA staff, bank and agency staff to cover. Clinical risks are considered to ensure safe and effective delivery of care.

The CQC acknowledged an overall increase in staffing levels but they identified pressures in working age adult acute wards

The concept of a more peripatetic workforce supported by an enhanced centralised bank staff management system is now established.

The inpatient workforce review has been completed for acute mental health wards. This has resulted in an uplift of establishment, to coincide with clearer career pathway for both our registered and non-registered workforce. The outcome of the review plans have been integrated into the annual workforce planning round.

TB provided a handout to the Committee regarding the safer staffing establishment review. MD highlighted an error regarding CHPPD on pg 7. (attached at appendix 1)

The introduction of the Care Hours Per Patient Day allows us to have an overview of where our staffing resources are needed but also closely monitor and support 'hot spots' to ensure that not only the safety but the quality of our care is maintained.

Recruitment and retention plans in progress with more initiatives planned for remainder of 2019/20.

New plans for Quarters 3 and 4 2019 include:

- Pilot implementation of staffing judgement tool within community teams
- Review the Medical Bank capability and assist in registering everyone on e-roster
- Liaise with a trust bank that has successfully implemented a medic bank/agency reduction
- Implement new acute mental health ward workforce model and establishment
- Review the staff bank procedure and hold various staff bank engagement events in each area to ensure that bank staffs are an integral part of our workforce.
- Continue expanding the bank to support other areas including AHPs and community teams
- Report staffing fill rates against new establishment by end of Quarter 3 2019.
- Support the introduction of the acuity staffing management tool, *SafeCare,* and develop pilot project plan
- Work with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners)
- Contribute to implementation of SWYPFT Recruitment & Retention Strategy
- Develop Service Line Arrangements with the local acute trusts to facilitate the reciprocated provision of specialist support
- Maintain link with NHSE&I on Return to Practice programme for nurses, financial support for the introduction of Nurse Associates and encouraging collaborative banking and agency intelligence particularly across ICSs

- Development modern career pathways in all professions

MD noted that there has been an appointment of a new Recruitment Manager who will be looking at marketing for the Trust and supporting the desired increase in registered and non-registered staff.

AM queried if the table shown on the presentation is reflective of actual assessed need. MD informed the Committee that 117% is an accurate reflection of what is required.

AD noted that there are issues around registers and that there are two types of register. Safe guard on ESR regarding registers.

AM raised a query regarding skill mix and how we will know the quality of skill mix is at the appropriate levels. TB informed the Committee that the criteria was used as described originally in the establishment review. TB advised that the Trust Board version of this paper will be enhanced to include a description of the establishment review and the professional judgement tool that was utilised.

Action: Tim Breedon

AM noted that repeat hot spots and trends in certain wards need to be reported. MD informed that this is done monthly with headlines reported into the IPR. Also escalation plans are in place as part of contingency planning. TB advised that additional detail regarding hot spots will be included in the Trust Board version of this report. AD acknowledged that safer staffing had moved from numbers to a more therapeutic system.

Action Tim Breedon

Committee agreed all the operational data was not needed however felt assured that there was good oversight by managers and OMG. .

The Committee agreed-

- The report provides a comprehensive review of activity relating to the safer staffing agenda and acknowledged that the increased scope of the report is beneficial.
- The revised reporting arrangements following the MH acute ward establishment review were supported.
- Update required on discussion with NHSI regarding new reporting arrangements

The Committee RECEIVED and COMMENTED on the report (requested revisions to be included in the Board report).

CG/19/43 Internal Audit – Complaints Audit (agenda item 18)

TB informed the Committee that all outstanding items had been signed off from the audit report and agreed with the auditors. Internal audit coming back in January 2020. Update to come back for 11 February 2020 meeting.

Action: Sarah Harrison

CG/19/44 CQC Registration Self Assessment (agenda item 19)

This item is no longer required and the work plan has been amended in accordance.

CG/19/45 Ligature Report (agenda item 20)

MD gave a brief overview to the Committee.
The Ligature Review Group (LRG) developed a new shared action plan log where BDU and Estates staff can input progress. A new electronic system for conducting environmental suicide and ligature risk assessments has also been developed by the clinical audit team.

En suite bedroom doors highlighted as a high risk in Barnsley acute mental health wards and on the forensic unit. Therefore, a multidisciplinary appraisal of options to mitigate the risk of high risk en suite bedroom doors was collaboratively completed. The preferred option based on safety was installation of shower curtains to replace ensuite doors.

Review of the scoring across the wards revealed some discrepancies between wards. Consistency and reliability of scores across wards remains a challenge, although due to close monitoring of LRG this has not resulted in unmitigated risks.

Headlines from preliminary analyses of these incidents are:

- 1101 incidents and 1069 where location on ward identified
- 830 incidents (78%) in bedroom/ensuite
- 934 incidents (87%) in bedroom/ensuite or bathroom
- The next most frequent location is the seclusion room with 41 incidents (3.8%)
- No incidents reported in outpatient clinics
- Female acute MH wards Nostell (370 incidents), Elmdale (170) and Clark (100) biggest risk areas
- Mixed ward 18 (172 incidents) and PICUs (Melton 100 and Walton 84) higher risk
- Very few on rehab wards and wards for older people with a range of 1 to 2

Funding has been allocated for ligature remedial work in 2019/20. Timescales on plans for replacing. Where no obvious solutions ongoing clinical, procedural and relational preventative measures in place in the interim.

The current round of environmental suicide and ligature risk assessments are due for completion by 30th November 2019.

Next steps

- Deliver training at the Ward Managers Forum on the 5th September 2019.
- Restructure our ligature review group and reform to create a Clinical Environment Safety Group (CESG), with new terms of reference (see Appendix 2).
- Review entrance and environments in order to ensure we have a consistent approach to access and egress and on our wards.
- Strengthen environmental awareness for workforce on inpatients wards
- BDU environmental suicide and ligature risk assessment leads to ensure their managers continue to monitor action plans and outstanding work throughout the year, escalate concerns and risks as required and mitigate in the interim.
- Repeat annual environmental suicide and ligature risk assessment tool in outpatient areas by 30th November 2019.
- Review IPC implications of new curtains in ensuite rooms.
- Develop proposals and business case for replacing all bedroom doors with latest anti-ligature option using a risk based approach

- Continue to monitor progress in achieving the remedial actions through CESG and consider wider environmental risks.
- Collaborate with partners and suppliers to seek solutions to high level risks where none currently exist.

The Committee noted that the report had been received by EMT felt assured of the progress made.

The Committee RECEIVED and NOTED the report.

CG/19/146 Whistleblowing & Freedom to Speak Up Guardians Position Update (agenda item 21)

AD made note of the title of the paper and asked that this be discussed with TB.

AD informed the Committee that there are two element to be considered the Freedom to Speak up element and the type of work they are undertaking.

