South West Yorkshire Partnership NHS Foundation Trust

**Trust Board (performance and monitoring)**
**Tuesday 30 June 2020 at 9.30am**
**Virtual Meeting**

## AGENDA

| Item | Approx. Time | Agenda item | Presented by | | Time allotted (mins) | Action |
|---|---|---|---|---|---|---|
| **1.** | **9.30** | **Welcome, introductions and apologies** | Chair | **Verbal** | 1 | To receive |
| **2.** | **9.31** | **Declarations of interest** | Chair | **Verbal** | 1 | To receive |
| **3.** | **9.32** | **Minutes from previous Trust Board meeting held 28 April 2020** | Chair | **Paper** | 1 | To approve |
| **4.** | **9.33** | **Matters arising from Trust Board 28 April 2020** | Chair | **Paper** | 2 | To approve |
| **5.** | **9.35** | **Service User/Staff Member Story** | Director of Operations | **Verbal** | 10 | To receive |
| **6.** | **9.45** | **Chair and Chief Executive's remarks** | Chair<br>Chief Executive | **Verbal**<br>**Paper** | 10 | To receive |
| **7.** | **9.55** | **Performance reports** | | | | |

With **all of us** in mind.

| Item | Approx. Time | Agenda item | Presented by | | Time allotted (mins) | Action |
|---|---|---|---|---|---|---|
| | 9:55 | 7.1 Integrated performance report Month 10 2019/20 | Director of Finance & Resource and Director of Nursing & Quality | **Paper** | 45 | To receive |
| | 10:40 | 7.2 Serious Incident Annual Report 2019/20 | Director of Nursing & Quality | **Paper** | 5 | To receive |
| | 10.45 | 7.3 Covid Risks Update | Director of Finance & Resource | **Paper** | 5 | To approve |
| | 10.50 | 7.4 CovidTrust-wide Equality Impact Assessment | Director of Nursing & Quality | **Paper** | 15 | To approve |
| | *11.05* | *Break* | | | | |
| **8.** | **11.20** | **Business developments** | | | | |
| | 11.20 | 8.1 South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) | Director of HR, OD & Estates and Director of Strategy | **Paper** | 10 | To receive |
| | 11.30 | 8.2 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 | 8.3 Covid Recovery and Restoration Planning | Director of Strategy | **Paper** | 15 | To receive |

| Item | Approx. Time | Agenda item | Presented by | | Time allotted (mins) | Action |
|---|---|---|---|---|---|---|
| **9.** | **11.55** | **Governance matters** | | | | |
| | 11.55 | 9.1 Internal Meetings Governance Framework | Director of Finance & Resource | **Paper** | 5 | To approve |
| | 12.00 | 9.2 Terms of Reference for EMT | Director of Finance & Resource | **Paper** | 5 | To receive |
| | 12.05 | 9.3 Emergency Preparedness, Resilience & Response (EPRR) Compliance | Director of HR, OD & Estates and Director of Strategy | **Paper** | 5 | To approve |
| | 12.10 | 9.4 Declaration of Self-Certification against NHSI provider licence | Director of Finance & Resource | **Paper** | 5 | To approve |
| | 12.15 | 9.5 Update on Annual Report process following auditors report and expected timescales for completion of the quality account | Director of Finance & Resource | **Paper** | 5 | To receive |
| | 12.20 | 9.6 Update on Policies and Strategies delayed due to Covid 19 with renewed timescales | Director of Finance & Resource | **Paper** | 5 | To receive |
| | 12.25 | 9.7 Planning Requirements | Director of Finance & Resource | **Paper** | 5 | To receive |

| Item | Approx. Time | Agenda item | Presented by | | Time allotted (mins) | Action |
|---|---|---|---|---|---|---|
| **10.** | **12.30** | **Assurance and receipt of minutes from Trust Board Committees**<br>- Audit Committee, 2 June 2020<br>- Clinical Governance & Clinical Safety Committee 9 June 2020 (to receive minutes from 7 April)<br>- Equality & Inclusion Committee, 2 June 2020 (to receive minutes from 3 March 2020)<br>- Finance, Investment and Performance Committee 23 June 2020 (to receive minutes from 23 January, 27 February and 23 April)<br>- Mental Health Act Committee, 12 May 2020 (to receive minutes from 12 November and 10 March) | Chairs of committees | **Paper** | 25 | To receive |
| **11.** | **12.55** | **Use of Trust Seal** | Chair | **Paper** | 2 | To receive |
| **12.** | **12.57** | **Trust Board work programme** | Chair | **Paper** | 3 | To approve |
| **13.** | **13.00** | **Date of next meeting**<br>The next Trust Board meeting held in public will be held on Tuesday 28 July 2020. | Chair | **Verbal** | 0 | To note |
| **14.** | **13.00** | **Questions from the public – received in writing in advance** | Chair | **Verbal** | 10 | To receive |
| | *13.10* | *Close* | | | | |

South West Yorkshire Partnership NHS Foundation Trust

# Minutes of Trust Board meeting held on 28 April 2020
## Virtual meeting

| | | |
|---|---|---|
| **Present:** | Angela Monaghan (AM) | Chair |
| | Charlotte Dyson (CD) | Deputy Chair / Senior Independent Director |
| | Laurence Campbell (LC) | Non-Executive Director |
| | Chris Jones (CJ) | Non-Executive Director |
| | Erfana Mahmood (EM) | Non-Executive Director |
| | Kate Quail (KQ) | Non-Executive Director |
| | Sam Young (SYo) | 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 | |
| **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:** | Andy Lister | Lead Serious Incident Investigator and Company Secretary designate |
| | Bill Barkworth | Publicly elected governor, Barnsley |
| | Bob Clayden | Publicly elected governor, Wakefield |
| | Dylan Degman | Publicly elected governor designate, Wakefield |
| | Csilla Fabian | SystmOne Optimisation / Corporate Governance |
| | Tom Sheard | Publicly elected governor designate, Barnsley |
| | Debs Teale | Staff elected governor, nursing support |
| | Tony Wright | Staff Side |



### TB/20/15 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. AM ran through the logistics of how the meeting would run. It was noted that, in response to Covid-19 (Coronavirus), the Trust Chair has taken the decision to suspend non-urgent and non-essential business in line with national guidance and decisions taken through the Trust emergency planning structures. All Trust Board and Board Committee meetings will be held remotely using tele / video conferencing technology until further notice.

This was the first virtual public session and AM welcomed those who had joined the session, reminding them that any questions from the public should be submitted by email for consideration at the end of the meeting. AM asked that all microphones were muted, except for a member of the Board presenting an item or asking a question. It was noted that the meeting was quorate and could proceed.

AM acknowledged the one minute's silence that would be observed across the country to remember health and care staff who have lost their lives during the pandemic. AM noted that

the minute's silence was due to take place during a planned break in the Board meeting, and that anyone who wishes to observe it may do so.

AM outlined the items to be covered in the private session of the Board meeting, including:

- Addressing any private risks that are commercial in confidence
- Updates on business developments in South Yorkshire & Bassetlaw and West Yorkshire & Harrogate which are commercially confidential
- Verbal update on serious incident investigations taking place
- Verbal update on contracting, which has been suspended during the Covid-19 pandemic and is commercially confidential.

## TB/20/16 Declarations of interest (agenda item 2)

The following declarations were considered by Trust Board for Erfana Mahmood (EM), Non-Executive Director and Carol Harris (CH), Director of Operations:

| Name | Declaration |
|---|---|
| **Non-Executive Director** | |
| MAHMOOD, Erfana | Non-Executive Director for Chorley & District Building Society<br>Non-Executive Director for Omega/Plexus part of Mears Group<br>Sister is employed by Mind in Bradford |
| **Non-voting director** | |
| HARRIS, Carol | Son has signed up with the Trust Bank. |

Kate Quail (KQ) also requested an amendment to the wording of her declaration to clarify the basis on which she undertakes Community Treatment Reviews. KQ to submit amended wording to Aimee Willett.

**Action: Kate Quail / Aimee Willett**

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/20/17 Minutes of and matters arising from the previous Trust Board meeting held 31 March 2020 (agenda item 3)

**It was RESOLVED to APPROVE the minutes of the session of Trust Board held 31 March 2020 as a true and accurate record.**

The following matters arising were discussed:

- Items shown in blue in the action log are complete.
- PS/20/11b – CH provided an update on the issue with social distancing at Urban House that was raised at the last Board meeting. CH advised that this has stabilised and that an update will be provided at the next Clinical Governance & Clinical Safety (CG&CS) Committee.

  **Action: Carol Harris**
- PS/20/17 – Board work plans have been updated, and will continue to be reviewed throughout the pandemic.
- PS/20/13d – Salma Yasmeen (SYa) updated regarding the timescale for the Involving People Strategy and advised that this will be June 2020.

  **Action: Salma Yasmeen**
- TB/20/06b – Mark Brooks (MB) noted that a copy of the report regarding cyber security that was discussed at the Audit Committee (AC) has been provided as an appendix to the action log.

- MB noted that NHS planning has been suspended and interim financial arrangements are in place for four months. A framework is in place to monitor the response to Covid-19 and our integrated performance report (IPR) has been amended to provide Trust Board with information on managing the response and impact on core services.

## TB/20/18 Staff stories (agenda item 4)

Rob Webster (RW) introduced the item, advising that the public Board usually received a service user story, however it felt pertinent to share some of the staff stories that have been sent through during the pandemic. RW noted that there are daily communications sent out to all staff and that a lot of responses have been received. RW shared the following:

- There is a lot of colour across the organisation, rainbows and murals are visible across the Trust. These serve multiple purposes as a visible symbol of hope, and as wards do not have visitors and no leave for service users, as one of the ways in which we provide meaningful activity to inpatients.
- Staff have embraced the digital way of working across the Trust. Microsoft Teams has been rolled out across the organisation and, as well as being used for the Board meeting, it is used in clinical settings for multi-disciplinary team meetings and virtual huddles. Other IT platforms are also used and RW expressed thanks to the IT team for providing support to make sure technology is available.
- Clinical staff in learning disability services are completing digital passports for service users, so that if they are admitted to hospital, they have up to date information regarding how they are care for and communicated with. Positive feedback from partners has been received in relation to this work.
- Recruitment continues across the Trust thanks to virtual interviewing involving a broad range of staff.
- Staff visiting service users out in the community are required to wear personal protective equipment (PPE) and a lot of the time this means that their faces are covered. Staff call ahead to inform service users of their visit and when they arrive, some staff are asking service users to wave through their window so they can see the faces of staff before they put on their PPE, which has helped to reduce anxiety for service users.
- Lots of donations of gifts have been received to support staff, which have been distributed across the Trust.

RW and AM reiterated their thanks to all staff, carers, volunteers and partners.

**It was RESOLVED to NOTE the Staff Stories.**

## TB/20/19 Chair's and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM noted that her remarks were included above.

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:

- Information is circulated to all staff daily, Non-Executive Directors (NEDs) hold a meeting weekly.
- Statement from the Prime Minister yesterday confirmed that restrictions on daily living will continue for some time, and the NHS will start bringing back some critical services that have been paused. Acute hospitals are running at 51-52% capacity, have discharged a lot of patients and stopped routine appointments and procedures to increase critical care capacity. This has expanded capacity significantly and meant that

the NHS has not been overwhelmed. This is only possible because of community staff, GPs, social care and third sector support for people at home. Awaiting final guidance on resuming services. The impact on the Trust will be mostly in community services.

- PPE for staff in the Trust is sufficient and has been for staff throughout pandemic. Clarity regarding how PPE is applied was provided to staff following guidance.
- Testing has significantly increased and we have been testing staff. 1 in 4 of those who are symptomatic have tested positive for Covid-19 and are receiving care and support, this has been a moderate illness for most.
- Testing for service users admitted to inpatient service is about to start. Working with partners to make sure that continues to be the case.
- A minute's silence will be held to mark the unfortunate loss of health and care workers during the pandemic.
- Statistics show that older people are more vulnerable to Covid-19, and it also suggests that males and people from BAME heritage appear to be more vulnerable. Work is underway to ensure that staff feel safe.

Charlotte Dyson (CD) queried if there is an opportunity for staff to be able to raise issues and when thing aren't working effectively. RW noted that staff need to provide this feedback and feel that issues are acted on. The first point of reference is the intranet, there is a lot of intelligence available there, and this addresses clusters of queries particularly in relation to PPE and changes to guidance. Question and answer sessions and walk arounds have also been conducted to address any staff issues, and the role of Freedom to Speak Up Guardians has been reinforced.

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

## TB/20/20 Interim governance arrangements – update (agenda item 6)

MB noted that the report identifies changes since the last report to Board. MB added that decision logs are produced every week internally and disseminated to NEDs and through planning command levels. All decisions taken are identified with a rationale behind each.

AM asked for each Committee chair to provide a brief update regarding changes to their Committee:

- Clinical Governance & Clinical Safety (CD) – the duration of the meeting has been reduced to two hours and some items have been deferred to allow a focus on Covid-19 and specific issues including staff wellbeing, patient safety and the risk register.
- Audit (Laurence Campbell (LC)) – the majority of agenda items focus on year end, timescales for year end submissions have not been relaxed. The agenda has been amended to address the most urgent issues and internal audit progress. LC noted that risk triangulation has not been collated in the same way, and alternative approaches will be considered under the risk register item.
- Finance, Investment & Performance (Chris Jones (CJ)) – the meeting duration has been reduced to one hour, and the agenda streamlined to focus on Covid-19 related costs and any loss of income. Focus also maintained on agency spend and out of area beds. Financial sustainability will be refocused after the pandemic.
- Workforce & Remuneration (Sam Young (SYo)) – the Committee will only meet to discuss any extraordinary items as key issues that the Committee would discuss such as staff wellbeing, attendance and testing are discussed in detail at Board who meet more frequently. SYo and Alan Davis (AGD) are in regular contact, and work is beginning to monitor staff burnout and resilience.
- Mental Health Act (KQ) – continues to focus on guiding principles, clinical risk and addressing any issues that are Covid-19 related, including changes to the Act. Meeting frequency remains the same, but continues to be under review.

- Equality & Inclusion (AM) – the agenda is shortened, with most items changed to verbal updates and some specific items to be deferred. Next meeting is early June and the time will be used to hear from staff networks, staff experiences and conducting Equality Impact Assessments for decisions made in the current circumstances.
- Charitable Funds (Erfana Mahmood (EM)) – frequency of meetings remain but with a shortened agenda reflecting projects affected by Covid-19 and maintaining a focus on communication within the community.
- West Yorkshire Mental Health, Learning Disability & Autism Committee-in-Common (AM) – continues to meet with a brief update on each workstream, plus changes in responses due to Covid-19. Performance dashboard has been suspended.

RW highlighted that as we move from the Covid-19 pandemic, there are lessons to be learnt regarding governance and some of the principles put in place could be adopted as good practice for use in normal arrangements, this will be considered at the May strategic session.

AM added that, in line with the above, a Clinical Ethics Advisory Group (CEAG) is under consideration and would be discussed under agenda item 10.6. In addition, the Members' Council will meet virtually on 1 May for the first time.

**It was RESOLVED to NOTE the interim governance arrangements.**

## TB/20/21 Performance reports (agenda item 7)

TB/20/21a Update on arrangements in place for the management of Covid-19 (agenda item 7.1)

AGD noted that emergency planning continues and the Trust is represented in external arrangements. Issues with PPE covered in other items above.

**It was RESOLVED to NOTE the update on arrangements in place for the management of Covid-19.**

TB/20/21b Integrated performance report (IPR) month 11 2019/20 (agenda item 7.2)

TB opened this item by noting:

- March IPR is to a good standard given the reduced time and focus due to Covid-19. Pages 10 – 13 of the IPR include the headings identified in the letter from Simon Stevens and Amanda Pritchard (NHS England and NHS Improvement) and talk through the Trust response to Covid-19.
  - Inpatient and critical care – CH updated regarding key actions and new updates since production of the IPR. The Trust has a refined service offer across general service planning in Barnsley. The Trust is supporting acute Trusts to discharge more patients and to reduce exposure for vulnerable patients. Staff have transferred from the GP Federation to make sure services can be provided in the community. Cohorting procedures are underway, ensuring that service users in inpatient services with a positive diagnosis of Covid-19 are separated from those with a negative result. There are standard, robust operating procedures for acute and older people services which are dynamic and reviewed regularly. Covid-19 outbreak on wards has been managed. 24/7 crisis support has been strengthened and publicised on the website. Lessons learnt from the pandemic will be used to shape the future of urgent care. Forensic services are still taking admissions and working with partners on the best use of capacity.
  - Respiratory support – TB advised that the Covid-19 clinical pathway has been finalised and work done regarding screening. Additional training and support has been provided to staff for the use of oxygen therapy. Updated guidance on the use of

PPE provided. The Trust has a strong enhanced physical health package prepared for different eventualities.

- Workforce support hub – AGD noted that health and wellbeing services are in place to support staff and managers. A talent pool has been developed to allow the movement of staff to support where required in the organisation, alongside ongoing recruitment processes. Further areas being considered are staff resilience and the impact of Covid-19 on Black, Asian and Minority Ethnic (BAME) staff.

**Action: Alan Davis**

- Wider population – Sean Rayner (SR) noted the Trust is working with partners and responding proactively through bronze, silver and gold command structures. Work underway regarding the medium to long term position for carers supporting the wider population methods. SYa added that the Trust is part of joint responses to supporting vulnerable groups and the shielded population.
- Stress testing – CH advised that all business continuity plans and trigger points have been reviewed to ensure they are fit for purpose. Staffing redeployment and Operational Pressures Escalation Levels (OPEL) reviewed regularly. Bronze command groups are responding to concerns relating to PPE, and additional security measures in relation to storage of PPE. Work with pharmacy partners is ongoing to ensure that the Trust has the medication required. Medical waste provisions are being considered in relation to what changes would be required if wards are changed to Covid-19 only wards.
- Removal of routine burden – MB noted that this is recognised and appreciated, and that there continue to be other pressures in the system.

TB added that enhanced risk scanning has been introduced which compares year on year risk reporting. There is also an additional element to the weekly clinical risk scanning which highlights any risks where Covid-19 is mentioned and are reviewed to highlight any themes and trends.

LC commented that business continuity plans have kicked in and been effective. The pandemic will not be over any time soon, but that risks and pressures may reduce. The Trust needs to consider the ongoing resilience of staff and how we can ensure this will be maintained. RW highlighted that the Board and Executive Team have shown leadership and the right approach, and that there is ongoing health and wellbeing support available to staff. The Board will discuss stabilisation and recovery at the strategic session on 21 May.

**Action: Salma Yasmeen**

CJ queried how we are assuring the quality of video and phone contact with service users, and if there is a long term plan for colleagues who are shielded. CJ also noted the new data included on page five, and queried if this had been analysed yet, particularly in relation to BAME populations and males.

CH noted that the quality of interventions is reviewed regularly by teams. An equality impact assessment has been completed for changes in ways of working for each service user group. It has been challenging to ensure that all service users are seen, and those who require face to face visits are still receiving them. TB added that trends highlighted through the risk scan inform practice. Subha Thiyagesh (SThi) added that qualitative data is also provided via feedback from clinicians and medical staff at all levels.

AGD updated that the Trust continues to support shielded colleagues and is in regular contact with them to provide welfare support and encourage access to the health and wellbeing offer. There are a number of members of staff required to shield who are successfully working from home. The Trust's approach is based on government advice and risk assessments, and the priority remains to keep staff safe and well. MB noted that new

data is being collected by individual managers which should allow us to monitor ethnicity and gender in relation to Covid-19.

SYo queried the 3.8% sickness rate for March, and suggested that this was not reflective of the information provided with the remainder of the report. AGD noted that absence rates have been dropping, however Covid-19 related absence is recorded separately in line with central guidance.

SYo queried if there are any clusters of cases of Covid-19, and any correlation between staff and patients on wards having Covid-19. SThi noted that there is a taskforce to review this, and research and development are looking into the literature and data from outside the Trust to try and create a complete picture and note emerging situations.

The Board discussed out of area beds and if any young people have had to be placed into adults beds, and if this was Covid-19 related or not. CH confirmed that at the end of March and throughout April, out of area bed placements have reduced significantly and bed capacity has increased, there has been a reduction in the number of adult acute admissions. The Trust has beds available but there are three out of area placements for service users in psychiatric intensive care (PICU).

MB highlighted that in April, there was an information governance incident that required reporting to the Information Commissioner Office. This was noted by the Board.

TB noted that there would be a review of safeguarding in May as there are national concerns regarding the reduction in referrals to safeguarding children. Any current issues will be picked up with the safeguarding boards.

MB noted that the year end targets were achieved and the Trust received an additional £940k of unexpected national mental health funding. The Trust's financial risk rating has improved to 1 and the surplus has increased to £1m with this funding. MB added that this is a positive out turn and congratulated staff on this. This, couple with the West Yorkshire & Harrogate integrated care system financial performance, meant that the Trust qualified for its full allocation of £1.8m of Provider Sustainability Funding (PSF).

AGD noted that the next version of the IPR will include a more detailed workforce dashboard which is currently in development, with a focus on Covid-19 and reporting against new and aligned national priorities.

**Action: Alan Davis**

**It was RESOLVED to NOTE the Integrated Performance Report.**

The Board observed a minute's silence to remember the health and care staff who have lost their lives during the Covid-19 pandemic.

TB/20/21c Safer staffing report (agenda item 7.3)

TB noted that the report has been through and discussed at the CG&CS Committee. Some items have been added in relation to Covid-19, including staffing and business continuity plans. CD stated that she had no further comments as Chair of CG&CS.

AM noted that the report relates to inpatient services and not community services, TB confirmed this and added that this will be made clearer in future reports.

**Action: Tim Breedon**

**It was RESOLVED to NOTE the safer staffing report.**

TB/20/21d Guardian of safe working hours report (agenda item 7.4)

SThi noted that the report is the annual and Q4 report. Key points included that this is a positive report though some key challenges remain such as junior doctor vacancies. 20 shifts had recently not had the availability of junior doctors. Covid-19 has also presented a challenge however junior doctors have supported to fill gaps where possible which is working well.

LC queried the gaps in Calderdale and whether there were any other factors contributing to this. The pre-Covid-19 plan was working on an on call rota and sustainable recruitment. Further medical training initiative also being considered to help the situation in Calderdale.

**It was RESOLVED to NOTE the guardian of safe working hours report.**

## TB/20/22 Risk and assurance (agenda item 8)

TB/20/22a Board Assurance Framework (BAF) (agenda item 8.1)

MB introduced the updated Board Assurance Framework (BAF) for quarter 4. 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 outlined that at the April Board meeting, the Board would usually have discussed and agreed 2020/21 process, however this had been delayed by the Covid-19 pandemic. The 2019/20 BAF process is complete, and the 2020/21 process will be discussed at the May strategic Board session. It was also noted that some of the actions from 2019/20 have been deferred into 2020/21 due to Covid-19.

**Action: Mark Brooks**

**It was RESOLVED to NOTE the updated Board Assurance Framework.**

TB/20/22b 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 advised that EMT had discussed and developed risks related to Covid-19 and also considered the impact on pre-existing risks. The risk register has been updated to reflect this.

LC noted the dynamic nature of the risk register, particularly in relation to the Covid-19 risks and queried the risk scoring and risk appetite. MB advised that there had been limited time to have a full reflection on the risks and that further reflection has taken place since the report was written, and will continue to do so on a weekly basis at EMT.

LC added that some of the Covid-19 risks had been allocated to Committees to review, however others had been allocated to Board, and queried if this is how the risks should be managed. MB highlighted that some of the risks had initially been allocated to Board to review due to the dynamic nature of the risks and the frequent changes and updates, the Board meets more frequently than Committees and it was felt that this would be of interest to Board members. Options to allocate to Committees will be considered as part of the ongoing review.

**Action: Mark Brooks**

RW noted that he was happy with the approach to the management of the risks so far, reminded Board members of the risk impact descriptions in the risk strategy, and queried if the Board felt there was anything missing. AGD suggested a further risk may be required in relation to the impact of Covid-19 on the BAME community. The Board discussed that this was currently reflected in risk ID 1531, however noted that an additional risk could be appropriate in the future with further intelligence relating to this.

**Action: Alan Davis**

CD queried the timing, actions and controls for issues relating to information governance, and questioned if there was a risk relating to staff using their own equipment. MB outlined that staff are not using their own equipment and those who are working from home have been provided with the appropriate equipment such as laptops and smartphones. MB added that any issues relating to Covid-19 are captured within risk ID 1080.

CD queried why the risk register did not reflect how issues would be managed in the future and stabilisation. MB noted that this was not discussed at the time of the report, and that a piece of work led by SYa will look at the stabilisation, recovery and restoration phase. This will consider learning from across the organisation and will be discussed at the May Board strategic session, and for inclusion on the risk register in the future at appropriate.

**Action: Mark Brooks / Salma Yasmeen**

RW added that there is a clear distinction between the stabilisation and recovery stages. The current position is relatively stable and the Trust has to consider the recovery to a 'new normal' with the different way of working.

CD suggested that a risk relating to legal claims that may come through to the NHS in the future following the pandemic should be considered for inclusion on the risk register. MB noted that this was not included at the time of the report, and advised that further consideration would be given once there was a better understanding of what the exposure is and where the Trust sees its level of risk.

**Action: Mark Brooks**

RW noted that there is a lot of work around BAME staff, service users and members of the public and the Trust is writing to staff to keep them informed. An equality and human rights assessment on decision making has been considered by gold command. The Board agreed that a paper should be considered by the Equality & Inclusion Committee and the Board to outline the Trust approach and the impact. It was also noted that the Communications team are working on involving governors and public in decision making.

**Action: Alan Davis**

AM queried if the risk appetite needs to be altered. MB advised that the risk appetite needs to be considered at board and changes to governance needs to be reflected on the risk register. TB noted that some of this is identified in risk ID 1523.

**Action: Mark Brooks**

KQ commented that some good work had been completed to compile the list of Covid-19 related risks quickly. KQ suggested that further work is required on the controls for risk ID 1522 to identify what is happening to keep staff, patients and service users safe.

**Action: Tim Breedon**

The Board discussed the scoring of risk ID 1526 and if the consequence should be higher than moderate. RW noted that the risk strategy is clear on descriptions of impact and that is what EMT has used when developing these risks.

CJ queried if the risk of service users not coming forward for help, or being referred for help, is adequately covered. CH noted that this relates to risk ID 1523 and EMT discussed the

possibility of missing something in core services. There are increased contacts because people were feeling more anxious, and now teams need to look at how we scope this and ensure service users are not missed. It was also noted that there are currently no actions for risk ID 1523.

**Action: Carol Harris**

RW outlined that the composite impact of all risk in the Trust should be reflected in OPEL levels and what level the Trust should be at. RW added that the risks give a clear indication that OPEL 2 is relevant at this time. This is reviewed regularly in EMT.

LC queried if there would be any difficulty absorbing so many new risks. MB added that the next Board meeting is three weeks away, and there will be few Committee meetings in that time, so it is important to consider what is proportionate to do between now and then. RW added that there are daily updates for all Board members regarding what is happening in the organisation, the NEDs have a weekly call and EMT meets fortnightly. The NED meeting also receives the governance decision log, which records decisions made in the command structure which are outside normal governance arrangements.

**It was RESOLVED to NOTE the updated Organisational Risk Register, supporting current risk levels.**

## TB/20/23 Business developments & collaborative partnership working (agenda item 9)

TB/20/23a South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 9.1)

AGD updated that work has been refocused for the Health Executives Group and board level arrangements focus on Covid-19. A workshop that starts 29 April will focus around the Covid-19 response, and how organisations can work together on this. SYa added that conversations are beginning to take place relating to restoration and recovery, and how we move to that phase. Routine business meetings postponed.

**It was RESOLVED to NOTE the updates on South Yorkshire and the South Yorkshire & Bassetlaw Integrated Care System.**

TB/20/23b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 9.2)

SYa noted that the presentation included as a paper sets out how the partnership is responding to Covid-19.

Four priorities have become six as we enter the next phase of the pandemic, emphasising the focus on workforce, and the wider work of the partnership, particularly around BAME staff and communities and the establishment of a BAME network.

Recovery and restoration work is considering what does this mean and what the 'new normal' may look like. Key considerations will be part of conversations at May Board strategic session. There is a partnership campaign nationally and regionally relating to targeted communication advising people to use key core services as and when needed. Our communication will be focused around those areas where there may be a drop off in use of services.

RW added that the Nightingale hospital opening in Harrogate reflects the extra critical care required, and there is mental health expertise required in relation to this, and discharge of patients to the community will also have an impact. The PPE concern with acute sector and

care homes remains regarding the availability of PPE, with some sourcing alternative supplies from overseas. This is less of an issue for the Trust as we have sufficient supplies. Local businesses have been getting involved in developing PPE and there is a West Yorkshire and Harrogate procurement hub which brings together national sources of PPE, which should allow us to have a much better understanding of what is available and what we can do ourselves. RW updated that local hospitals are providing tests and that we have drive through testing facilities too. The lead Chief Executive is Martin Barkley from Mid Yorkshire Hospitals Trust, who is drawing together the different resources, which is working well in difficult circumstances due to the partnership arrangements.

**It was RESOLVED to NOTE the updates on West Yorkshire and the West Yorkshire & Harrogate Health & Care Partnership.**

TB/20/23c Receipt of Partnership Board minutes (agenda item 9.3)
**It was RESOLVED to RECEIVE the minutes from partnership boards.**

**TB/20/24 Governance matters (agenda item 10)**

TB/20/24a Draft Annual Governance statement (agenda item 10.1), Going concern report for annual accounts (agenda item 10.2) and Compliance with NHS provider licence conditions and code of governance self-certifications (agenda item 10.4)

MB covered the three agenda items (10.1, 10.2 and 10.4) together as they are all requirements as part of the year end process. Discussions have taken place through the Audit Committee regarding year end reporting, and it was agreed that the Trust would stick to the previously agreed timescales whilst staff capacity remained in place.

The draft Annual Governance Statement has been considered by the Audit Committee. EM queried if the impact of streamlining governance on the 2019/20 processes due to Covid-19 needed to be included in the report. MB noted that this would only apply to the last 10 days of the time period covered in the report, and the report reflects compliance across the whole of the year. Some reference has been made to this in the draft and MB will review with RW if any further narrative is required. AM noted that the report needs to reference the Workforce Disability Equality Standard (WDES) as well as the Workforce Race Equality Standard (WRES). It was also suggested that the implementation of SystmOne should be considered as one of the key risks from 2019/20.

**Action: Mark Brooks**

Going concern report for the annual accounts – MB highlighted that the draft planning process was not finalised due to Covid-19 but that for the first four months of 2020/21, costs are covered by interim finance arrangements. MB confirmed that, based on our financial performance, draft plan, the interim financial arrangements and out current cash position, he had no reason to believe the Trust would not be sustainable for the next 12 months.

Provider licence conditions – MB advised that this used to be a reporting requirement, however as the Trust has not been updated as to whether this is a continued requirement, this has been completed to ensure compliance.

**It was RESOLVED to APPROVE the Annual Governance statement, the going concern report for the annual accounts, and the compliance with NHS provider licence conditions and code of governance self-certifications.**

TB/20/24b Audit Committee Annual Report 2019/20 including updated terms of reference for Trust Board Committees (agenda item 10.3)

MB noted that this is an annual requirement to ensure the effectiveness of committees. For each Committee, an annual report and review of terms of reference is completed following a self-assessment survey. MB noted that there are no key issues or concerns that have been highlighted from the review, and the reports are submitted for Board recognition and approval.

LC added that the evaluation asks Committees to observe three key points: to comment on the Committee overall, how it has improved in terms of performance and where it has added value. LC noted that there has been a general improvement in Committees meeting their terms of reference and the outcome of the review is positive.

AM noted that there has been a delay in completing the first annual review for the West Yorkshire Committee-in-Common due to Covid-19. AM added that this would follow the same structure as other Committees, and that the review will be considered by the Audit Committee once finalised for completeness.

**Action: Angela Monaghan**

**It was RESOLVED to RECEIVE the Audit Committee Annual Report 2019/20 and to APPROVE the updated terms of reference for each of the Trust Board Committees.**

TB/20/24c Assurance from Nominations Committee 14 April 2020 (agenda item 10.5)

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

TB/20/24d Development of a Clinical Ethics Advisory Group (CEAG) (agenda item 10.6)

SThi introduced the item and thanked Dr Adrian Berry for his work in developing the clear and comprehensive paper for Board on a short timescale. There are two stages to development of the group, there will be an interim arrangement to help to establish a long term group. This will allow for a more consistent approach and to provide assurance on appliance of ethical principles. The group will report in to the CG&CS Committee and into the annual report.

RW added that this is an important development to support difficult clinical choices that could occur, particularly during the pandemic.

**It was RESOLVED to APPROVE the establishment of the Interim Clinical Ethics Advisory Group (CEAG), SUPPORT the process for the development of the CEAG and AGREE to the governance arrangements for the groups.**

## TB/20/25 Assurance and receipt of minutes from Trust Board Committees (agenda item 11)

AM asked the chair of each Committee to provide an update where appropriate:

**Audit Committee** – LC noted that wrong set of minutes is referred to in the cover paper, and that this should be January 2020.

**Clinical Governance and Clinical Safety Committee –** CD advised that the Committee will continue to discuss the Care Quality Commission (CQC) action plan as this is important in relation to quality improvements, but noted that reporting requirements have reduced and timelines have been extended.