AD noted that Estelle Myers who is doing a day per week has been of great value and has been used for promotion work within the clinical teams and BDU's and the benefits the case work with role she has. Ad noted that there are still a few cases coming to light around bullying and harassment and the action plan is going to be reviewed and the network is being embedded in the action plan.

AD acknowledge the need to move forward with more promotion and less case work.

CD queried a couple of items relating to the action plan and how will we know what has been successful. AD noted we are starting from a good place so are aware what has been successful and AD noted that staff are seeing a social change.

AD noted the action plan needs to be reviewed and go back to EMT

Action: Alan Davis

The Committee NOTED the report from the Freedom To Speak Up Guardians and SUPPORTED the 2019/2020 Action Plan.

CG/19/147 Patient Led Assessment of the care Environment PLACE (agenda item 22)

This year the whole PLACE process has been put back by NHS Improvement and the PLACE surveys are being undertaken at the moment and will complete in November. The release date for the PLACE information is decided centrally and at present we have no indication of that date.

The change in dates has been to alter some of the question sets and to reset score boundaries on the national returns. It has been made clear that due to these changes the scores for 2019 should not be compared to previous years.

The report received good feedback from Members Council regarding governors enrolments.

The Committee NOTED the update

CG/19/148 Sub-groups – exception reporting (agenda item 23)

Drug & Therapeutic (agenda item 23.1)
Report received and noted.

It was RESOLVED to NOTE the report.

Safety & Resilience (agenda item 23.2)
Report received and noted.

It was RESOLVED to NOTE the report.

Infection Prevention and Control (agenda item 23.3)
The IPC event on the 15th October went well and positive.

It was RESOLVED to NOTE the report.

Safeguarding adults & children (agenda item 23.4)
Report received and noted..

It was RESOLVED to NOTE the report.

Reducing Restrictive Physical Interventions Group (agenda item 23.5)
An increase on assaults on staff were noted however robust processes are in place.

It was RESOLVED to NOTE the report.

Improving Clinical Information Governance Group (agenda item 23.6)
Met yesterday and agreed to provide a summary into CGCS in the Committee

Physical Health (agenda item 23.7)
Report received and noted.
It was RESOLVED to NOTE the report.

CG/19/149 Serious Incidents Update (agenda item 24)

TB noted that there was nothing new to highlight from the Trust Board update.

CG/19/150 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 25)

Issues were identified as:

- Priority Programme
- CQC action plan
- CAMHS
- Serious Incidents
- Safer Staffing
- Ligature report
- FTSUG

CG/19/151 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 26)

The Committee noted:-

Risk ID 905 Safer Staffing. Committee agreed the risk is right and aligned to the Committee

Risk ID 1424 Patient Safety Inpatient ligature. Committee agreed the risk is right and aligned to the Committee

No other issues highlighted.

CG/19/152 Work Programme (agenda item 27)

The Committee agreed the changes to the work plan and agreed to add the Smoking Policy to the Plan

CG/19/153 Date of next meeting (agenda item 28)

The next meeting will be held at 2pm – 5pm 11 February 2020 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of Equality & Inclusion Committee held on 10 December 2019 Meeting room 1, Block 7, Fieldhead, Wakefield

Present:	Angela Monaghan (AM)	Chair of the Trust (Chair of Committee)
	Tim Breedon (TB)	Director of Nursing and Quality (Lead Director)
	Erfana Mahmood (EM)	Non- Executive Director
	Chris Jones (CJ)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
Apologies:	Members	
	Others	
	Dr Subha Thiyagesh (SThi)	Medical Director
	Emma Jones (EJ)	Company Secretary
	Mohammad Navsarka (MN)	Activity Coordinator
	Elaine Shelton (ES)	Unison Branch Secretary
	Aboobaker Bhana (ABB)	Manager (Public Engagements Lead) Partnerships Team
	Claire Hartland (CH)	HR Business Manager
	Tim Mellard (TM)	Matron
	Sean Rayner (SR)	Director of Provider Development
	Christine Symonds (CS)	Senior Finance Manager
In attendance:	Sarah Harrison (SH)	PA to Director of Nursing and Quality (author)
	Zahida Mallard (ZM)	Equality & Engagement Manager
	Cherill Watterston (CW)	Specialist Physiotherapist
	Sue Threadgold (ST)	Deputy Director
	Chris Lennox(CL)	Deputy Director
	Andrew Allcock (AA)	Staff Nurse
	Sam Jarvis (SJ)	General Manager
	Dawn Pearson (DP)	Marketing, Communications, Engagement & Inclusion Lead

EIC/19/46 Welcome, introductions and apologies (agenda item 1)

The Chair Angela Monaghan (AM) welcomed everyone to the meeting and noted apologies. AM welcomed the new attendees to the meeting.

EIC/19/47 Declarations of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2019 or subsequently.

EIC/19/48 Minutes of previous meeting held on 10 September 2019 (agenda item 3)

Minutes of the previous meeting were agreed.

It was RESOLVED to APPROVE the minutes of the meeting held on 10 September 2019

EIC/19/49 Matters arising (agenda item 4)

Actions from the meeting held on 10 September 2019 were noted and the action log was updated as appropriate.

- EIC/19/34 Equality Delivery System 2. Tim Breedon (TB) discussed at the Quality Board. Chair Penny Woodhead noted, understanding more detail of the proposal and the impact on SWYPFT. TB also informed the Committee of the changing level of engagement at the clinical commissioning groups (CCGs).
- EIC/19/36 - Staff networks and welcome events. AM has agreed with Rob Webster (RW) to include information on staff equality networks in the monthly Welcome Event for new staff.
- EIC/19/38 – Responsibility for consultation with regard to changes in Barnsley community services. Salma Yasmeen responded and understands this sits with the CCG.
- EIC/19.06f Strategic session in March 2020 agreed so action complete. RW made a suggestion of a strategic session with Board.

EIC/19/50 Consideration of items from the organisational risk register relevant to the remit of the Equality & Inclusion Committee (agenda item 5)

AM explained, for the benefit of new members, that corporate risks are assigned to Board Committees for more scrutiny, however the Equality & Inclusion Committee (EIC) is still awaiting formal assignment of any risks.

RISK ID 1157. The Committee had discussed this risk previously and it has been reviewed. TB discussed with RW as to whether the right description was noted.

AM highlighted that the current control measures do not mention the black, Asian and minority ethnic (BAME) or working carers' staff equality networks. AD informed the Committee that more support would be needed and this can be reviewed in light of the information received today. RW informed that NHS Equality Delivery System (EDS2) focuses on staffing and not services and there remains a gap for the Trust. Chris Jones (CJ) noted the moderate rating for consequence and suggested that there needed to be more challenge and a possible re-writing of the description. RW also queried what the consequence score and what is driving the particular rating. Erfana Mahmood (EM) noted that that the Trust feels like it has more diverse services but a separate risk for workforce would maybe be more beneficial. Zahida Mallard (ZM) queried the need to measure our services to address some of those challenges noted and the need to upskill the workforce. Dawn Pearson (DP) highlighted that the Equality Impact Assessment (EIA) is a key tool to address the issues noted and is intelligence that needs to be used and drives our systems.

The Committee agreed rating needs to be reviewed.

AM and TB agreed to ask Trust Board to formally align the risk to EIC.

Action: AM/TB

It was RESOLVED to NOTE the comments raised in relation to risk 1157 and request that this risk is reviewed and reassigned to the EIC by the Board.

EIC/19/51 Equality Standards updates (WRES, WDES) (agenda item 6)

Alan Davis (AGD) gave a brief overview to the Committee.

The main purpose of the NHS workforce race equality standards (WRES) and workforce disability equality standards (WDES) is to help local and national NHS organisations to review their workforce data against the metrics. This review should then enable organisations to produce action plans to close any gaps and improve the experience between white and black, Asian and minority ethnic (BAME) staff, and disabled and non-disabled staff as valued members of the workforce.

As a starting point, problem areas are being looked at at a high level with a need to understand the different issues within cultures and drill down into this. Need to move to a more focused agenda.

AGD also noted that the workforce strategy needs to look at the WRES and WDES structure with regards to recruitment.

AGD informed that the RACE Forward initiative needs more organisational focus. This has been noted from the staff surveys. Sue Threadgold (ST) noted that this is not a forensic-led initiative, however forensics are ahead with this but support is needed to roll this out. Front line staff responded better to workshops rather than meeting-based learning. AD noted it is a difficult issue and that support for RACE Forward is needed. ST highlighted Datix has the ability to create a report for this information however this will need to be investigated. Cherill Watterston (CW) highlighted that staff have felt unable to report issues. ZM agreed and noted there is an issue on the wards with reporting by managers. Chris Lennox (CL) queried where this information is shared as there is a lack of communication to managers. It was noted that RACE forward needs to be positioned prominently within the Trust to set the right tone within the organisation. RW wanted to highlight to the Committee that individuals need support and that the RACE Forward is working and if the Trust has the intelligence, to ensure that this is being shared appropriately. The Committee agreed the need to look at the reporting mechanisms on protected characteristics. AGD to discuss at WRC.

Action: AGD

DP queried whether a preventable measures box on Datix could be a possibility to address the issues raised.

CJ queried what would move us toward a more representative workforce? The data on recruitment and disability is showing at 30% in regards to workforce and it was noted that this feels a low number. AGD informed that this is correct, there is a need to look at the current system to see what we can address. CJ agreed that this needs addressing and is an urgent issue. RW informed the Committee that he met with Sean Rayner and the University of Leeds regarding job carving and job crafting.

The Committee noted that the action plan is good and lots of focused work is being undertaken. The full plan is available for the Committee and AGD will circulate.

Action: AGD

AM highlighted that whilst the Board had members from the BAME community, there were currently no disabled members.

The Committee RECEIVED and COMMENTED on the Equality Standards Update.

EIC/19/52 Equality Impact Assessments (EIA) updates (agenda item 7)

The impact of any proposed service change is subject to EIA as well as new strategy and policy.

The report spreadsheet shows the up to date position as of December 2019 by business development unit (BDU) teams/services.

Not all EIAs are progressing well due to reviews not being undertaken by the service/team in a timely manner. BDU support is required to ensure improvement.

Support service functions i.e. policy development, is now an area of focus for Equality and Engagement Managers, as the support required by clinical services is now less pressing. Training and guidance is/will be provided to policy authors as and when required.

We need a more robust system in place, to evidence that all policies have a valid EIA included and a central log to ensure we have an assurance process in place.

ZM informed the Committee that these are a work in progress and that action plans are being addressed, however teams are still learning. DP has noted on wards that there is some level of understanding, however work is still on-going and connections need to be made to the work they are already undertaking. CL agreed and highlighted that this needs embedding further with more connectivity with people's work experience and to focus on the process rather than outcomes.

RW highlighted some areas of concern with the report and tables relating to EIAs. CL noted that this is a priority for the BDUs and that issues are being addressed as ownership sits with the BDUs.

AM highlighted that some good EIAs have been produced and queried whether these could be used to encourage and assist others in completing, and also could the QI methodology be used on this to reframe the EIAs as an improvement rather than a compliance tool.

The Committee noted the progress made.

The Committee SUPPORTED the ongoing work in BDUs/Quality Academy, and the future focus on support function issues and increased rigour at Executive Management Team (EMT)/Trust Board in seeking assurance that suitable EIAs have been undertaken.

EIC/19/53 Equality Delivery System 2 update (agenda item 8)

EDS2 is a tool designed to measure equality performance by NHS England and CCGs. It helps organisations understand how driving equality improvements can strengthen accountability to service users and the public. EDS2 includes 18 outcomes, grouped into 4 goals:

1. Better health outcomes
2. Improved patient access and experience

3. A representative and supported workforce
4. Inclusive leadership

NHS organisations are required to work with local stakeholders to evaluate performance annually to assess performance against the goals. Performance can be graded as undeveloped, developing, achieving or excelling. SWYPFT was assessed as achieving in 2019.

There will be grading events in February and March with the CCGs in Wakefield, Calderdale and Kirklees for the 2020 assessment and we are on track preparing for these. The topic chosen by the CCGs for this year is complaints/patient experience. A similar process will be undertaken in Barnsley by the Trust.

ZM highlighted to the Committee that the revised EDS3 has now gone through government processes.

RW reminded the EIC that the EDC was focused on staffing in its current incarnation. He suggested that much more was required on the experience of people using services and that this should be the focus of the EDC as it develops. DP concurred and suggested that there was an opportunity with the development of the Equality and Inclusion Strategy to improve the qualitative and quantitative data collected

The Committee NOTED the update and the topic chosen by Kirklees, Calderdale and Wakefield CCGs, and SUPPORTED the actions identified.

EIC/19/54 Performance Dashboard (agenda item 9)

TB described the development of the dashboard to the Committee. The Committee discussed the content and commented as follows;

The Committee agreed that they were happy with the 3 key domains of workforce data, service user data, and corporate data and queried if additional information would be required.

RW noted that it was difficult to know if numbers were representative in the data and that more intelligence was needed. RW also noted useful indicator and highlighted that we need numbers large enough to make conclusions, plus trends would be helpful.

CJ noted that core service indicators need analysing.

TB queried whether service user access and single point of access (SPA) data needed to be added.

RW noted that half of the serious incidents are white in ethnicity and half are not reported to the strategic executive information system (STEIS).

TB noted that serious incident data is already included in quarterly reports so Committee queried whether this is needed.

Complaints – noted that the data relates to the person reporting, not necessarily the patient/service user.

TB noted that the MHA Committee received and reviewed the MHA monitoring information. Community treatment order (CTO) data to be included in future.