**West Yorkshire Mental Health, Learning Disability & Autism Collaborative Committees in Common** – AM noted that the meeting took place on 23 April, after the circulation of Board papers, and the following key points were discussed:

- The programme has reviewed its role and which elements continue, are repurposed or paused during the Covid-19 pandemic.
- Specific West Yorkshire and Harrogate offers are in development, including bereavement, keeping people connected, supporting cohorting arrangements, learning lessons and planning for a post Covid-19 response.
- Dialogue with Tyne, Esk and Wear Valley NHS Foundation Trust continues regarding the possibility of developing a subsidiary organisation to provide care packages for complex individuals with learning disabilities and autism.
- All organisations have well implemented business continuity plans; the role of the collaborative has been in testing these from a footprint perspective and sharing good practice.

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

## TB/20/26 Trust Board work programme (agenda item 12)

The Board noted the changes to the work programme. AM noted that this will be kept under review.

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

## TB/20/27 Date of next meeting (agenda item 13)

The next Trust Board meeting held in public will be held on Tuesday 30 June 2020.

## TB/20/28 Questions from the public (agenda item 14)

No questions were received.

**Signed:** **Date:**

South West Yorkshire Partnership NHS Foundation Trust

# TRUST BOARD 28 APRIL 2020 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

## Actions from 28 April 2020

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| **TB/20/16** | KQ requested an amendment to the wording of her declaration to clarify undertaking CTRs. KQ to submit amended wording to AW. | KQ / AW | April 2020 | Complete. |
| **TB/20/17** | PS/20/11b –CH advised that this [social distancing at Urban House] has stabilised and that an update will be provided at the next Clinical Governance & Clinical Safety (CG&CS) Committee. | CH | June 2020 | |
| | PS/20/13d – Salma Yasmeen (SYa) updated regarding the timescale for the Involving People Strategy and advised that this will be June 2020. | SYa | June 2020 | |
| **TB/20/21b** | Workforce support hub health and wellbeing services are in place to support staff and managers. A talent pool has been developed to allow the movement of staff to support where required in the organisation, alongside ongoing recruitment processes. Further areas being considered are staff resilience and the impact of Covid-19 on Black, Asian and Minority Ethnic (BAME) staff. | AGD | June 2020 | |

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| | Business continuity plans have kicked in and been effective…The Trust needs to consider the ongoing resilience of staff and have we can ensure this will be maintained… The Board will discuss stabilisation and recovery at the strategic session on 21 May. | SYa | May 2020 | Complete – scheduled on the agenda for strategic board 21 May 2020. |
| | The next version of the IPR will include a more detailed workforce dashboard which is currently in developments, with a focus on Covid-19 and reporting against new and aligned national priorities. | AGD | June 2020 | |
| **TB/20/21c** | AM noted that the report [safer staffing] relates to inpatient services and not community services, TB confirmed this and added that this will be made clearer in future reports. | TB | July 2020 | |
| **TB/20/22a** | MB outlined that at the April Board meeting, the Board would usually have discussed and agreed 2020/21 process, however this had been delayed by the Covid-19 pandemic. The 2019/20 BAF process is complete, and the 2020/21 process will be discussed at the May strategic Board session. It was also noted that some of the actions from 2019/20 have been deferred into 2020/21 due to Covid-19. | MB | May 2020 | Complete – scheduled on the agenda for strategic board 21 May 2020. |

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| **TB/20/22b** | Some of the Covid-19 risks had been allocated to Committees to review, however others had been allocated to Board, and queried if this is how the risks should be managed… some of the risks had initially been allocated to Board to review due to the dynamic nature of the risks and the frequent changes and updates, the Board meets more frequently than Committees and it was felt that this would be of interest to Board members. Options to allocate to Committees will be considered as part of the ongoing review. | MB | July 2020 | An attachment has been included which suggests which committee has oversight of each risk. This will allow each committee to have a review of Covid-19 risks when it does meet. |
| | AGD suggested a further risk may be required in relation to the impact of Covid-19 on the BAME community. The Board discussed that this was currently reflected in risk ID 1531, however noted that an additional risk could be appropriate in the future with further intelligence relating to this. | AGD | May 2020 | Complete, and discussion held at the private board in May. |
| | Query why the risk register did not reflect how issues would be managed in the future and stabilisation… noted that this was not discussed at the time of the report, and that a piece of work led by SYa will look at the stabilisation, recovery and restoration phase. This will consider learning from across the organisation and will be discussed at the May Board strategic session, and for inclusion on the risk register in the future at appropriate. | MB / SYa | May 2020 | This is complete SYa gave a detailed presentation to the board on 21st May. Covid risks are being collated and assessed as to whether they need to be on the risk register. |

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| | Suggested that a risk relating to claims that may come through to the NHS in the future following the pandemic should be considered for inclusion on the risk register… this was not included at the time of the report, and advised that further consideration would be given once there was a better understanding of what the exposure is and where the Trust sees its level of risk. | MB | May 2020 | Complete. |
| | There is a lot of work around BAME staff, service users and members of the public and the Trust is writing to staff to keep them informed. An equality and human rights assessment on decision making has been considered by gold command. The Board agreed that a paper should be considered by the Equality & Inclusion Committee and the Board to outline the Trust approach and the impact. It was also noted that the Communications team are working on involving governors and public in decision making. | AGD | June 2020 | Complete went to May board. |
| | Query if the risk appetite needs to be altered. MB advised that the risk appetite needs to be considered at board and changes to governance needs to be reflected on the risk register. | MB | July 2020 | Discussed in May Board. Complete |
| | Suggested that further work is required on the controls for risk ID 1522 to identify what is happening to keep staff, patients and service users safe. | TB | May 2020 | |

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| | Queried if the risk of service users not coming forward for help, or being referred for help, is adequately covered. CH noted that this relates to risk ID 1523 and EMT discussed the possibility of missing something in core services. There are increased contacts because people were feeling more anxious, and now teams need to look at how we scope this and ensure service users are not missed. It was also noted that there are currently no actions for risk ID 1523. | CH | May 2020 | Actions now in place. Completed. |
| **TB/20/24a** | The draft Annual Governance Statement has been considered by the Audit Committee... noted that the report needs to reference the Workforce Disability Equality Standard (WDES) as well as the Workforce Race Equality Standard (WRES). It was also suggested that the implementation of SystmOne should be considered as one of the key risks from 2019/20. | MB | May 2020 | Complete. |
| **TB/20/24b** | AM noted that there has been a delay in completing the first annual review for the West Yorkshire Committee-in-Common due to Covid-19. AM added that this would follow the same structure as other Committees, and that the review will be considered by the Audit Committee once finalised for completeness. | AM | TBC | |

**Actions from 31 March 2020**

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| **PS/20/11b** | CH noted that issues with social distancing at Urban House had been reported in the Independent (noted that this was not by the Trust) and a briefing will be circulated to Board highlighting the issues and steps we are taking to resolve this. | March 2020 | | Complete – social distancing has stabilised, further updates to CG&CS Committee. |

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| **PS/20/13d** | It was agreed that further engagement overall is required – Involving People Strategy. | AM / SYa | June 2020 | Superseded by actions above. |
| **PS/20/17** | AM and RW will review the board work plans for the next 3-6 months in the light of further Covid-19 guidance and today's discussions. | AM | April 2020 | Complete – board work plans have been updated, and will continue to be reviewed throughout the pandemic. |

## Actions from 28 January 2020

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| 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 | |

## Actions from 26 November 2019

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| 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 | TB | September 2020 | Plan to pilot nationally recognised staffing judgement across four community teams has been postponed due to Covid-19. Position will be reviewed by CG&CS September meeting. Noted in the report at agenda item 7.3. |

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| | 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/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 | Complete – superseded by action PS/20/13d, timescale June 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. Delayed due to Covid-19.<br><br>Discussed at May Strategic Board. BAF will be further reviewed in September Strategic Board.. |
| 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. Delayed due to Covid-19.<br><br>Discussed at May Strategic Board. BAF will be further reviewed in September Strategic Board. |
| 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 wondered if the target completion date was always achievable and whether we should again review. | TB | July 2020 | Proposal for revised target on hold due to Coivd-19, to consider post pandemic. |
| **Actions from 24 September 2019** | | | | |

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| TB/19/83a<br>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 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. | EMT | April 2020 | Initial reporting on Mental Health Act indicators commenced in the September report. Given the impact of long-term 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<br>This has been further delayed by Covid 19. |

| Risk No | Description | Committee |
|---|---|---|
| 1521 | Risk that staff do not have appropriate IT equipment and access to facilitate home-working during the Covid-19 pandemic meaning staff unable to work effectively or provide appropriate clinical contact and key activities not delivered. | Finance, Investment & Performance Committee |
| 1522 | Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19. | Clinical Governance & Clinical Safety Committee |
| 1523 | Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak. | Clinical Governance & Clinical Safety Committee |
| 1524 | Risk that staff do not have access to necessary personal protective equipment (PPE) during the Covid-19 outbreak leading to issues with personal safety and weak staff morale. | Clinical Governance & Clinical Safety Committee |
| 1525 | Risk the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services. | Workforce & Remuneration Committee |
| 1526 | Risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service users, their families and themselves. | Workforce & Remuneration Committee |
| 1527 | Risk that the Covid-19 testing regime is delayed or inadequate leading to sub-optimal utilisation of staff and sub-optimal care. | Clinical Governance & Clinical Safety Committee |
| 1528 | Risk that new models of care arising from Covid19 are not adequately tested, leading to a deterioration in the quality of care. | Clinical Governance & Clinical Safety Committee |
| 1530 | Risk that Covid-19 leads to a significant increase in demand for our services as anxiety and mental health issues increases in our populations. | Finance, Investment & Performance Committee |
| 1531 | Risk that Covid-19 response disproportionately affects people with protected characteristics leading to poorer quality of care. | Equality & Inclusion Committee |
| 1537 | Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation. | Clinical Governance & Clinical Safety Committee |
| 1533 | Risk that as a number of key workforce activities have stopped they could cause future problems around burnout and resilience, professional and personal development, staff and service safety. | Workforce & Remuneration Committee |
| 1536 | BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus. | Equality & Inclusion Committee |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 30 June 2020
# Agenda Item 7.2

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| **Title:** | **Incident management annual report 2019/20** |
| **Paper prepared by:** | Director of Nursing and Quality |
| **Purpose:** | The purpose of the paper is to provide assurance to Trust Board that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust. |
| **Mission/values:** | The report demonstrates the Trust's commitment to delivering safe and effective services. |
| **Any background papers/ previously considered by:** | Trust Board has received quarterly Incident Management reports, which have also been considered by the Clinical Governance and Clinical Safety Committee. |
| **Executive summary:** | This report has been produced in a shortened version in the context of our revised governance arrangements during the Covid-19 response. The patient safety support team will be preparing two further reports. The first, 'Our Learning Journey' report which will present the ongoing work across the trust in terms of sharing and implementing the learning from serious incident investigations. The second report to be prepared is the 'Apparent Suicide Report'. This will be available in September 2020.<br>The annual report key headlines follow;<br>• The Trust showed a 4% increase in incidents reported on the previous year.<br>• 87% of all incidents reported resulted in no harm or low harm. A high level of incident reports, particularly of less severe incidents is an indication of a strong safety culture (NPSA Seven Steps to Safety).<br>• The number of incidents reported across the Trust (13206) has increased and the number of serious incidents (47) has slightly increased on last year. However the reporting threshold in Forensic services has changed during the year, increasing the number of Forensic SIs. A number of amber incidents were classed as serious incidents and investigated by the service. The overall proportion of serious incidents is about the same (0.35) compared to previous years.<br>• During 19/20 there have been no 'never events'.<br>• There has been one homicide.<br>• We have reviewed 286 deaths that were in our learning from healthcare deaths scope. This is comparable with 2018/19 (270). The reviews ranged from accepting the death certification, case record reviews through to investigations, in line with the National Quality Board levels.<br>**The report was scrutinised at the clinical governance and clinical safety committee 9/06/2020 where the following comments were made**;<br>• The National Reporting and Learning System report, published in March 2020, shows no evidence of potential under reporting and that our reporting rate per 1000 bed days remains consistent. Our reporting timeliness has improved.<br>• Our current internal 360 audit report (awaiting formal internal sign off) shows significant assurance and includes positive comments on our learning from incidents approach |

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| | • Highest incident category is apparent suicide which affirms our focus on suicide prevention – this is the subject of a report due in September<br>• The production of the report by the patient safety team, given current circumstances, was noted.<br>• The report provides important assurance which will be considered again alongside the apparent suicide annual report at the next meeting.<br>• The committee noted that the current covid-19 incident monitoring and review of learning disability deaths (discussed during the covid-19 response section of the agenda) will be included in future quarterly reports.<br><br>**Risk appetite**<br>• 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.<br>• 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.<br>• 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.<br>• Financial or commercial risks -Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious/Moderate 4-6<br><br>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, we continue to meet the national guidance, and make revisions as needed. We publish our quarterly data on deaths on the internet page. |
| **Recommendation:** | **The Trust Board is asked to RECEIVE and comment on the annual report on incident management and to NOTE the next steps identified.** |
| **Private session:** | Not applicable. |

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# Incident Management Annual Report

## April 2019 to March 2020

**Patient Safety Support Team**

**2 June 2020**

With **all of us** in mind.

## Executive Summary

This report provides an overview of **all** the incidents reported in the Trust during 2019/20. It also includes further analysis of Serious Incidents, and analysis of action themes arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2019 to 31 March 2020 (data as at 03/04/2020).

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

- **13206** incidents reported
- **4%** increase in reporting on 2018/19
- **87%** of incidents resulted in no/low harm
- **47** Serious incidents reported
- No Never Events
- One homicide reported
- Serious Incidents account for **0.35%** of reported incidents
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture[1]

The Trust reported **13206** incidents during the year; a slight increase on the previous year. A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (NPSA: Seven Steps to Patient Safety[1]). The distribution of these incidents is in line with an established reporting process showing a triangle with **87%** of incidents resulting in no/low harm.

There were **47** serious incidents reported during the year accounting for 0.35% of all incidents. The highest overall category of serious incident is apparent suicide of service users in current contact with community teams (24) consistent with the figure in 2018/19 (23).

**No 'Never Event'** incidents were reported by SWYPFT in 2019/2020. The last Never Event reported by the Trust was in 2010/11. Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Further detailed analysis of all apparent suicides occurring in 2019/20 will be available in September 2020 in the apparent suicide report.

[1] NPSA. (2004). Seven Steps to Patient Safety

## Contents

## Introduction

This incident management annual report focusses on incidents and serious incidents reported within the Trust during 2019/20.

This report provides an overview of all incidents reported and does not include detail of specific incident types. Specialist advisors produce separate annual reporting for this purpose. The report does not cover incidents that are managed through other processes such as safeguarding (including Serious Case Reviews (now known as Safeguarding Child Practice Reviews), Domestic Homicide Reviews) or whistleblowing (staff survey). The information is this report is high level, and further breakdown is possible on Datix. Further information can be provided on request.

The patient safety support team will be preparing two further reports. Firstly, we will prepare 'Our Learning Journey' report which will present the work of the BDUs in terms of implementing learning and learning from serious incident investigations. At the present time (May 2020) this is delayed due to the impact of Covid -19. The second report to be prepared is the 'Apparent Suicide Report'. This will be available in September 2020.

The report does not include broader patient safety work which will be updated on separately when possible.

The report is structured into the following sections:

**Section 1** includes a summary of all reported incidents occurring from 1 April 2019 to 31 March 2020. It should be noted that this report provides only an overview; detailed reports are produced on a quarterly basis for Business Delivery Units and many specialist advisors run/analyse incident reports.

**Section 2** focusses on incidents reported as Serious Incidents during 2019/20. The first part looks at what these incidents were, and secondly provides more details on the different types of serious incidents that were reported.

**Section 3** sets out an analysis of the serious incident investigations that have been completed and sent to commissioners during 2019/20. It includes an analysis of the themes arising from serious incident recommendations.

**Section 4** focusses on reported deaths in line with the Learning from health care deaths policy. It includes figures on deaths that were reported as serious incidents.

**Section 5** Overview of incident management plans for 2020/21.

## Section 1 - Incident Reporting Analysis

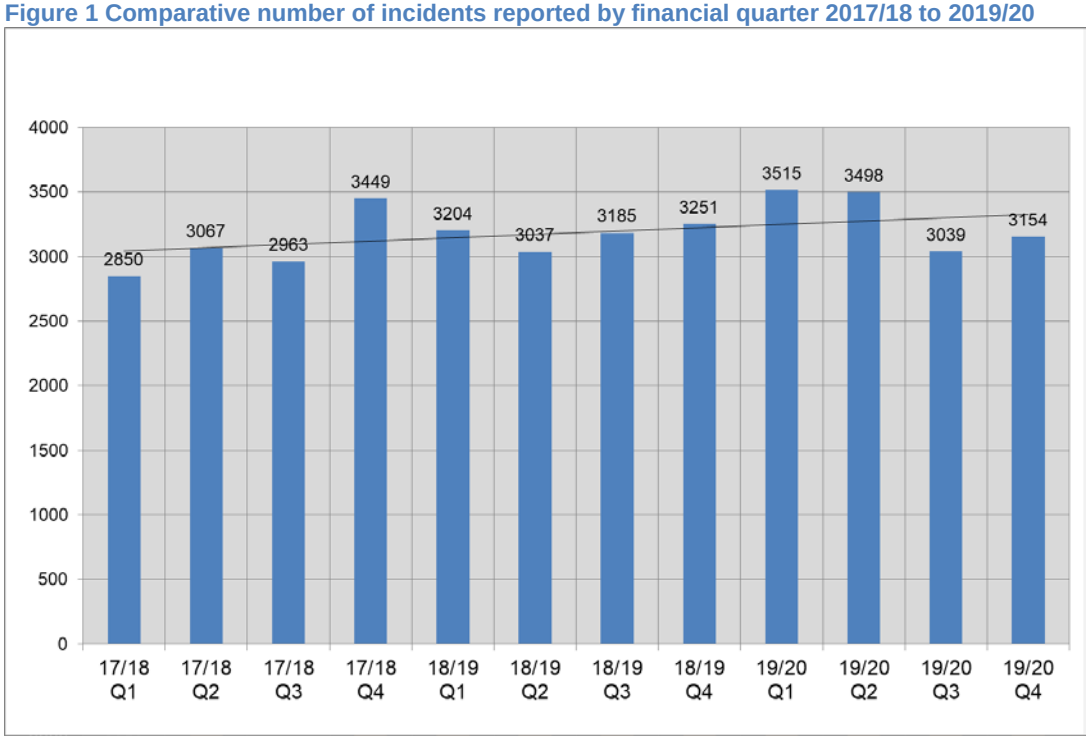
### Headlines

The Trust reported **13206** incidents of all severity during the year, a 2.7% increase on 2018/19 (**12640**). The average number of incidents reported per financial year over a 3 year period is 12737 incidents.

- **13206** incidents reported
- **4%** increase in reported incidents compared with 2018/19
- **87%** of incidents resulted in **no/low harm**
- **47** Serious incidents reported (0.35% of all incidents)
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

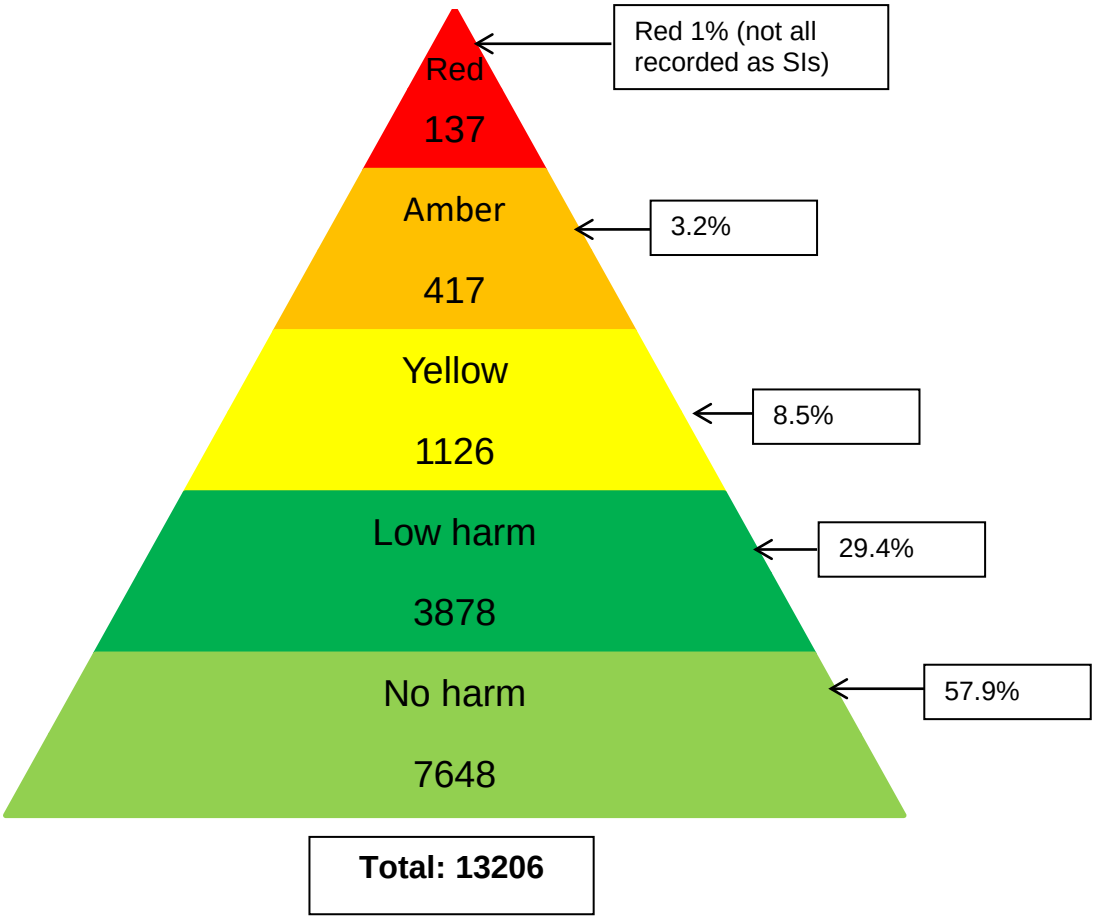
Figure 1 below shows the pattern and number of incidents reported by quarter in the Trust over the last 3 financial years, and indicates the average is stable, with natural fluctuations each quarter. It should be noted that direct comparisons should be viewed with caution due to the changing profile of service provision.

**Figure 1 Comparative number of incidents reported by financial quarter 2017/18 to 2019/20**



The distribution of these incidents in terms of severity is pyramid-shaped, with red incidents being fewest in number; and most incidents being graded green (87%) resulting in no/low harm, as illustrated in Figure 2. The proportion of no/low harm incidents has remained consistent with previous years. An organisation with a high reporting rate, particularly with a high proportion of no/low harm is indicative of a positive safety culture where staff are encouraged to report incidents and near misses.

**Figure 2 Incidents reported by severity 2019/20**



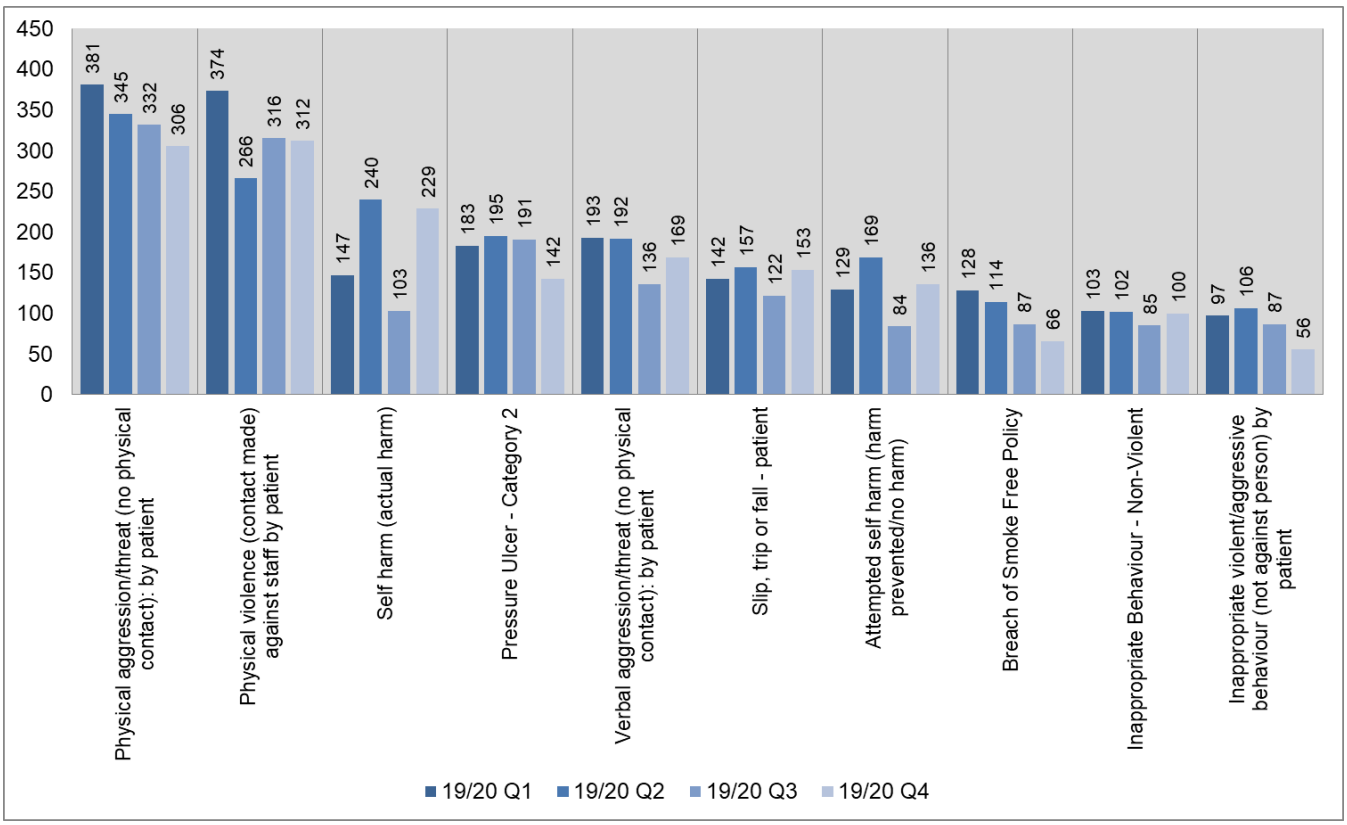

*Note: The red incidents in this chart are based on the date when the incident occurred, which is often different to the date it was reported on the Strategic Executive Information System (StEIS) as a Serious Incident (SI) figures use the date reported on StEIS. Not all Red incidents are reported as SIs.*

## Type and Category of incidents

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'.

Figure 3 shows the top 10 highest reported categories of incidents across the Trust during 2019/20. During 2019/20 incidents were reported against 153 different categories of incident. The top 10 categories account for 53% of all incidents reported, which is consistent the proportion in 2018/19.

**Figure 3 Trust-wide Top 10 most frequently reported incident categories in year 2019/20**




'Physical aggression/threat (no physical contact): by patient' was the highest reported incident category in 2019/20 with a total of 1364 incidents, accounting for 10% of all incidents reported. This is an increase on 2018/19 (1212) but this has remained the top reported category in both years. This includes incidents such as threatening behaviour against others or where physical violence was prevented.

There are three other categories of violence and aggression related incidents appearing in the top 10; 'Physical violence against staff by patient (where contact was made)', 'Verbal aggression/threat (no physical contact): by patient', and 'Inappropriate violent/aggressive behavior (not against person) by patient'. All four categories have appeared in the top 10 in the last 3 years.

In relation to incidents of violence and aggression, like 2018/19, we have continued to see an increase in acuity across certain areas. Some of these incidents also feed into the other sections of the report as contributing factors, e.g. Breach of smoke free policy and self-harm. This is due to a large increase in actual and attempted self-harm within areas and the need for staff's intervention. The Reducing Restrictive Intervention Team continued to push the need for consistent and precise reporting of all incident of both physical and verbal aggression. The consistently improving reporting of verbal aggression is to be commended as this can be used by staff to identify changes or increasing levels of aggression with a service user's presentation, and also show that there are many incidents (near misses) where staff have been confronted by an angry aggressive individual and through the de-escalation skills employed, have limited the incident to verbal aggression. During 2019/20, the Reducing Restrictive Physical Intervention (RRPI) team worked with the Datix team to further improve recording of incidents in-line with the National Data set.

The third highest category of incident is 'Self harm (Actual)' with 'attempted self harm' also appearing in the top 10. In 2019/20 there were 719 actual self harm incidents. The figures for self-harm fluctuate through the year and numbers are closely affected by individual service user presentation.

‘Pressure ulcer – category 2’ appears in the top 10. It should be noted that these are incidents that are generally identified by staff in the general community services and many are attributable to other agencies. The Datix system is used to capture the identification and actions taken by our staff.

Patient falls appears in the top 10, as it has done in previous years. The reporting remains at a fairly consistent through the year, and is similar to previous years.

Breach of Smoke Free policy incidents have continued to reduce during 2019/20 compared with 2018/19.

## External Review

### 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 (see Figure 2). This includes actual and potential harm of all incidents and near misses (i.e. psychological harm, potential risks).

The Trust uploads patient safety incidents[2] (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 was 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 [3] 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). The launch date is awaited.

### National Reporting and Learning System reports

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 ensures that the data uploaded externally is as accurate as it can be. Data can also be refreshed if details change. 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 publishes data from the NRLS system on a six monthly basis. These reports 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 reports have changed over time, but now encourage 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 published reports are added to the NRLS intranet page when released.

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[2] 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.

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

The latest NRLS Summary Report published in March 2020, covers the period 01 April 19 to 30 September 19 compares the Trust's data for the same period in 2018. The areas compared are:

**Reporting culture and reporting patterns**

- No evidence of potential under-reporting
- Our reporting rate per 1,000 bed days remains consistent

**Has the timeliness of your incident reporting improved?**

- Our reporting timeliness improved in April 2019 to September
- 2019 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 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 direct correlate with those collected locally. Work takes place every 3 years to confirm our mapped data with NHS Improvement. It is anticipated this will next be reviewed as part of the new national reporting system.

**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.

In 2019/20, the Trust uploaded a total of 6278 patient safety incidents to the NRLS (at 22/4/20), compared with 5487 reported in 2018/19 Quality Accounts. 95% of the 6278 incidents resulted in no harm or low harm.

The Trust reported a total of 53 severe harm and patient safety related death incidents in 2019/20, compared to 58 incidents in 2018/19.

In relation to the total number of incidents uploaded, the percentage of severe harm incidents has decreased to 0.38% when compared with 0.47% in 2018/19. The percentage number of patient safety related deaths (uploaded to NRLS) has continued to decrease to 0.46% when compared to previous years and last year which was 0.58%.

## Internal Audit

During Winter 2019/20, 360 Assurance undertook an internal audit of our incident reporting and associated processes. The Trust received Significant Assurance. A number of actions have been identified and an action plan is in development. The actions are summarised below and focus on clarifying:

- Responsibilities for completion of the degree of harm field and timeliness of reviewing incidents
- Policy terminology and definitions to ensure they align with Datix (egg closed date, near miss definition, Green1 (no harm) severity)
- Investigation timescales for incidents of all grades, and where relevant, how we manage investigation extensions.
- Level of performance information in Clinical Risk Reports for Operational Management Group

## Royal College of Psychiatrists Serious Incident Review Accreditation Network (SIRAN)

The Trust was been involved in the pilot of Serious Incident Investigation standards during 2018/19 and 2019/20. These have now been agreed and a network officially launched in January 2020. The next phase will involve a self-review process and a peer review visit which is anticipated to be around September 2020. We will need to upload evidence that supports our Serious Incident processes.

## Duty of Candour

Duty of Candour applies to all patient safety incidents that result in moderate harm or above. The Trust has been following the principles of Being Open since 2008 and had a policy in place since that time. The NHS contract includes Duty of Candour for patient safety incidents with moderate harm and above and the Trust has been reporting on this since April 2014. In November 2014 this was strengthened when this became a statutory CQC regulation[4] to fulfil the Duty of Candour requirement.

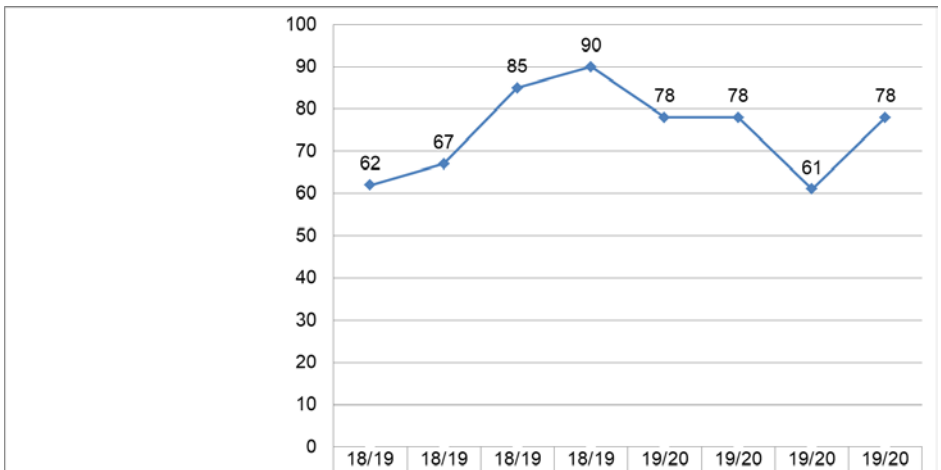
Failure to comply with the contractual requirements could result in recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown (NHS Contract) and/or it is a criminal offence to fail to provide notification of a notifiable safety incident and/or to comply with the specific requirements of notification. On conviction a health service body would be liable to a potential fine of £2,500.
The data contained in this section of the report was correct at the time of reporting (13/5/20). The data is extracted from a live system, and is subject to change. The degree of harm (moderate, severe or death) is initially recorded by the Patient Safety Support Team based upon the potential harm, and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed.