AM noted, regarding bullying and harassment, that there was no reference to LGBT+ and asked if we could see this by BDU. The Committee agreed that we need to keep a focus on this.

EM queried whether the information could be more future focused with targets.

AD advised that this could possibly be looked at through the pay audits also.

The Committee noted that the dashboard is work in progress. TB confirmed that the vast majority of data will stay in the dashboard but for the next Committee data will have narrative to inform future focus. The Committee agreed that the serious incident (SI) information is helpful and to leave this data in the dashboard. RW noted that there would be more detail to incidents than what the data is telling us.

Action: Tim Breedon

The Committee DISCUSSED the development of the dashboard and NOTED the data and trends to be reviewed.

EIC/19/55 Feedback from Staff Equality Networks (agenda item 10)

Disability

- It was noted that progress is slow at the moment. Site access for Fieldhead is being reviewed.
- There are low numbers of attendees at forum meetings. The reason for this is not clear and this is being investigated. Work is underway to involve the networks more.

BAME

- Reciprocal mentoring has now launched and is reported to be going well with 6 pairs at the moment.
- Happy with progress of RACE Forward and the involvement of Board.
- Mental health act committee (MHAC) received a presentation from CW on the experience of BAME service users.
- Work continues with HR on bullying and harassment
- CW and Mohammad Navsarka (MN) will be attending a workshop on staff networks and the West Yorkshire integrated care system (ICS) in the New Year.
- The celebration event was a success.

LGBT+

- NHS rainbow badges have now been received and will be launched in January.
- Concerns have been raised that Datix doesn't capture specific abuse based on sexual orientation. The only protected characteristic where abuse is captured is race. Work is underway with Datix regarding this.
- LGBT+ members network meeting to be held January 2020 and will be looking to appoint to permanent network roles early into the next financial year.

ST queried the attendance of staff to the network meetings, being mindful that services are stretched; however trust support for attendance is clear. ZM suggested a rota if attendance

is high in teams and BDU's to keep a note. AM also noted a rota may be useful for attendance at the EIC.
DP queried if there was a way to be involved in the Committee without physically attending the meetings.

Action: Sarah Harrison / Network Reps

RW noted the possibility of using the ihub to share information amongst network members.

The Committee RECEIVED and NOTED the update

EIC/19/56 Inclusive Leadership and Development Programme update (agenda item 11)

AGD updated the Committee on the Leadership & Development Programme.
The second phase of money is now coming through for Building Leadership for Inclusion (BLFI) and discussions with the Tavistock about how we use this are underway, with a proposal being pulled together.

The Committee RECEIVED the update

EIC/19/57 Feedback from BDU Equality Forums (agenda item 12)

Calderdale and Kirklees (C&K) BDU
Sam Jarvis (SJ) noted the presentation from Richard Porter (part of this item) which was also shown in the E&I forum C&K. SJ noted that the attendees at the meeting were compassionate but queried how we connect and make a difference so agreed the need for champions within the BDUs. Aboobaker Bhana will take a lead on this. Conversations in the forum are fed back through to the BDUs. EIAs were also discussed and mirrors what we have discussed today and agreed a lead will be needed to embed these issues. Forensic services are to be invited to the meeting re EIAs as theirs are very good.

Barnsley and Wakefield (B&W) BDU
Staff networks are being discussed and pushed within the BDUs. Equality strategy has also been discussed along with EIAs.

Forensics BDU
ST noted that Forensic and LD forums are separate. Connectivity at the meeting was great however felt more oversight is needed but that the right discussions are taking place in the right places.

Committee felt assured that these meetings are taking place.

Presentation from Richard Porter – received for information
Public Health Team, Calderdale Council

EIC/19/58 National & Regional Issues and Impact Locally (agenda item 13)

- CCG linkages
- EDS3
- Draft strategy for West Yorkshire and Harrogate Health and Care Partnership, which includes 10 high-level objectives, including reducing health inequalities for people

from deprived background and improving BAME representation across senior leaders.
- Pushing out the national equality networks and encouraging staff to sign up to these.

EIC/19/59 Commitment to Carers (agenda item 14)

The Trust has worked with local people to co-produce a carers' charter. The charter sets out the Trust's commitment to carers. The three commitments are:

1. We will work with you as partners
2. We will support you to get help and assistance when you need it
3. We will train our staff to be aware of carers' needs

The charter acknowledges the challenging role involved in being a friend, family or carer of someone and a poster has been created to display on all SWYPFT premises.

Kirklees now support carers through a dedicated post which is jointly funded by the Local Authority and SWYPFT. The post supports adult carers of people with mental health to ensure that timely assessments take place and support is identified.

In addition there are a number of forums and networks available to carers across the Trust footprint. Understanding the networks available is essential if the Trust is to support carers. The Trust is already signposting people to support using the following;

- Making space in Barnsley
- Calderdale Carers support group
- Making space workers based at Laura Mitchell Health Centre
- Carers count Kirklees
- Informal carers groups in BDUs across the Trust in various locations, including Folly Hall and Newton Lodge
- Admiral nurse teams in Kirklees and Wakefield
- Carer liaison workers employed on some wards in North Kirklees and Barnsley
- Staff working on the wards in the Dales and in Wakefield as carer leads

DP informed the Committee that the Charter is very recent and there has been no chance to measure this. DP noted that we need to wait to see if what is said within the charter is working and we are awaiting carers to inform us of this.

DP also noted:-

- Identify a carer lead: The Trust need to identify a lead who will ensure that the commitments in the charter are delivered through an annual action plan.
- Develop a Trust wide delivery plan for carers: This will ensure that all the strands relating to carers are in one place. This would be delivered through an annual action plan.
- Map the support networks in place and identify any gaps: by understanding the gaps the Trust can support the areas where more work is needed.
- Build on the training opportunities for carers: following a successful mental health first aid training a few years ago the Trust could identify training available for carers.

Andrew Allcock (AA) noted that Helen Wiggins could be a link regarding the training. CL suggested looking at links to standard operating procedures (SOPs) and how systems support that to make a practical contribution.

AM noted we discussed the carers' data on the dashboard however we have no SOP data.
RW noted that it was good to see the WY&H link and would like to also include South Yorkshire and Bassetlaw information.

RW highlighted that the working carers' passport needs to be incorporated and adopted.

The Committee SUPPORTED and ACCEPTED the plan and recommendations.

EIC/19/60 Equality Strategy update and Communication, Engagement & Involvement Strategy update (agenda item 15)

DP gave a brief overview to the Committee and noted that the paper sets out the proposed approach, process and timescales to refresh the Communication, Engagement and Involvement Strategy, now known as the Involving People strategy. It will also be important to ensure that the development of this strategy considers an alignment with the existing Equality Strategy. It is proposed this can be achieved through the development of a joint delivery plan.

It was noted that the proposed approach to developing the strategy went to Trust Board in November 2019. DP informed that they have been looking at how to refresh the strategy and to make sure we can involve everyone in its design. There is a dedicated team meeting to discuss this, take this forward and also to discuss mapping what we have in place and address any gaps we might want to improve on. DP noted that a revamp of the website will also be undertaken.

Members' Council will also discuss the strategy in January 2020.
The Committee noted that it was good to see this coming through and also to harness the assets we already have such as Creative Minds, Spirit in Mind, the Mental Health Museum and Altogether Better. RW also suggested DP look at the WYH ICS website.

RW offered capacity and resource to DP to enable this to progress.

The Committee AGREED and SUPPORTED the recommendations.

EIC/19/61 Items to bring to the attention of Trust Board or other Committees (agenda item 16)

- Link to MHA work on BAME service users.
- Equality Strategy and Communication, Engagement & Inclusion Strategy update.
- Equality impact assessments update
- Performance dashboard development
- WRES and WDES updates
- BDU E&I forums and staff equality networks
- Commitment to Carers

EIC/19/62 Work Programme (agenda item 17)

The Committee approved the work programme and noted the further meetings for 2020/2021.

The Committee APPROVED the Work Programme

EIC/19/63 Date of next meeting (agenda item 19)

The next meeting will be held at 10.30 – 13.00 on 3 March 2020 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

Minutes of the

West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)

held Tuesday 21 January, 10.00 – 12.00pm in

Small Conference Room, Wellbeing and Learning Centre, SWYPFT, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP

Present:

Angela Monaghan (Chair) (AM) – Chair, South West Yorkshire Partnership NHS Foundation Trust
Brent Kilmurray (BK) – Chief Executive Officer, Bradford District Care NHS Foundation Trust
Cathy Elliott (CE) – Chair, Bradford District Care NHS Foundation Trust
Rob Webster (RW) – Chief Executive Officer, South West Yorkshire Partnership NHS Foundation Trust
Sara Munro (SM) – Chief Executive Officer, Leeds & York Partnership NHS Foundation Trust
Thea Stein (TS) – Chief Executive Officer, Leeds Community Healthcare NHS Trust

In attendance:

Keir Shillaker (KS) – Programme Director, Mental Health, Learning Disability & Autism
Helen Grantham (HG) – Non-Executive Director, Leeds & York Partnership NHS Foundation Trust
Jonathan Booker (JB) – Senior Analyst, WY&H Health and Care Partnership
Helen Eade (notes) (HE) – Programme Support Officer, Mental Health, Learning Disability & Autism

Apologies:

Neil Franklin – Chair, Leeds Community Healthcare NHS Trust, Sue Proctor – Chair, Leeds & York Partnership NHS Foundation Trust

Glossary of acronyms in this document can be found on page 5.

Item	Discussion / Actions	By whom
1	**Introductions:** A Monaghan (AM) welcomed the group and noted apologies as above.	
2	**Declaration of Interests Matrix / Conflict of Interest:** The declaration of interests was reviewed and agreed to be correct. No conflicts were identified.	
3a	**Review of Previous Minutes:** **ACTION 1/01**: Private and public minutes to be circulated to the group for future meetings. With the above noted, the notes from the previous meeting held 3 October were accepted as an accurate record.	**HE**
3b	**Actions log and matters arising:** The actions log had been updated to reflect progress with members discussing the actions below: 10/6 – completed. 11/6 – completed. 12/6 – to mark as closed. 8/10 – LD resilience tabletop exercise undertaken in December, working through MOU as part of emergency planning. Action 8/10 from the action log has been specifically noted to be included in this update. **ACTION 3/01**	**BK**
4	**Context Setting: Expectations of the Planning Guidance:** RW described how the Planning Guidance had not yet been released, so was unable to set out expectations. However, there is the expectation that the role of ICS will be strengthened including a 'system-first' ethos for planning, with two main roles being transformation and holding the system to account.	

Item	Discussion / Actions	By whom
5	**Programme update:** The group noted the items for information and considered three main items: 1. Risk and the escalation of risks 2. Committee membership and what this looks like 3. Workplan 1. The risk reporting process is still a work in progress to ensure consistency however the group were asked to consider what should be appropriately escalated to the C in C. It was agreed that the three main types of risk that C in C should discuss are: Any risk that is red rated or has been escalated by NHSE/I. Related to core delivery, or New or underlined historic issues, and any risk escalated during the meeting by a member of the CinC. Discussion also concluded that the focus should be on programme/transformation risks rather than provider operational risks, as they will be well served within each individual organisation. It was agreed to review the risk escalation process after 9 months **ACTION 4/01** – to put on work programme. 2. It was agreed that AM will chair the next meeting, then CE will take over. KS, AM and CE will review the existing terms of reference and bring back for approval in April. **ACTION 5/01**. Members were asked to feedback to KS in respect of terms of reference within next 3 weeks (by 11th February). **ACTION 6/01.** The group also discussed current membership, concluding that the focus should remain on the provider collaborative until WY&H is clearer on the outputs of the Commissioning Futures work being led by the CCG Accountable Officers. 3. The aim is to develop a clearer workplan so we know what is coming up at future meetings. This included reaffirming the need to spend time on decision making regarding the big ticket provider focused items such as ATUs, PICU and Complex Rehabilitation. The discussion also covered: • The need to reflect on the planning guidance when issued and implications regarding digital capital and workforce. **ACTION 7/01.** • The need for slightly longer C in C meetings (extending to 2.5 hrs) due to the volume and complexity of discussion items. • The need to undertake deep-dives on certain risks. • The development of strategic sessions once per year to review the full programme of work. **ACTION 8/01.** The group also reflected on the draft communications and engagement plan, and how there is more detailed planning undertaken for each specific workstream (e.g.. ATU). A communications manager has been recruited with dedicated time for this programme. Feedback on the draft plan was that it was strong on communication but needed to be more explicit regarding inclusion, understanding of	**KS** **KS/AM/ CE** **ALL** **KS** **KS**

Item	Discussion / Actions	By whom
	cultural sensitivity and staff side/union engagement. **ACTION 9/01.**	**KS**
	The Committee **NOTED** the report and supported the recommendations. It was **AGREED** that KS, AM and CE would review the terms of reference and bring any recommendations back the the Aril meeting.	
6	**Programme Metrics & Dashboard:** There are three categories of metrics being developed: • Big programme ambitions • Individual workstream measures – including proxy measure for transformation • Core performance measures The CinC was asked to consider the regularity of metrics being presented and what types of information would be useful. Discussion covered the proposed metrics which the programme board will review on a regular basis through highlight reports/deep dives, and some of the practical issues with obtaining timely and valuable data. It was agreed that the main purpose of bringing metrics to the CinC is to help with decision making, or manage risk. Not all data is needed in this forum, the focus will be on core performance. And when particular items are brought for decision they will need to be accompanied by up to date metrics that relate to the required decision. However, the annual strategic session can take a broader view and look at the full suite of information.	
7	**Steady State Commissioning:** The group noted the items for information and discussed two main topics: 1. The development of a commissioning team 2. Agreement of a reporting process 1. It was noted that the specialised services programme board had not yet had chance to receive and agree a formal proposition regarding the commissioning team. Following this meeting on Friday 24th January a proposition will be reviewed by the Collaborative Executive on 4th February before recommending to individuals boards/the Committees in Common for approval outside of the formal meeting. It was also agreed that the proposal should also be tested with governance leads in the provider collaborative before being finalised. HG reflected on a development session from Hill Dickinson about different governance arrangements and will send details of this to all members of C in C. It could be a useful session at a future NED/Governor event. **ACTION 10/01.** The Programme Board will deal with specialised services as a key workstream, so highlight reports on CAMHS, forensics and AED will be presented at Programme Board along with any other services that join the specialised services list. It was agreed that this highlight report will also be provided to the Committees in Common to provide direct assurance on the steady state commissioning work. **ACTION 11/01.**	**HG** **KS**