During 2019/20, there were 295 potentially applicable patient safety incidents (2.2% of all incidents reported). The number of patient safety incidents meeting the NRLS definition of moderate or severe harm or death steadily rose in 18/19, however has fallen slightly in 19/20 as shown in Figure 4. The percentage of Duty of Candour applicable incidents against the total number of incidents reported each quarter has remained fairly similar. Some data is still subject to change.

It should be noted that the figures included in this section of the report regarding Duty of Candour will not match the number of incidents reported to the National Reporting and Learning System (NRLS) as some incidents where Duty of Candour applies, are not reportable to NRLS, e.g. apparent suicide of a discharged community patient.

**Figure 4 Total number of patient safety incidents with moderate or severe harm or death between 2018/19 and 2019/20**

[4] Care Quality Commission. Duty of Candour guidance




| | 18/19 Q1 | 18/19 Q2 | 18/19 Q3 | 18/19 Q4 | 19/20 Q1 | 19/20 Q2 | 19/20 Q3 | 19/20 Q4 |
|---|---|---|---|---|---|---|---|---|
| Total number of incidents meeting NPSA definition of moderate, severe harm or patient safety related death | 62 | 67 | 85 | 90 | 78 | 78 | 61 | 78 |
| % of moderate, severe harm or patient safety related deaths compared with all incidents reported | 1.9% | 2.2% | 2.6% | 2.7% | 2.2% | 2.2% | 2.0% | 2.4% |

Figure 5 shows the degree of harm (moderate, severe or death) from patient safety incidents over a three year period. The average for each degree of harm has been added.

**Figure 5 Duty of Candour applicable incidents by degree of harm and month 1/4/2018 – 31/3/2020**

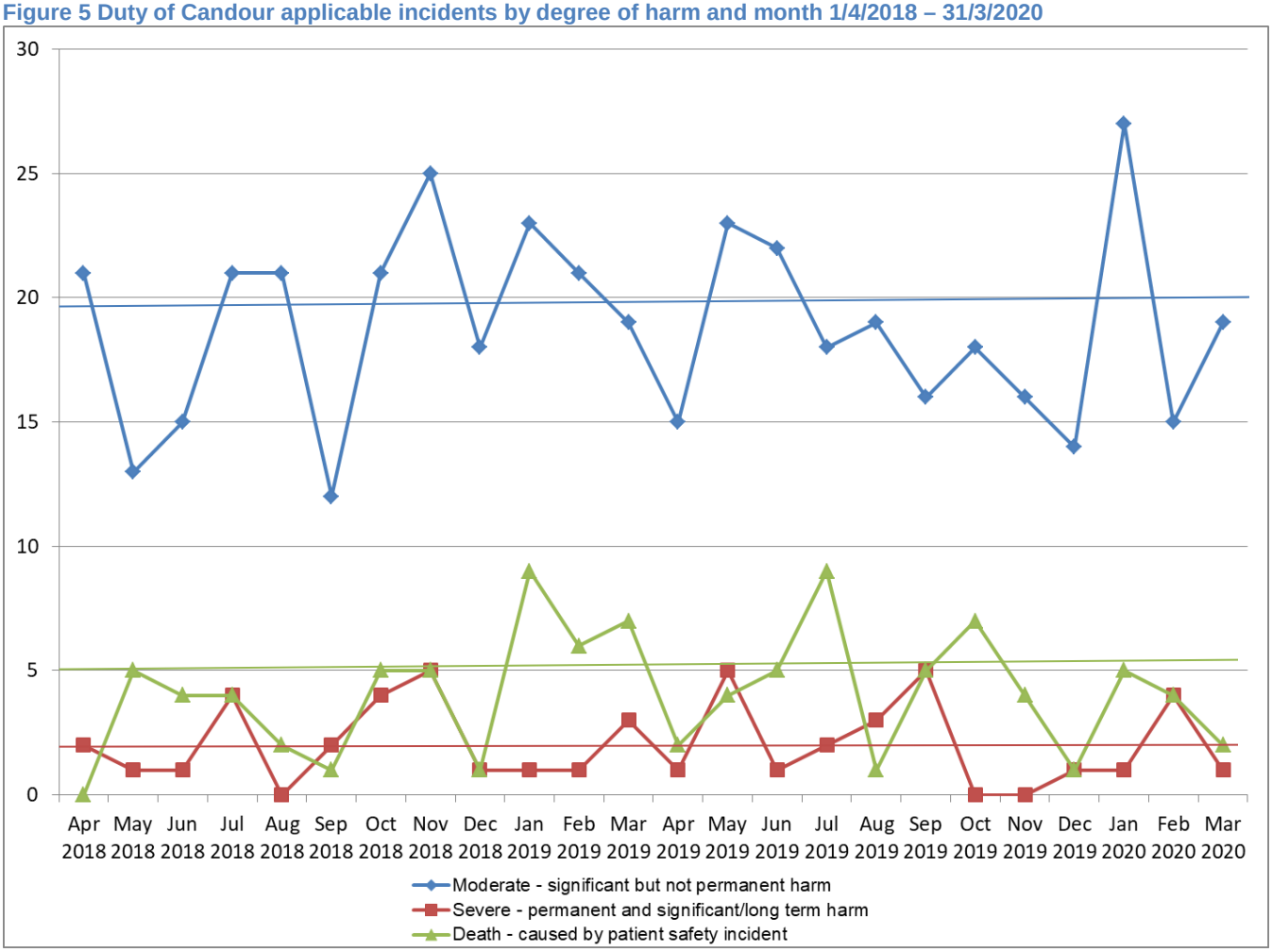



Figure 6 shows the highest number of applicable incidents is in Barnsley General Community Services with 152 incidents. This is an increase of 2 in comparison to 2018/19. A high proportion of these were pressure ulcers, category 3 (moderate harm), and category 4 (severe harm).

**Figure 6 Duty of Candour applicable incidents in 2019/20 by BDU and financial quarter**

| | Barnsley General Community | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | **Total** |
|---|---|---|---|---|---|---|---|---|
| 19/20 Q1 | 36 | 2 | 9 | 8 | 22 | 1 | 0 | **78** |
| 19/20 Q2 | 36 | 7 | 7 | 14 | 11 | 2 | 1 | **78** |
| 19/20 Q3 | 37 | 4 | 6 | 7 | 5 | 0 | 2 | **61** |
| 19/20 Q4 | 43 | 6 | 5 | 13 | 9 | 2 | 0 | **78** |
| **Total** | **152** | **19** | **27** | **42** | **47** | **5** | **3** | **295** |

## *Compliance with Duty of Candour*

Each BDU has an identified lead who is responsible for reviewing their BDU's compliance with Duty of Candour. The Patient Safety Support Team provides data on a monthly basis to the Operational Management Group to support BDUs with monitoring their compliance with Duty of Candour. Figure 7 shows the monitoring position which breaks down as below:

- In 77% of cases (228), a verbal conversation has happened with the patient and/or family within 10 days of the incident occurring or being identified (as per the contract).
- There were 20 cases where Duty of Candour was not completed but exception reasons were given (6%). The number of exceptions has stayed the same as in 2018/19 (6%).
- There were three cases where Duty of Candour was underway.
- There were 44 (14%) cases where the Duty of Candour monitoring was not completed by the BDU, these could include possible breaches.

**Figure 7 Duty of Candour compliance 2019/20**

| | Barnsley General Community | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | **Total** |
|---|---|---|---|---|---|---|---|---|
| Stage 1 Duty of Candour - underway | 1 | 0 | 0 | 1 | 0 | 0 | 0 | **2** |
| Stage 1 Duty of Candour - awaiting further clarification from manager | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** |
| Stage 1 Duty of Candour - verbal apology completed within 10 days | 132 | 10 | 15 | 30 | 41 | 0 | 0 | **228** |
| Stage 1 Duty of Candour verbal apology not given following MDT decision (exception) | 0 | 1 | 7 | 1 | 1 | 0 | 0 | **10** |
| Stage 1 Duty of Candour - not completed (exception) | 0 | 0 | 2 | 4 | 4 | 0 | 0 | **10** |
| Awaiting BDU monitoring | 19 | 8 | 3 | 6 | 1 | 5 | 2 | **44** |
| **Total** | 152 | 19 | 27 | 42 | 47 | 5 | 3 | **295** |

Exception reasons include verbal apology not being given following MDT decision due to clinical presentation or being detrimental to patient's wellbeing. In other cases Duty of Candour was not

possible with the patient as they were too unwell. In some cases, particular where patients had died, there were no family contact details known to enable us to make contact with family members.

# Section 2 - Serious Incidents reported during 2019/20

## 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 corers, 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." [5]

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*[6].

## 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 2019/20, 47 Serious Incidents were reported to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS). This compares with 45 in 2018/19.

[5] NHS England. Serious Incident Framework. March 2015
[6] NHS Improvement. Never Event policy and framework 2018

- 47 Serious incidents reported
- Serious incidents account for 0.35% of all incidents
- Highest incident category is 'apparent suicide of service users in current contact with community teams' (24)
- One homicide reported
- No Never Events

**No 'Never Event'** incidents were reported by SWYPFT in 2019/2020. The last Never Event reported by the Trust was in 2010/11. Never Events is a list (DOH) of serious, largely preventable patient safety incidents where national safety alerts/procedures are in place to prevent occurrence. These events should not occur if the available preventative measures have been implemented. Examples of Never Events relevant to SWYPFT include failure to install functional collapsible shower or curtain rails in mental health settings; and in all settings, overdose of insulin due to abbreviations or incorrect device; falls from poorly restricted windows; chest or neck entrapment in bed rails; scalding of patients; unintentional connection of a patient requiring oxygen to an air flowmeter. There is specific guidance for circumstances of each Never Event.

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 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.

There was one **homicide** reported in 2019/20.

## Serious Incident Analysis

Figures 8 and 9 below shows all serious incidents reported on StEIS between 1 April 2015 and 31 March 2020, with figure 8 showing breakdown by financial quarter.

**Figure 8 Breakdown of serious incidents reported each financial year by financial quarter 2015/16- 2019/20**

| | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| Quarter 1 | 18 | 13 | 15 | 8 | 12 |
| Quarter 2 | 23 | 13 | 18 | 9 | 12 |
| Quarter 3 | 15 | 15 | 26 | 10 | 8 |
| Quarter 4 | 20 | 23 | 12 | 17 | 15 |
| **Total** | **76** | **64** | **71** | **44** | **47** |

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

**Figure 9 Total number of Serious Incidents reported by financial year 2015/16 to 2019/20**

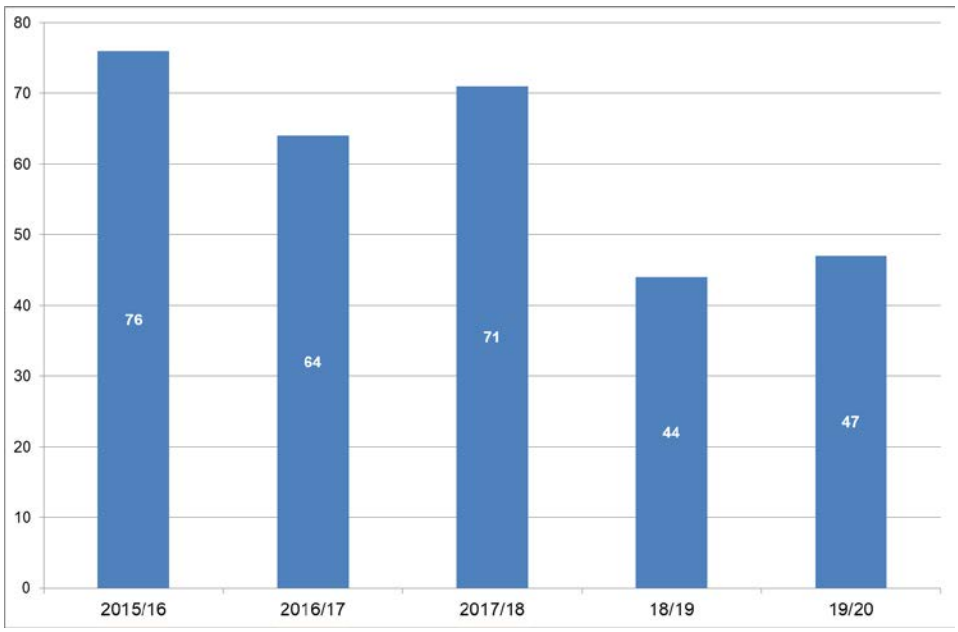
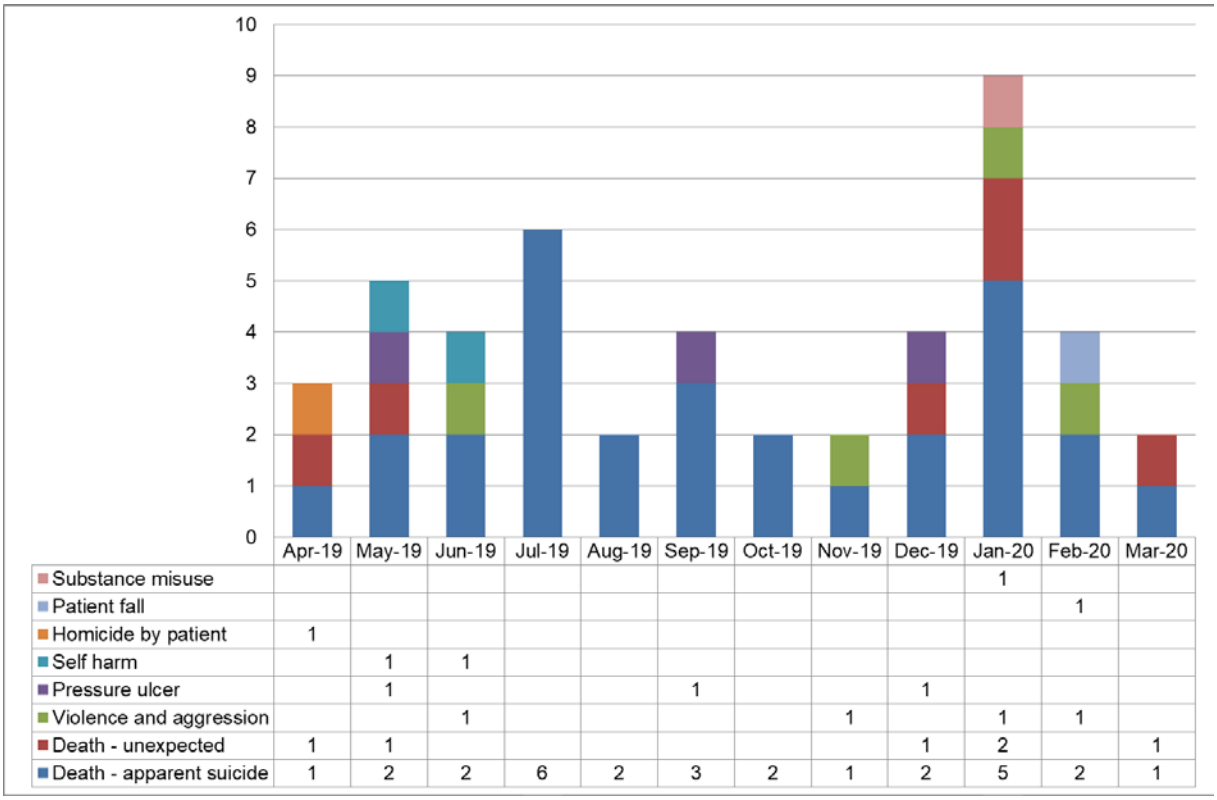



Figure 10 shows a breakdown of the 47 serious incidents reported during 2019/20 by the type of incident and month reported.