Item	Discussion / Actions	By whom
8	**CAMHS Update:** LCH indicated that October 2020 is too soon to go live and recommended pushing this back until April 2021. Both the financial modelling and potential commissioning implications are too risky at this stage. We need more clarity regarding integrated commissioning costs and from NHSE regarding staff transfer. It was acknowledged that there is a collective set of financial and clinical risks to deal with. We need to understand the degree of risk and what is needed, then discuss the implications of this with NHSE. The group **AGREED** to postpone the CAMHS go live date to April 2021 in principle, but for further information to be provided to individual provider boards to support a final decision. **ACTION 12/01.** Once confirmed the collaborative will send a formal letter in respect of CAMHS to NHSE. TS to consider when letter should be sent. **ACTION 13/01.**	**TS** **TS**
9	**Any other business** LYPFT will submit a bid to provide High Intensity Mental Health Services for Veterans for the North of England. Isolation units in schools for CAMHS services were raised, and although this is mainly an issue for individual places within the partnership it is something the collaborative can remain aware of.	
	Date and Time of Next Meeting: Thursday 23rd April 2020, Meeting Room 1, Block 7, SWYPFT, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.	

Item	Discussion / Actions	By whom

Glossary

ATU	Assessment and Treatment Unit
BDCFT	Bradford District Care Foundation Trust
CQC	Care Quality Commission
CAMHS	Child and Adolescent Mental Health Services
C-In-C	Committees in Common
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MHLDA	Mental Health, Learning Disabilities and Autism
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SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
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VCH	Voluntary and Community Sector
WY&H	West Yorkshire & Harrogate
WY&H HCP	West Yorkshire & Harrogate Health and Care Partnership
WY&H ICS	West Yorkshire & Harrogate Integrated Care System (internal reference to WY&H HCP)
WYMHSC C-In-C	West Yorkshire Mental Health Services Collaborative Committees in Common

Minutes of the

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3b	**Actions log and matters arising:** The actions log had been updated to reflect progress with members discussing the actions below: 9/6 conversations with Colin Martin re: PIPs set up to deal with most complex LD service users. Their model has been in existence for 3 years and is very successful and could expand to WY&H or help us to set up a franchise. **ACTION 2/01** BK to arrange a meeting with Paul Newton (MD of company) to discuss options, then bring back for discussion in April. **PRIVATE** 10/6 – completed. 11/6 – completed. 12/6 – to mark as closed. 8/10 – LD resilience tabletop exercise undertaken in December, working through MOU as part of emergency planning. Action 8/10 from the action log has been specifically noted to be included in this update. **ACTION 3/01**	**BK** **BK**

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Item	Discussion / Actions	By whom
	• The development of strategic sessions once per year to review the full programme of work. **ACTION 8/01.** The group also reflected on the draft communications and engagement plan, and how there is more detailed planning undertaken for each specific workstream (e.g.. ATU). A communications manager has been recruited with dedicated time for this programme. Feedback on the draft plan was that it was strong on communication but needed to be more explicit regarding inclusion, understanding of cultural sensitivity and staff side/union engagement. **ACTION 9/01.** The Committee **NOTED** the report and supported the recommendations. It was **AGREED** that KS, AM and CE would review the terms of reference and bring any recommendations back the the Aril meeting.	**KS** **KS**
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	on CAMHS, forensics and AED will be presented at Programme Board along with any other services that join the specialised services list. It was agreed that this highlight report will also be provided to the Committees in Common to provide direct assurance on the steady state commissioning work. **ACTION 11/01.**	**KS**
8	**Assessment and Treatment Units – Information and Update: PRIVATE** Discussions are continuing with local partners, including scrutiny bodies regarding ATU proposals and engagement to date. This includes a first public discussion of the Joint Health Overview and Scrutiny Committee on 18th February. At this time there are no confirmed next steps, but we expect to either need to undertake further engagement or to enter a period of formal consultation on the proposals. Overview and Scrutiny Committees (OSCs) are generally accepting of the likely need for consultation and doing so will provide a blueprint for similar changes in other services across the ICS. Staff in the Leeds unit are now aware that the proposal model recommends the closure of Parkside Lodge and work is underway within LYPFT to support staff. This includes considering what incentives can be provided to keep staff in the service, and regular staff meetings. A new project lead is to be appointed to develop the one team approach throughout the 3 sites and align the ways of working from April or May.	
9	**CAMHS Update:** LCH indicated that October 2020 is too soon to go live and recommended pushing this back until April 2021. Both the financial modelling and potential commissioning implications are too risky at this stage. We need more clarity regarding integrated commissioning costs and from NHSE regarding staff transfer. It was acknowledged that there is a collective set of financial and clinical risks to deal with. We need to understand the degree of risk and what is needed, then discuss the implications of this with NHSE. The group **AGREED** to postpone the CAMHS go live date to April 2021 in principle, but for further information to be provided to individual provider boards to support a final decision. **ACTION 12/01.** Once confirmed the collaborative will send a formal letter in respect of CAMHS to NHSE. TS to consider when letter should be sent. **ACTION 13/01.**	**TS** **TS**
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WY MHLD&A Committees in Common - Action Log