**Figure 10 Types of All Serious Incidents reported in 2019/20 by date reported on StEIS**



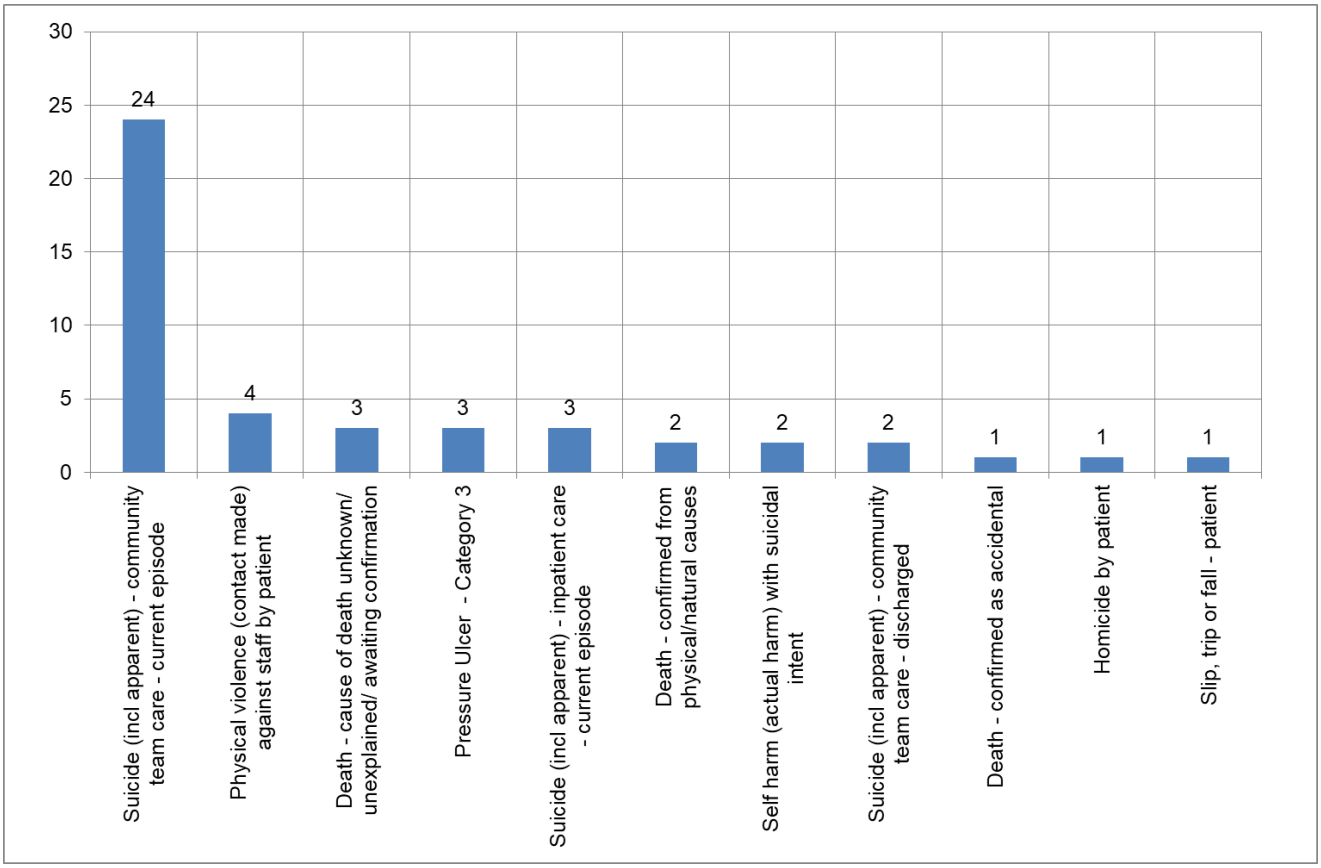

| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Substance misuse | | | | | | | | | | 1 | | |
| Patient fall | | | | | | | | | | | 1 | |
| Homicide by patient | 1 | | | | | | | | | | | |
| Self harm | | 1 | 1 | | | | | | | | | |
| Pressure ulcer | | 1 | | | | 1 | | | 1 | | | |
| Violence and aggression | | | 1 | | | | | 1 | | 1 | 1 | |
| Death - unexpected | 1 | 1 | | | | | | | 1 | 2 | | 1 |
| Death - apparent suicide | 1 | 2 | 2 | 6 | 2 | 3 | 2 | 1 | 2 | 5 | 2 | 1 |

As in previous years, the highest type of serious incident is death of a service user (35) including death by apparent suicide or unexpected death.

Figure 11 shows a breakdown of the reported serious incidents by category. The category of incident (a subset of 'type', as shown in Figure 10) provides more detail of what occurred. It shows that apparent suicide of service users in current contact with community teams is the highest reported category with 24 (compared with 2018/19 [23]; 2017/18 [34]). There are a further five

incidents relating to apparent suicide. These include three deaths where the patient was under the care of inpatient services at the time of death; two deaths where the service user was discharged from Intensive Home Base Treatment Team (IHBTT) at the time of their death.

**Figure 11 Serious Incidents reported during 2019/20 by reported category**




As Figure 12 shows, during 2019/20, the area with the highest number of SIs reported was Kirklees with 15 serious incidents, the same as 2018/19. Fourteen of the 15 cases were death of service users. Two were apparent suicides of inpatients on leave from wards (not the same ward) at the time of death; a third was an unexpected death of inpatient on leave from the ward. Wakefield has also shown an increase with 11 serious incidents in 2019/20 compared with eight in 2018/19. Ten of Wakefield SIs were deaths.

Forensics has had an increase in serious incidents with 7 reported across the service. This included three inpatient deaths, one of which was apparent suicide in hospital ward. In 2018/19 there were no serious incidents reported. This increase follows a change in Forensic commissioning reporting guidance and thresholds that was implemented in November 2019. This has resulted in some amber incidents now being classed as serious incidents.

Barnsley General Community has reported four SIs in 2019/20 which remains consistent with reporting figures in 2018/19.

A number of BDU's have seen a reduction in the number of serious incidents reported compared with 2018/19 figures. Calderdale's figure reduced from nine in 2018/19 to six in 2019/20. Barnsley Mental Health had four serious incidents in 2019/20 compared with 10 in 2018/19.

There were no serious incidents reported in CAMHS or Learning Disability services.

**Figure 12 2019/20 Reported Serious incidents by BDU and category**

| | Barnsley General Community | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Services | Total |
|---|---|---|---|---|---|---|---|
| Suicide (incl apparent) - community team care - current episode | 0 | 3 | 5 | 7 | 9 | 0 | 24 |
| Physical violence (contact made) against staff by patient | 0 | 0 | 0 | 0 | 1 | 3 | 4 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 0 | 0 | 0 | 3 | 0 | 0 | 3 |
| Pressure Ulcer - Category 3 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| Suicide (incl apparent) - inpatient care - current episode | 0 | 0 | 0 | 2 | 0 | 1 | 3 |
| Death - confirmed from physical/natural causes | 0 | 0 | 0 | 0 | 1 | 1 | 2 |
| Self harm (actual harm) with suicidal intent | 0 | 1 | 1 | 0 | 0 | 0 | 2 |
| Suicide (incl apparent) - community team care - discharged | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| Death - confirmed as accidental | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Homicide by patient | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Slip, trip or fall - patient | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Substance misuse | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Total | 4 | 4 | 6 | 15 | 11 | 7 | 47 |

Figure 13 shows all reported serious incidents by reporting team (primary involvement at time of the incident) and financial quarter. It should be noted that some incidents involve several other teams.

**Figure 13 Serious Incidents reported by Team and financial quarter**

| **Team** | Q1 2019/20 | Q2 2019/20 | Q3 2019/20 | Q4 2019/20 | Total |
|---|---|---|---|---|---|
| Enhanced Team South 2 - Kirklees | 1 | 1 | 0 | 3 | 5 |
| Assessment and Intensive Home Based Treatment Team / Crisis Team - Calderdale | 2 | 1 | 0 | 1 | 4 |
| Intensive Home Based Treatment Team (Kirklees) | 1 | 2 | 1 | 0 | 4 |
| Intensive Home Based Treatment Team (IHBTT) - Wakefield | 0 | 1 | 1 | 1 | 3 |
| Core Team West - Wakefield | 1 | 1 | 0 | 0 | 2 |
| Enhanced Team West - Kendray, Barnsley | 2 | 0 | 0 | 0 | 2 |
| Priestley Ward, Newton Lodge | 0 | 0 | 1 | 1 | 2 |
| Sandal Ward (Bretton Centre) | 0 | 0 | 0 | 2 | 2 |
| Appleton, Newton Lodge, Forensic BDU | 1 | 0 | 0 | 0 | 1 |
| Ashdale Ward (based at The Dales, Kirklees BDU) | 0 | 0 | 0 | 1 | 1 |
| Core Team - Calderdale | 0 | 1 | 0 | 0 | 1 |
| Core Team East - Wakefield | 0 | 1 | 0 | 0 | 1 |
| Core Team North - Kirklees | 0 | 0 | 1 | 0 | 1 |
| Criminal Justice Liaison Team, Barnsley | 0 | 0 | 1 | 0 | 1 |
| Early Intervention Service (Insight) - Kirklees | 1 | 0 | 0 | 0 | 1 |
| Enhanced Lower Valley Team - Calderdale | 0 | 0 | 1 | 0 | 1 |
| Enhanced Team East - Wakefield | 0 | 0 | 0 | 1 | 1 |
| Enhanced Team South 1 - Kirklees | 0 | 1 | 0 | 0 | 1 |
| Enhanced Team West - Wakefield | 0 | 1 | 0 | 0 | 1 |
| Hepworth Ward, Newton Lodge, Forensic | 0 | 0 | 0 | 1 | 1 |

| Team / continued | Q1 2019/20 | Q2 2019/20 | Q3 2019/20 | Q4 2019/20 | Total |
|---|---|---|---|---|---|
| Intensive Home Based Treatment Team (IHBTT) - Barnsley | 0 | 1 | 0 | 0 | 1 |
| Neighbourhood Team - North (Barnsley) | 0 | 1 | 0 | 0 | 1 |
| Neighbourhood Team - Penistone (Barnsley) | 1 | 0 | 0 | 0 | 1 |
| Neighbourhood Team - South (Barnsley) | 0 | 0 | 1 | 0 | 1 |
| Neuro Rehab Unit - Barnsley | 0 | 0 | 0 | 1 | 1 |
| Single Point of Access, (Wakefield) | 1 | 0 | 0 | 0 | 1 |
| Stanley Ward (Trinity 2) | 1 | 0 | 0 | 0 | 1 |
| Thornhill Ward (The Bretton Centre) | 0 | 0 | 1 | 0 | 1 |
| Ward 18, Priestley Unit | 0 | 0 | 0 | 1 | 1 |
| Ward 19 - Priestley Unit (OPS) | 0 | 0 | 0 | 1 | 1 |
| Total | 12 | 12 | 8 | 15 | 47 |

### *Demographic comparison of Serious Incidents reported*

The numbers in Figure 12 must be considered by BDU population sizes and service configuration.

**Population**
When serious incidents are viewed against population size (Figure 14) it shows a decrease in the number of serious incidents reported per 100,000 population in Barnsley and Calderdale. Kirklees has remained about the same rate, and Wakefield shows a small increase.

**Figure 14 BDU population estimates and serious incident figures (STEIS reported) per 100,000 population**

| Geographical district | Population estimates Mid 2019 (ONS) | Serious Incident figures per 100,000 population for 2018/19 (based on population figures from 2017) | Serious Incident figures per 100,000 population for 2019/20* |
|---|---|---|---|
| **Barnsley** | 245,199 | 4.55 | 3.26 |
| **Calderdale** | 210,082 | 4.29 | 2.86 |
| **Kirklees** | 438,727 | 3.43 | 3.41 |
| **Wakefield** | 345,038 | 2.64 | 3.18 |
| **Total** | 1,230,730 | 3.57 | 3.81 |

*7 Forensic SIs have been excluded from the geographical calculations but are included in the overall Trust wide total

## Breakdown of all Serious Incidents

### *Deaths (apparent suicides and unexpected deaths)*

Of the 47 serious incidents reported, 35 related to the death of a service user as mentioned earlier. Please note this is not all deaths that were reported on Datix and reviewed, only those reported on StEIS.

Figure 15 shows the apparent category of death. This is extracted from Datix and was correct at the time of writing, based on information known at the time. This is subject to change as more information comes to light or inquest conclusions are received. Apparent suicide is based on the circumstances of death.

**Figure 15 Breakdown of all deaths reported as SIs 2019/20 by category of death and BDU**

| | Barnsley General Community Services | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Total |
|---|---|---|---|---|---|---|---|
| Suicide (incl apparent) - community team care - current episode | 0 | 3 | 5 | 7 | 9 | 0 | 24 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 0 | 0 | 0 | 3 | 0 | 0 | 3 |
| Suicide (incl apparent) - inpatient care - current episode | 0 | 0 | 0 | 2 | 0 | 1 | 3 |
| Death - confirmed from physical/natural causes | 0 | 0 | 0 | 0 | 1 | 1 | 2 |
| Suicide (incl apparent) - community team care - discharged | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| Death - confirmed as accidental | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Total | 0 | 3 | 5 | 14 | 10 | 3 | 35 |

### Death - confirmed from physical/natural causes

Deaths of service users where the cause of death appears to be natural or physical cause would not usually be reported as Serious Incidents unless there were significant concerns about the care provided or it met external reporting requirements. During 2019/20, there was one death which has since been confirmed from a physical cause (pneumonia). This was reported as a serious incident as it was the unexpected death of Forensic Services patient, which are reportable as serious incidents under their revised contract.

There are a further two cases where the cause of death was not confirmed at the time of reporting the serious incident. One related to a patient who died following a choking incident. The second was a patient who was found deceased in Scotland. The cause of death has since been received as being related to physical health. The investigation for both has continued.

### Death – other causes

There were 3 serious incidents reported relating to the unexpected death of service users. This figure includes two unexpected deaths related to service users who died in house fires at home. A third incident involved the death of an informal patient on leave from a ward. At the time of reporting cause of death was not known.

It can take a significant amount of time for the cause of death to be identified through the coroner's office. However, irrespective of the outcome, this does not prevent the investigation being completed.

### Apparent Suicide

Of the 35 deaths reported as serious incidents, 29 were apparent suicides. Three of these occurred whilst under the care of inpatient settings, one on a ward (Forensic low secure) and two whilst on leave from wards. Further detailed analysis of all apparent suicides in 2019/20 will be available in September 2020.

## Violence and Aggression

During 2019/20 there were four violence and aggression incidents, the same figure as 2018/19. All four incidents involved violence by patients against staff members using weapons. Three of the cases occurred in Forensic BDU (two in low secure, one in medium secure care) resulting in staff

injuries. The fourth case occurred in an acute inpatient ward and also resulted in injuries to a staff member.

### Homicide by a service user

During 2019/20 there was one homicide by a service user reported as a serious incident. This incident involved a service user under the care of an Enhanced Team. The service user was charged in connection with the death of a member of the public following a stabbing. The investigation for this case was led by an externally appointed investigator on behalf of the Trust. The individual is awaiting trial.

### Pressure ulcers

During 2019/20, a total of three category three pressure ulcers were reported as Serious Incidents on StEIS. This compares with four in 2018/19. All were reported by Neighbourhood teams in Barnsley General Community Services. Two of the three patients affected were male.

### Self-harm/attempted suicide

During 2019/20 there were two serious self-harm incidents. Both cases involved service users falling from bridges, resulting in significant injuries. These occurred whilst under the care of different teams; Intensive Home Based Treatment Team in Calderdale and Enhanced Team West in Barnsley.

### Inpatient fall

During 2019/20 there was one incident where an inpatient in Neuro Rehabilitation unit in Barnsley fell, resulting in a fractured neck of femur.

### Substance misuse

During 2019/20 there was one incident in Forensic medium secure services, where an inpatient was found to be unresponsive, suspected to have injected illegal substances. After treatment, the patient returned to the ward the following day.

## Section 3 - Findings from Serious Incident Investigations completed during 2019/20

This section of the report focusses on the **43** serious incident investigation reports were completed and submitted to the relevant commissioner during the period 1 April 2019 to 31 March 2020. Please note this is not the same data as those reported in this period (see Section 3) as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

- 43 serious incident investigations completed
- 174 associated actions
- All investigations include a recommendation to share learning
- Top 3 action themes:
  1) Staff education, training and supervision
  2) Record keeping
  3) Joint between Risk Assessment and Communication

### Headline data

Of the 43 serious incidents investigation reports completed and submitted to the relevant commissioner between 1 April 2019 and 31 March 2020, there were 174 actions made.

A standard recommendation to share learning and the outcome of the investigation with staff involved and wider is now in place. All 43 serious incident reports completed had a recommendation to share learning. This increases the number of actions. 44 of the 174 actions were related to sharing learning.

One incident investigation can generate a high number of actions. The breakdown by BDU and team type is shown in figures 16 and 17.

**Figure 16 Breakdown of the number of Serious Incidents completed in 2019/20 per BDU, compared with the number of actions**

| BDU | Number of SIs completed | Number of SI actions |
|---|---|---|
| Barnsley General Community Services | 5 | 20 |
| Barnsley Mental Health | 6 | 21 |
| Calderdale | 6 | 26 |
| Kirklees | 15 | 63 |
| Wakefield | 9 | 31 |
| Specialist Services | 1 | 6 |
| Forensic Services | 1 | 7 |
| **Total** | 43 | 174 |

**Figure 17 Breakdown of the number of Serious Incidents completed in 2019/20 per team type, compared with the number of actions**

| | Number of SIs completed | Number of SI actions |
|---|---|---|
| Enhanced Pathway | 9 | 26 |
| Core pathway | 8 | 27 |
| Crisis/IHBTT (Adult) | 8 | 28 |
| District Nursing | 5 | 20 |
| Acute Inpatients (Adult) | 4 | 33 |
| Early Intervention Services | 2 | 7 |
| 136 Suite (Adult) | 1 | 3 |
| Child and Adolescent Mental Health Services, Wakefield | 1 | 6 |
| Dual Diagnosis (Adult) | 1 | 4 |
| Inpatient Service (OPS) | 1 | 4 |
| Forensic Learning Disability Inpatient units | 1 | 7 |
| Mental Health Liaison Services | 1 | 6 |
| Single Point of Access (SPA) | 1 | 3 |
| Total | 43 | 174 |

Over the last three years the highest numbers of actions have arisen from apparent suicide incidents. This correlates with this being the largest type of Serious Incident reported. During 2019/20 completed serious incident investigations for apparent suicides resulted in 120 actions (69%).

It is important to understand that in undertaking an investigation of an incident, the Trust takes the view that all areas for learning or improvement should be identified and lead to a recommendation being made. These are often care delivery issues, and not considered to have been the direct root cause of the incident.

A majority of the recommendations 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 produce a report on learning from recommendations where further information/breakdown about each BDU and the lessons learnt is presented. This is called 'Our learning journey from incidents'. This will be available separately.

## Categorisation of actions

In order to analyse actions, each action is given a theme to capture the issue/theme that best matches from a pre-designed list of approximately 20 themes. We also try to add a sub-theme to group similar issues together. In an attempt to gain consistency, this is undertaken by the Lead Serious Incident Investigators. The recording of themes and sub-themes is subjective and isn't always straightforward to identify which theme/sub-theme an action should be given. Some don't easily fit into any one theme, and could be included under more than one.

**Figure 18 Ordinal list of action themes from 2019/20 compared with position in 2018/19**

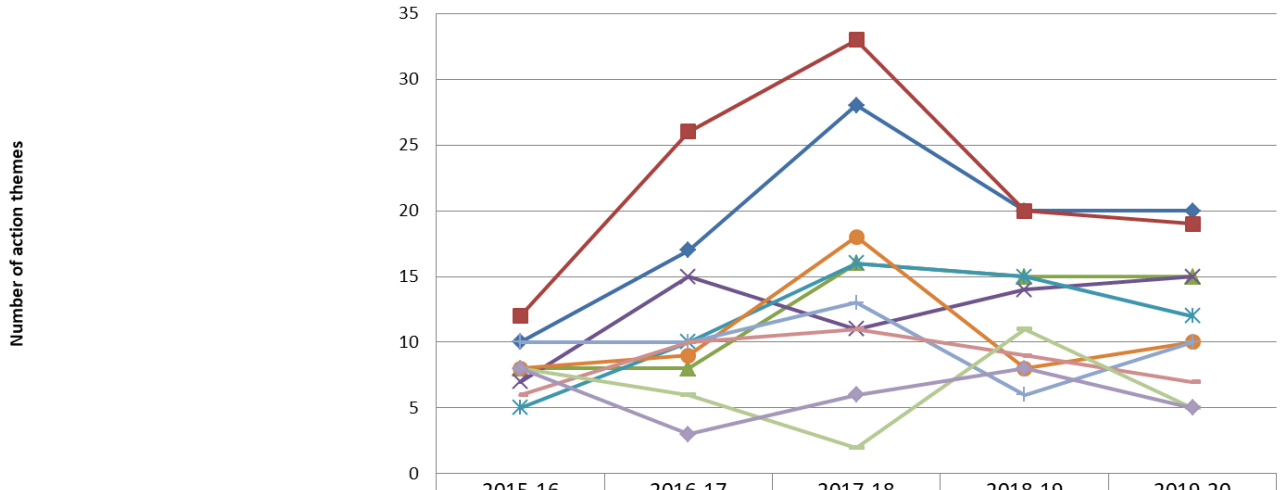
| Top 6 Recommendation types | 2019/20 | 2018/19 |
|---|---|---|
| F1 Staff education, training and supervision | 1st | Joint 1st |
| A5 Record keeping | 2nd | Joint 1st |
| A4 Risk assessment | Joint 3rd | Joint 3rd |
| B1 Communication | Joint 3rd | 5th |
| F2.1 Policy and procedure - in place but not adhered to | 5th | Joint 3rd |
| F4 Team service systems, roles and management | 6th joint | Joint 3rd |
| A2 Care delivery | 6th joint | Not in top 6 |

The types of SIs completed in the year affects the action themes, for example, an Information governance serious incident, is more likely to have actions related to Organisational systems, increasing that figure.

Figure 18 illustrates the ranking of the most common themes this year in comparison to last year. The top 3 themes are the same as last year.

The top 10 action themes have also been reviewed over the last five financial years for comparison. As shown in Figure 19, Record keeping and Staff education, training and supervision have remained the two commonest themes.

**Figure 19 Top 10 action themes in the 5 years between 1/4/2015 and 31/3/20**




| | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|---|---|
| F1 Staff education, training and supervision | 10 | 17 | 28 | 20 | 20 |
| A5 Record keeping | 12 | 26 | 33 | 20 | 19 |
| A4 Risk assessment | 8 | 8 | 16 | 15 | 15 |
| B1 Communication | 7 | 15 | 11 | 14 | 15 |
| F2.1 Policy and procedure - in place but not adhered to | 5 | 10 | 16 | 15 | 12 |
| F4 Team service systems, roles and management | 8 | 9 | 18 | 8 | 10 |
| A2 Care delivery | 10 | 10 | 13 | 6 | 10 |
| A1 Care pathway | 6 | 10 | 11 | 9 | 7 |
| B3 Carers/family | 8 | 6 | 2 | 11 | 5 |
| J1 Other | 8 | 3 | 6 | 8 | 5 |

In 2019/20 the top three most common action themes were 'Staff education, training and supervision', 'Record keeping', and joint third 'Risk assessment' and 'Communication'. These are generally consistent with top 3 themes in previous years. Below is a summary of some of the issues identified within these themes; where possible these have been grouped together (called subthemes). There is natural overlap between themes and subthemes.

## *1) Staff education, training and supervision (#1):*

Staff education, training and supervision has remained within the top 3 action themes in the last seven years. During 2019/20, there were 20 actions relating to staff education, training and supervision. Where possible these have been grouped by broad sub-theme:

| | Barnsley General Community Services | Barnsley Mental Health | Kirklees | Calderdale | Forensic Service | Specialist Services | Total |
|---|---|---|---|---|---|---|---|
| Physical health | 0 | 0 | 3 | 0 | 2 | 0 | 5 |
| Supervision | 0 | 0 | 1 | 0 | 1 | 2 | 4 |
| Risk assessment | 1 | 1 | 0 | 1 | 0 | 0 | 3 |
| Incident reporting | 0 | 0 | 1 | 1 | 0 | 0 | 2 |
| MDT working | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| CPA policy | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Training - other | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Dual diagnosis | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Care pathway | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Support for staff | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| **Total** | **3** | **3** | **6** | **3** | **3** | **2** | **20** |

Below is a summary of the actions identified:

### Physical health

- Review the effectiveness of training programmes in building competence and confidence in carrying out resuscitation, and consider with Service Managers what further steps can be taken to ensure staff proficiency under pressure.
- Ensure that staff have up to date awareness and knowledge of physical health problems that are known to shorten life expectancy for patients with long-term mental illnesses.
- Ensure that staff are able to recognise the link between aspiration pneumonia and coughing when eating and drinking.
- Improve education and support to staff in understanding and managing risks associated with dysphagia, including ensuring dissemination of recent relevant guidance and prioritising relevant Trust training programmes on food and nutrition for attendance.
- Consider what changes if any are needed to ensure first aid techniques available to staff are as effective as possible for all patients including bariatric patients.

### Risk assessment and formulation

- The IHBTT should re-establish psychology led supervision sessions with a focus on risk formulation and understanding risk for individuals with a personality disorder and where non-suicidal self-injury and suicidal intentions are present.
- Review the knowledge and skills of the Neighbourhood Nursing Service relating to the factors which affect the Waterlow score.
- Caseload supervision should include checks of the current risk assessment and management plans recorded on the clinical system.

### Care pathway

- Embed the moisture lesion pathway within the Neighbourhood Nursing Service by providing further training and support.

### Dual diagnosis

- Provide training in dual diagnosis for clinical staff as per Trust policy.

### Supervision

- The service should review the current procedures for the delivery of clinical supervision to ensure that they are robust.
- The service needs to provide assurance that clinical supervision is being completed in line with Trust policy.
- Improve the access staff have to on-going supervision and support when they are relying on the Mental Capacity Act for treatment and care of vulnerable patients, particularly where they are concerned that such patients are making unwise decisions.
- 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.

### Support for staff

- 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.

### CPA policy

- Thorough handover to take place when transferring care. The meeting must fully involve the service user and all key individuals involved in the persons care as per Care Programme Approach and Care co-ordination policy and procedural guidance.

### MDT working

- All new service users to the enhanced teams must be reviewed by medical staff as part of the multi-disciplinary assessment/review

### Training – other

- Neighbourhood Nursing Service Employees (SWYPFT) involved in the incident will have knowledge, skills, and training reviewed and further training identified

### Incident reporting system

- Ward staff should ensure when allegations of abuse, or violence are made against staff during their working practice, that these are uploaded to the Datix system to enable the Trust to understand what may be going wrong and where, so that action can be taken to avoid this happening again and improve patient and staff safety.
- The Team manager should ensure that staff are provided with initial support at the uploading of Datix incidents to ensure that tasks are not lost where additional advice and information is required.

## 2) *Record keeping (#2):*

Record keeping has remained within the top 3 action themes in the last six years. There were 19 actions relating to record keeping. Where possible these have been grouped by broad sub-theme:

| | Barnsley Mental Health | Calderdale | Forensic Service | Kirklees | Wakefield | Total |
|---|---|---|---|---|---|---|
| Clinical decision making | 1 | 0 | 0 | 1 | 1 | 3 |
| Communication with other agencies | 0 | 1 | 0 | 0 | 0 | 1 |
| Contemporaneous recording | 2 | 0 | 0 | 1 | 3 | 6 |
| Care plan | 0 | 1 | 1 | 1 | 0 | 3 |
| Risk assessment | 0 | 1 | 0 | 1 | 0 | 2 |
| Crisis/contingency plan | 0 | 0 | 0 | 1 | 0 | 1 |
| MDT | 1 | 0 | 0 | 1 | 1 | 3 |
| **Total** | **4** | **3** | **1** | **6** | **5** | **19** |

Below is a summary of the actions identified:

### Clinical decision making

- During telephone consultations by the Intensive Home Based Treatment Team with the service user there was no clear documentation of an opinion on his capacity to consent to assessment and treatment, and how this decision provided a rationale for his capability to refuse.
- Document all decisions for the deferment of treatment
- Where there is a difference in clinical opinion as to the acceptance of a referral from enhanced into the IHBTT the decision should be reviewed by the team consultant and senior practitioner/manager as part of the FACT meeting and full rationale/discussion documented within the clinical notes by both teams.

### Communication with other agencies

- There is no uniform practice across the Trust for AMHP reports following assessment. Some AMHPS provide a hand written summary and some don't. This depends on the area.

### Contemporaneous recording

- The Triage Nurse did not make an entry in the progress notes to say that the plan of contact between the Kirklees Intensive Home Based Treatment Team and the Acute Assessment Unit had been changed. This meant that the last entry in the progress notes was misleading because it said that the team would ring daily for an update on discharge plans.
- Services were contacted by family on two occasions, no recorded entry of calls made re concerns over deteriorating mental state. Service user had stated she was not consenting.
- Document contact from service user's family members expressing concern
- Individual's mental state to be recorded following each visit to clozapine clinic
- All discussions and pertinent information must be recorded within the care record
- 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.

### Care plan

- The initial plan of care was not transferred into a formal care plan and the care plan and crisis and contingency plan had not been provided to the service user.
- Care plans need to ensure they are current, easy to follow, provide evidence of the patient's involvement, are being implemented, and are being reviewed if they are not meeting service users' needs

- Breach of operational CPA policy and procedure by the lack of the presence of a clear care plan to support CPA care delivery

### Risk assessment

- 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
- Lack of risk assessment at the point of ward discharge, lack of risk assessment at the point of acceptance on to Core HCP Caseload, Lack of clarification on understanding risk factors in progress notes to support clinical decision making in to moving from 24 hour follow-up. Inconsistencies in clinical communication of risk across teams.

### Crisis/contingency plan

- A team response should be included in the actions in a Crisis Care Plan.

### MDT

- 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.
- Timely and comprehensive documentation including outcome of MDT case discussions and follow up arrangements.
- The team is recommended to ensure that multi-disciplinary clinical decision making and outcomes for care and treatment is recorded in the service user's clinical notes.

## *3) Risk Assessment issues (joint #3):*

Risk assessment issues have been in the top 6 in the last two years. There were 15 actions relating to risk assessment. These have been grouped by broad sub-theme:

| | Barnsley General Community Services | Barnsley Mental Health | Calderdale | Kirklees | Specialist Services | Wakefield | Total |
|---|---|---|---|---|---|---|---|
| Monitoring compliance | 1 | 0 | 1 | 4 | 1 | 1 | 8 |
| Changes in risk | 0 | 1 | 0 | 1 | 0 | 1 | 3 |
| Inadequate exploration of risk | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Transitions in care | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Training | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Record keeping | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| **Total** | **2** | **1** | **2** | **6** | **1** | **3** | **15** |

Below is a summary of the actions identified:

### Changes in risk

- Risk assessments must be updated with any new relevant risk information with instances of increased risk or attempted harm being shared with the team via the morning meeting.
  The risk assessment was not updated to reflect reported incidents of self-harm
  The family were not involved in care planning including risk assessment and formulation of risk
  There was limited communication with the family at points of transition and when changes in the plan of care had been made
- Ensuring risk assessments are updated when risks change

### Monitoring compliance

- That the Trust considers how it could be assured through audit or other means, that risk assessment and management plans are effectively communicated and implemented when patient care is transferred.

- That the Trust considers through audit or other means how comprehensive, up to date and accurate risk assessment and management plans are with regard to physical or environmental problems, and whether these are fully implemented.
- 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.
- There must be a clinical audit on the ward (and possibly wider) to review the current state of risk assessments
- The service needs to provide assurance that risk assessments are being completed in line with Trust policy.
- All services should ensure that level 2 risk assessments are updated in accordance to operational policy and procedure and that risk assessments are closed to future editing at the time of completion.
- Monitoring of completion of Waterlow Risk assessments
- Systems used to monitor completion of risk assessments and care plans (including crisis and contingency plan) remain up to date.

### Record keeping

- The system of having risk assessment forms prepopulated with the last risk information should be reviewed in order to ensure the risk of inaccurate information being perpetuated is minimised and to ensure that there is a robust assessment of current risk.

### Training

- Provide further training to staff members in Waterlow risk scoring to ensure that staff members has an understanding of how Long term conditions (LTC) in can impact on Waterlow scores and decisions in the provision of pressure relieving equipment.
- Moisture Lesion Pathway: Ensuring at appropriate Risk assessments are carried out when pressure damage of any grade / treatment is identified.

### Transitions in care

- Risk management plans should be completed prior to ward transfers and where possible personal behaviour support plans.

### Inadequate exploration of risk

- Where service users have overdosed on medications, the risk assessment should extend to understanding the origins of the medications and whether additional access to other medications is a considered risk. Reducing the access to additional means to self-poison/deliberately overdose should be considered a care action as part of the assessment.

## *4) Communication (joint #3):*

Communication has been in the top 6 in the last two years. There were 15 actions relating to risk assessment. These have been grouped by broad sub-theme:

| | Barnsley General Community Services | Calderdale | Kirklees | Wakefield | Total |
|---|---|---|---|---|---|
| Communication with other agencies | 0 | 0 | 1 | 2 | 3 |
| MDT | 2 | 0 | 0 | 0 | 2 |
| Care delivery | 0 | 1 | 0 | 0 | 1 |
| Communication - service contact details to patient | 0 | 0 | 0 | 1 | 1 |
| Communication between colleagues in team | 0 | 1 | 0 | 0 | 1 |
| Communication not completed following discharge | 0 | 0 | 1 | 0 | 1 |
| Dual diagnosis | 0 | 1 | 0 | 0 | 1 |
| Record keeping | 0 | 0 | 0 | 1 | 1 |
| Team roles | 0 | 0 | 0 | 1 | 1 |
| Specialist advice | 0 | 0 | 0 | 1 | 1 |
| Poor sharing of information between services | 0 | 0 | 0 | 1 | 1 |
| Inadequate transfer of information between services, including discharge summaries from ward | 0 | 1 | 0 | 0 | 1 |
| **Total** | **2** | **4** | **2** | **7** | **15** |

Below is a summary of the actions identified:

### Care delivery

- Where other agencies are involved the Intensive Home Based Treatment Team to ensure effective joint working with them is evidenced throughout a service user's episode of care.