Completed items
Item in progress/longer term items

*Action.Month No e.g. Action 1, September meeting =1/9

Item Name	Action No.*	Action	Lead	Deadline	Status	Outcome / Update
Actions from previous meeting (Engagement)	2/7	Draft Communications and Strategy Plan to be shared at Octobers meeting. (The differing levels of staff/service involvement in the programme to be reflected in the communication's plan)	K Coleman / K Shillaker	Oct-19	Completed	Draft plan going to programme board for discussion on 17 January. Attached for information
Org check in	5/3	Rob Webster to contact Claire Murdoch about NHSE investment standard to gain a fuller understanding of the rationale behind NHSE not following the same MHIS.	R Webster	Sep-19	Completed	
TCP contingency planning	9/6	A meaningful conversation to be had with Colin Martin, TEWV about a potential franchising model from PIPs. An option to scope out to see what this would look like.	BK			BK to arrange meeting with Paul Newton/Colin Martin. Fuller update in meeting notes for 21.01.2020.
TCP contingency planning	10/6	Ensure the workforce directors are fully aware of the workforce issues and potential plans to ensure overview ownership – avoiding missing opportunities and potential gaps.	BK		Completed	
TCPs - Response to independent sector crisis in LD inpatient provision	11/6	B Kilmurray to liaise with Anthony Kealy, local locality officer regarding potential NHSE/I support.	BK		Completed	
TCPs - Response to independent sector crisis in LD inpatient provision:	12/6	B Kilmurray to draft letter to NHSE/I from himself and A Monaghan, C-In-C chair.	BK			Action closed.
Declaration of Interests Matrix / Conflict of Interest	1/10	L Quirk (LQ) to update Cathy Elliott (CW) and Rob Webster's (RW) declaration of interests.	LQ	Jan-20	Completed	Declaration of interested updated.
Review of previous minutes	2/10	Private and public minutes to be circulated to the group for future meetings. With the above noted, the notes from the previous meeting held 28 June were accepted as an accurate record.	LQ		Completed	
W Y & H HCP MHLD & A programme update	3/10	Draft programme reporting dashboard to be presented at the next meeting.	KS		Completed	On the agenda
W Y & H HCP MHLD & A programme update	4/10	The risk register to be presented at the next meeting.	KS		Completed	On the agenda
W Y & H HCP MHLD & A programme update	5/10	Draft version of NCM/steady state commissioning milestones to be presented at the next meeting.	KS		Completed	On the agenda
W Y & H HCP MHLD & A programme update	6/10	TS to provide a CAMHS update to a future C-in-C; timing in line with progress and if appropriate include a service user story.	TS		Completed	On the agenda
W Y & H HCP MHLD & A programme update	7/10	L Quirk (LQ) to enquire if Woodhouse Hall is available for the next meeting.	LQ		Completed	Room not available at Woodhouse Hall, so meeting will be held at Fieldhead as previously arranged.
TCP: Independent Sector LD Placements MoU PRIVATE only	8/10	The penultimate bullet point on 9.2 within the MOU; issues relating to gender; also needs to be sensitive to age, given that this is an all-age MoU	BK			Amendments to be made to MOU and brought to Exec to be signed off, this point has been noted and will be amended as part of this.
Business & Strategy: MHLDA Programme Strategy	9/10	KS to incorporate the feedback from the meeting into the next version of the strategy.	KS		Completed	Strategy finalised and links provided in programme report
Business & Strategy: MHLDA Programme Strategy	10/10	SM/KS to pick up 'supporting the workplace outside of the NHS' e.g. MH first aiders to private sector with Sarah Smith, improving population health programme as broader MH prevention is one of their priorities.	SM/KS		Completed	KS and SS have discussed in the context of IPH priorities. Possible opportunities via the prevention concordat action plan and the suicide prevention campaign if we work with specific organisations (ie construction)
Business & Strategy: MHLDA Programme Strategy	11/10	Any further comments on the structure to be relayed to KS.	ALL		Completed	Structure being progressed

Review of Previous Minutes	1/01	Private & public minutes to be circulated to the group for future meetings	HE			
Actions log and matters arising PRIVATE only	2/01	BK to arrange a meeting with Paul Newton (MD of company) to discuss options, then bring back for discussion in April.	BK			
Actions log and matters arising PRIVATE only	3/01	LD resilience tabletop exercise undertaken in December, working through MOU as part of emergency planning. Action 8/10 from the action log has been specifically noted to be included in this update	BK			
Programme update	4/01	Review Risk Escalation process after 9 months, to put on work programme	KS	October		
Programme update	5/01	KS, AM & CE to review existing terms of reference and bring back for approval	KS/AM/CE	April		
Programme update	6/01	Members were asked to feedback to KS in respect of terms of reference within next 3 weeks (by 11th February).	ALL	February		
Programme update	7/01	Reflect on the planning guidance when issued and implications regarding digital capital and workforce.	KS			
Programme update	8/01	The development of strategic sessions once per year to review the full programme of work	KS			
Programme update	9/01	Feedback on the draft communications and engagement plan was that it was strong on communication but needed to be more explicitly regarding inclusion, understanding of cultural sensitivity and staff side/union engagement.	KS			
Steady State Commissioning	10/01	HG to send details of development session from Hill Dicxkinson to C in C members.	HG			
Steady State Commissioning	11/01	Highlight reports presented to Programme Board on CAMHS, forensics and AED and other specialised services will also be provided to Committees in Common to provide assurance re steady state commissioning work.	KS			
CAMHS Update	12/01	Further information to be provided to support final decision of CAMHS go live date to April 2021.	TS			
CAMHS Update	13/01	Formal letter to be sent to NHSE in respect of CAMHS, TS to consider when this should be sent.	TS			

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 March 2020
Confidential agenda item 11

Title:	**Use of Trust Seal**
Paper prepared by:	Corporate Governance Manager on behalf of the Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Mission / values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers / previously considered by:	Quarterly reports to Trust Board.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used seven since the report to Trust Board in November 2019 in respect of the following: ➢ Deed of variation and licence for works: Mount Vernon Hospital, Barnsley S70 4DP between the Trust and Orion Homes Limited. ➢ Deed of variation of contract relating to the former Mount Vernon Hospital, Barnsley S70 4DP between the Trust and Orion Homes Limited. ➢ Lease relating to New Street Health Centre, Upper New Street, Barnsley S70 1LP between the Trust and Rotherham NHS Foundation Trust. ➢ Lease of Unit 2, 2a and 5 Agbrigg and Belle Vue Community Centre, Montague Street, Wakefield WF1 5BB between the Trust and Wakefield Council. ➢ Lease for Unit 2 Flemming Court, Glasshoughton WF10 5HW, continuing occupation of the CAMHS team base. ➢ Lease of Unit 11 Agbrigg and Belle Vue Community Centre, Montague Street, Wakefield WF1 5BB between the Trust and

	Wakefield Council for the Live Well service. ➢ Assignment license for Airedale Health Centre, the Square, Castleford between the Trust and Airedale Dental Practice. Owing to the retirement of the current dentist there has been an agreement to assign to a new provider of services.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in November 2019.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2019-20

! – item amended to focus on Covid-19 and business continuity

Agenda item/issue	Apr	June	July	Sept	Oct	Nov	Jan	Mar	Amended/ Deferred Covid-19
Standing items									
Declarations of interest	✘	✘	✘	✘	✘	✘	✘	✘	
Minutes of previous meeting	✘	✘	✘	✘	✘	✘	✘	✘	
Chair and Chief Executive's report	✘	✘	✘	✘	✘	✘	✘	✘	!
Business developments	✘	✘	✘	✘	✘	✘	✘	✘	!
STP / ICS developments	✘	✘	✘	✘	✘	✘	✘	✘	!
Integrated performance report (IPR)	✘	✘	✘	✘	✘	✘	✘	✘	!
Serious Incidents (private session)	✘	✘	✘	✘	✘	✘	✘	✘	!
Assurance from Trust Board committees	✘	✘	✘	✘	✘	✘	✘	✘	!
Receipt of minutes of partnership boards	✘	✘	✘	✘	✘	✘	✘	✘	
Question from the public	✘	✘	✘	✘	✘	✘	✘	✘	✘!
Quarterly items									
Corporate/organisational risk register	✘		✘		✘		✘		
Board assurance framework	✘		✘		✘		✘		
Serious incidents quarterly report		✘		✘		✘		✘	
Emergency Preparedness, Resilience & Response (EPRR) Compliance		✘		✘		✘		✘	✘ (covered in Covid-19 update)
Use of Trust Seal		✘		✘		✘		✘	
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	✘	!
Half yearly items									
Strategic overview of business and associated risks	✘				✘				
Investment appraisal framework (private session)	✘				✘				
Safer staffing report	✘				✘				
Digital strategy (including IMT) update	✘				✘				

Agenda item/issue	Apr	June	July	Sept	Oct	Nov	Jan	Mar	Amended/ Deferred Covid-19
Estates strategy update			✘				✘		
Annual items									
Draft Annual Governance Statement	✘								
Audit Committee annual report including committee annual reports	✘								
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘	✘							
Guardian of safe work hours	✘								
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘								
Review of Risk Appetite Statement	✘								
Annual report, accounts and quality accounts - update on submission		✘							
Health and safety annual report		✘							
Patient experience annual report		✘							
Serious incidents annual report		✘							
Equality and diversity annual report			✘						
Medical appraisal/revalidation annual report			✘						
Sustainability annual report				✘					
Workforce Equality Standards				✘					
Assessment against NHS Constitution						✘			
Eliminating mixed sex accommodation (EMSA) declaration								✘	
Data Security and Protection toolkit								✘	
Strategic objectives								✘	✘
Trust Board annual work programme								✘	!
Operational plan	✘					✘ (draft / private)	✘ (draft / private)	✘ (draft / private)	✘
Five year plan				✘					
Policies and strategies									
Constitution (including Standing Orders) and Scheme of Delegation					✘			✘	
Involving people strategy (formerly) Communication, Engagement and Involvement strategy		✘ (update)						✘	
Organisational Development Strategy						✘			

Agenda item/issue	Apr	June	July	Sept	Oct	Nov	Jan	Mar	Amended/ Deferred Covid-19
Risk Management Strategy	✘								
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)								✘	
Workforce Strategy								✘	✘

Policies/strategies for future review:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(reviewed as required)*
- Membership Strategy *(next due for review in April 2020)*
- Customer Services Policy *(next due for review in June 2020)*
- Equality Strategy *(next due for review in July 2020)*
- Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in October 2020)*
- Learning from Healthcare Deaths Policy *(next due for review in October 2020)*
- Digital Strategy *(next due for review in January 2021)*
- Quality Strategy *(next due for review in March 2021)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in March 2021)*
- Estates Strategy *(next due for review in July 2022)*
- Sustainability Strategy *(to be reviewed with the Estates Strategy)*

	Business and risk
	Performance and monitoring
Strategic sessions (including Board development work) are held in February, May, September and December which are not meetings held in public.	
There is no meeting scheduled in August.	
# Corporate Trustee for the Charitable Funds which are not meetings held in public.	

South West Yorkshire Partnership NHS Foundation Trust

DRAFT Trust Board annual work programme 2020-21

! – item amended to focus on Covid-19 and business continuity
 # - item deferred
Note that some items may be verbal

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Standing items													
	Declarations of interest	✘		✘	✘		✘	✘	✘		✘		✘	
	Minutes of previous meeting	✘		✘	✘		✘	✘	✘		✘		✘	
	Chair and Chief Executive's report	!		!	✘		✘	✘	✘		✘		✘	
	Business developments	!		!	✘		✘	✘	✘		✘		✘	
	STP / ICS developments	!		!	✘		✘	✘	✘		✘		✘	
	Integrated performance report (IPR)	!		!	✘		✘	✘	✘		✘		✘	
	Serious Incidents (private session) - verbal	✘		✘	✘		✘	✘	✘		✘		✘	
	Assurance from Trust Board committees	✘		✘	✘		✘	✘	✘		✘		✘	
	Receipt of minutes of partnership boards	✘		✘	✘		✘	✘	✘		✘		✘	
	Questions from the public (to receive in writing during Covid-19 pandemic)	✘		✘	✘		✘	✘	✘		✘		✘	

With **all of us** in mind.

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Quarterly items													
	Corporate / organisational risk register	!			✘			✘			✘			
	Board assurance framework	#			✘			✘			✘	✘		
	Serious incidents quarterly report			#			✘		✘				✘	
	Emergency Preparedness, Resilience & Response (EPRR) Compliance – Covid-19 response update?			!			✘		✘				✘	
	Use of Trust Seal			✘			✘		✘				✘	
	Corporate Trustees for Charitable Funds# (annual accounts presented in July)			!			✘		✘				✘	
	Half yearly items													
	Strategic overview of business and associated risks	#						✘						
	Investment appraisal framework (private session)	#						✘						
	Safer staffing report	✘?						✘						
	Digital strategy (including IMT) update	#						✘						
	Estates strategy update				✘						✘			
	Annual items													
	Draft Annual Governance Statement	✘?												
	Audit Committee annual report including committee annual reports	✘?												
	Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘?	✘?											
	Guardian of safe work hours	✘?												
	Risk assessment of performance targets, CQUINs and Single	#												

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Oversight Framework and agreement of KPIs													
	Review of Risk Appetite Statement	#												
	Annual report, accounts and quality accounts - update on submission			✘?										
	Health and safety annual report			#										
	Customer Service annual report			#										
	Serious incidents annual report			#										
	Equality and diversity annual report				✘									
	Medical appraisal / revalidation annual report				✘									
	Sustainability annual report						✘							
	Workforce Equality Standards						✘							
	Assessment against NHS Constitution								✘					
	Eliminating mixed sex accommodation (EMSA) declaration												✘	
	Data Security and Protection toolkit												✘	
	Strategic objectives												✘	
	Trust Board annual work programme											✘ (draft)	✘	
	Operational plan										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)	
	Five year plan						✘							
	Board development													
	TBC		✘			✘				✘		✘		
	Policies and strategies													

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Constitution (including Standing Orders) and Scheme of Delegation	# (if req'd)												
	Digital Strategy	#												
	Customer Services policy			#										
	Estates strategy			#										
	Involving people strategy	# (if req'd)												
	Sustainability strategy			#										
	Organisational Development Strategy			#										
	Equality strategy				✘									
	Quality strategy												✘	
	Trust Board declaration and register of fit and proper persons, interests and independence policy												✘	