### Communication - service contact details to patient

- Ensure service users are aware of how to contact the service whilst awaiting access to groups.

### Communication between colleagues in team

- Check that notifications go to an administrator/duty worker to ensure the message is picked up and actioned in a timely way

### Communication not completed following discharge

- The Intensive Home Based Treatment Team (IHBTT) needs to provide assurance that discharges from their service is being documented in line with Trust policy

### Communication with other agencies

- The Psychiatric Liaison Team practitioners will ensure that when making a referral for a Mental Health Act assessment that they will call the Intensive Home Based Treatment team to advise them of this action.
- Where partnership working is identified across other organisations, all efforts should be made to approach investigations jointly to optimise information sharing and learning
- The Intensive Home Based Treatment Team should seek to strengthen the connections with the external agencies for reduction in harmful alcohol use. A review of the tools in use in this area should be conducted and the team should seek to mirror the use of such tools when creating care actions and interventions for those people where alcohol misuse is identified.

### Dual diagnosis

- Review links with Recovery Steps as per Trust's Dual Diagnosis Policy

### Record keeping

- Letter templates to be signed from a named professional to support effective engagement and provide a point of contact with the service.

### Team roles

- A written management/contingency plan should be provided to the acute trust department by the Psychiatric Liaison Team detailing onward referral, management of risks and the need to refer back where risks have changed

### Specialist advice

- 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.

### MDT

- 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
- The Patient Safety Strategy BDU action plan to include specific actions around MDT working and a flexible workforce to improve communication and patient experience
- Poor sharing of information between services
- The Single Point of Access team to discuss communication issues with the Turning Point Talking Therapies in the interface meeting.

### Inadequate transfer of information between services, including discharge summaries from ward

- Medics discharge summaries should be opened and updated to reflect current patient presentation with a plan for ongoing treatments including medication arrangements and made available to General Practitioners within 24 hours as per operational policy and procedure.

## Implementation of recommendations and actions

Work to ensure monitoring and implementation of all Serious Incident action plans continues through the Operational management group and BDU Serious incident meetings.

BDUs ensure that recommendations and resulting actions are SMART and that evidence is collected against each action to demonstrate implementation. BDUs are asked to develop actions that will result in change when creating their plans.

Some Business Delivery Units hold regular learning lessons events that look at the themes of learning and have presentations on key topics. All BDUs are supported to hold these events and feedback from the events run have been very positive.

A Trust wide event was held in June 2019 which brought the opportunity for BDUs to share their learning more widely. The Patient Safety Support Team share learning from serious incidents in the learning library by sharing Executive summaries.

A common question asked is if investigations and recommendations change practice. This is difficult to answer. Over the number of years we have been analysing action themes, the top 6 themes have remained fairly similar. The type of incidents and teams involved will affect this. We are developing methods of thematic review through the Clinical Mortality Review Group which focuses attention on an individual theme to extract the common messages for particular incident types, with the intention to share these messages across the Trust. This work is being developed and will evolve over time

beyond deaths. One challenge is not losing sight of the original incident and retaining the meaning behind the action.

Anecdotally, we know the investigation process is valued by individuals and teams and we know the quality of reports is generally high from the Commissioners' reviews and the Trust processes are well regarded.

## Section 4 Learning from healthcare deaths

### 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.

All deaths that are in scope are reported to Trust Board each quarter. The latest reports are published on the Trust website.

### 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 introduced our Learning from healthcare deaths policy in 2017. Staff report deaths where there are concerns from family, clinical staff or through governance processes and where the Trust is the main provider of care. This is what we refer to as 'in scope deaths' (further details are available in the Learning from Healthcare Deaths policy). The policy has continued to be reviewed and updated to reflect national guidance.

### Learning from Healthcare Deaths reporting

During 2019/20, 3262 deaths (row one in Figure 20) were recorded on our clinical systems (figure correct at 15/5/20). This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems through Business Intelligence software. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number of cases, the Trust was not the main provider of care at the time of death.

**Figure 20 Summary of 2019/20 Annual Death reporting by financial quarter***

| | Quarter 1 2019/20 | Quarter 2 2019/20 | Quarter 3 2019/20 | Quarter 4 2019/20 | 2019/20 total |
|---|---|---|---|---|---|
| 1) Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death | 778 | 700 | 902 | 882 | 3262 |
| 2) Total number of deaths reported on Datix by staff (by reported date, not date of death) | 74 | 78 | 95 | 108 | 355 |
| 3) Total number of deaths reviewed | 74 | 78 | 95 | 108 | 355 |
| 4) Total Number of deaths which were in scope | 63 | 61 | 80 | 82 | 286 |
| 5) Total Number of deaths reported on Datix that were not in the Trust's scope | 4 | 15 | 12 | 21 | 52 |
| 6) Total Number of reported deaths which were rejected following review, as not reportable or duplicated. | 7 | 2 | 3 | 5 | 17 |

*Data extracted from Business Intelligence Dashboards 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

Not all these deaths were reportable as incidents on Datix. Row 2 in Figure 20 shows that 355 deaths were reported on Datix in the year, with the quarterly breakdown. The yearly total is an increase on 2018/19 (307).

All deaths reported on Datix are reviewed by the patient safety support team to ensure they meet the scope criteria. For 2019/20, 286 deaths were in scope and subject to one of the 3 levels of scrutiny the Trust has adopted in line with the National Quality Board guidance (figure 21):

**Figure 21 National Quality Board Levels of mortality scrutiny**

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

Each quarter, there are a number of reported deaths that do not meet the Learning from Healthcare Deaths reporting criteria which receive no further review. These are not in scope and are not included in data report, although the record remains on Datix.

For the purpose of this section, the date of reporting on Datix is used rather than the date of death. This is to ensure all deaths are systematically reviewed. The figures may differ from other sections of the report.

Figure 22 shows the 286 in scope deaths reported by the service areas.

**Figure 22 In scope deaths reported by financial quarter and service type**

| | Mental Health Community | Mental Health Inpatient | General Community | General Community Inpatient | Learning Disability | CAMHS and ADHD | Forensic Services | Total Number of Deaths reviewed |
|---|---|---|---|---|---|---|---|---|
| Quarter 1 | 45 | 3 | 3 | 0 | 12 | 0 | 0 | **63** |
| Quarter 2 | 40 | 4 | 3 | 0 | 14 | 0 | 0 | **61** |
| Quarter 3 | 65 | 5 | 0 | 0 | 9 | 0 | 1 | **80** |
| Quarter 4 | 61 | 5 | 3 | 1 | 11 | 0 | 1 | **82** |
| **Year total** | **211** | **17** | **9** | **1** | **46** | **0** | **2** | **286** |

The 286 in scope deaths were reviewed in line with the National Quality Board levels of scrutiny as outlined in Figure 21. Figure 23 shows the in scope deaths by financial quarter they were reported in, against the review level and process. Figures 24 and 25 show the deaths BDU and category.

**Figure 23 Learning from Healthcare Deaths during 2019/20 by financial quarter and mortality review process**

| Financial quarter | Level 1 | Level 2 | | Level 3 | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | Death certified | Manager's 48 hour review | Structured Judgment Review (SJR) | Service Level Investigation | Serious Incident Investigation | Learning Disability Mortality Review (LeDeR) | Other investigation | |
| Quarter 1 | 23 | 8 | 8 | 0 | 9 | 14 | 1 | 63 |
| Quarter 2 | 13 | 15 | 8 | 1 | 10 | 14 | 0 | 61 |
| Quarter 3 | 35 | 16 | 9 | 2 | 8 | 8 | 2 | 80 |
| Quarter 4 | 34 | 16 | 6 | 1 | 10 | 13 | 2 | 82 |
| **2019/20 total** | 105 | 55 | 31 | 4 | 37 | 49 | 5 | 286 |

**Figure 24 Reported In scope deaths by financial quarter (date reported) and BDU 2019/20**

| | Barnsley General Community Services | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | Total |
|---|---|---|---|---|---|---|---|---|
| 19/20 Q1 | 3 | 8 | 15 | 14 | 11 | 0 | 12 | 63 |
| 19/20 Q2 | 3 | 6 | 11 | 11 | 16 | 0 | 14 | 61 |
| 19/20 Q3 | 0 | 11 | 12 | 26 | 21 | 1 | 9 | 80 |
| 19/20 Q4 | 4 | 11 | 8 | 19 | 28 | 1 | 11 | 82 |
| **Total** | **10** | **36** | **46** | **70** | **76** | **2** | **46** | **286** |

**Figure 25 Reported deaths by category and BDU reported during 2019/20**

| | Barnsley General Community Services | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | Total |
|---|---|---|---|---|---|---|---|---|
| Death - confirmed from physical/natural causes | 5 | 18 | 26 | 34 | 51 | 1 | 30 | 165 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 5 | 10 | 8 | 14 | 7 | 0 | 10 | 54 |
| Suicide (incl apparent) - community team care - current episode | 0 | 5 | 6 | 9 | 13 | 0 | 1 | 34 |
| Death - confirmed from infection | 0 | 1 | 0 | 0 | 3 | 0 | 5 | 9 |
| Suicide (incl apparent) - community team care - discharged | 0 | 0 | 4 | 4 | 1 | 0 | 0 | 9 |
| Death - confirmed related to substance misuse (drug and/or alcohol) | 0 | 0 | 2 | 5 | 1 | 0 | 0 | 8 |
| Suicide (incl apparent) - inpatient care - current episode | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 3 |
| Death - confirmed as accidental | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| Death of service user by homicide (alleged or actual) | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| Total | 10 | 36 | 46 | 70 | 76 | 2 | 46 | 286 |

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur.

## Deaths reported as SIs

Of the 286 in scope deaths reported on Datix between 1 April 2019 and 31 March 2020, 37 were reported as serious incidents. Three of these cases were later withdrawn as serious incidents after the investigation revealed that care was as it should have been and no learning was identified. This is in agreement with commissioners.

Please note this figure will not necessarily match those reported in the Serious Incident section of this report due to the use of different dates for different processes (Serious incident reporting uses date reported on STEIS; mortality uses date reported on Datix).

## Apparent suicides

The apparent suicides will be reported on further in the Apparent Suicide annual report which will be available later in the year. The figures will be based on the live data, so may not match figures in this report.

## Learning from Deaths findings

Learning from deaths report is prepared quarterly and included in the Quarterly Incident reports. On six monthly basis, an analysis report is prepared to consider our findings.

## Section 5 - Key Actions and Areas for Development in 2020/21

Recent years have seen substantial developments in mortality processes, processes supporting the review, investigation, management and learning from incidents in the Trust along with the ongoing development of staff within the patient safety support team. This provides a secure platform from which to develop further.

Plans for 2020/21 include:

- Implementation of actions identified in a recent 360 Assurance report following an audit Incident reporting and associated processes.
- Review of policies:
    - Incident Reporting and Management (including Serious Untoward Incidents) policy
    - Investigating and analysing incidents, complaints and claims to learn from experience policy.
- There are two major changes anticipated arising from the NHS Patient Safety Strategy relating directly to Incident reporting and management. This will include:
    - Work to connect Datix to the new Patient Safety Incident Management System (PSIMS) which will replace NRLS and StEIS systems. Timescales will be given by NHS Improvement.
    - Implementation of the new Patient Safety Incident Response Framework (PSIRF) which will replace the Serious Incident Framework. Full implementation is anticipated by July 2021.
- Work to realign Datix with new BDU structures. It is acknowledged that this work is outstanding from Q4 2019/20 but has been delayed during Covid 19 period.
- Review operational interconnectivity within Patient Safety Support Team alongside strengthening governance arrangements with BDUs.
- Partake in Royal College of Psychiatrists Serious Incident Review Accreditation Network (SIRAN), expected September 2020.

Patient Safety Support Team
2/6/2020

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# Trust Board 30 June 2020
# Agenda item 8.1

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| **Title:** | **South Yorkshire update including the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)** |
| **Paper prepared by:** | Director of Human Resources, Organisational Development and Estates and Director of Strategy |
| **Purpose:** | The purpose of this paper is to update the Trust Board on the developments within the SYB ICS and Barnsley integrated care developments. |
| **Mission /values / objectives:** | The Trust's mission to **enable people to reach their potential and live well in their communities** will require strong partnerships working across the different health economies. It is, therefore, important that the Trust plays an active role in the SYB ICS. |
| **Any background papers / previously considered by:** | The Trust Board have received regular updates on the progress and developments in the SYB ICS, including Barnsley Integrated Care Developments. |
| **Executive summary:** | **1. SYB ICS Update**<br>The leadership and management arrangements have changed in the ICS to respond initially to the coronavirus. A weekly Strategic COVID-19 Health Group replaced the monthly Health Executive Group.<br><br>These arrangements have changed again in July with the Health Executive Group (HEG) being re-established on a monthly basis. In addition there is now a new weekly Health Care Management Group.<br><br>The Health Executive Group has a clear focus on ICS strategic planning based on Placed based service plans. The HEG will lead on the development of the overall ICS plan for South Yorkshire and Bassetlaw. Although national planning guidance is expected in mid-July service modelling has begun at the ICS level. The first reconvened meeting of the HEG took place on the 9 June 2020 and covered timescales for the planning arrangements with a view that July's meeting will be the start of the development process.<br><br>The Health Care Management Group has been focused on partner organisations working together on key operational issues including COVID-19 related matters. This includes the stress testing with the military on the response to four different scenarios related to COVID-19. The stress test will take place on the 1 July 2020 and the Trust will be represented at the workshop. |



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| | Personal and Protective Equipment continues to be an important agenda item although supplies have significantly improved.<br><br>Overall the ICS has coped well with management and response to COVID-19 and this has included strong joint working and mutual aid.<br><br>**2. SYB ICS Mental Health, Learning Disabilities and Autism programme**<br>The ICS Mental Health Executive steering group has a number of programmes of work that have been prioritised, below is an update on some of these programmes: The Programme group is effectively on hold due to Covid-19 focus and instead the CEOs from the mental health provider trusts meet virtually bi-weekly to share information and explore mutual aid arrangements. The Programme team have held a workshop to support recovery planning and reprioritisation of the programmes. Members from this group have also contributed to the ICS recovery planning workshop.<br><br>**Individual Placement and Support (IPS)** - The SY&B IPS wave 2 roll out was progressing well with South Yorkshire Housing (SYHA) as the lead provider and coordinating the mobilisation process, prior to Covid-19. All the posts had been advertised across SY&B, and the two SWYPFT roles recruited to by SWYPFT to cover Barnsley. The partnership agreement, data sharing agreement and collaboration agreement between SYHA and the Trust have been agreed and signed. Throughout COVID-19 the two SWYPFT workers have maintained roles as IPS workers for the majority of time, and have successfully supported 5 service users to gain paid employment.<br><br>**Mental Health Liaison and Crisis Care** - The Trust in partnership with Barnsley Clinical Commissioning Group (CCG), secured transformation funding from NHS England as part of the SYB ICS. One bid (circa £500,000) was to enable the all-age mental health liaison service to achieve 'Core 24' status and the second bid (circa £231,000) was to enable Barnsley to enhance alternatives to crisis support to be delivered through an extension to its current IHBT provision; in terms of resources and skill mix and in accordance with Fidelity to the Model. Prior to Covid-19 recruitment and mobilisation was underway in relation to all the new investment and in terms of the additional Core 24 resources. All posts were out to recruitment with the exception of the High Intensity Worker and Consultant roles. All further recruitment has now been delayed due to the current situation but we are shortlisting as and when jobs close and updating candidates. Once this work is able to progress it is expected to have a significant impact on reducing Accident and Emergency attendance and building resilience in individuals experiencing mental health crisis. |

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| | **NHS England specialised commissioning Lead Provider Collaborative** - The Specialist Forensic providers across the ICS are working together to develop a Lead provider model for Forensic services. The bid submitted to NHSE by the partners was on the development track with a gateway review / sign off by April 2020, with the intention of going live from October 2020. However, due to Covid-19, the timescales will not continue as planned and a review of the appropriate timeline for implementing development track collaboratives is underway by NHS England.<br><br>The Trust is not a partner in the delivery of the model in South Yorkshire (Lead for the equivalent model in the West Yorkshire Health and Care Partnership) however will continue to work with providers in South Yorkshire to ensure that pathways in to care and the impact on community services is considered as part of the development phase.<br><br>Providers of Eating Disorder Services across the ICS are working together to develop a Lead provider model. The bid submitted to NHSE by the partners was also on the development track with a gateway review / sign off by April 2020, with the intention of going live from October 2020. However, as above, due to Covid-19, the timescales will not continue as planned and a review of the appropriate timeline for implementing development track collaboratives is underway by NHS England. The Trust is not a partner in the delivery of the model in South Yorkshire however is actively involved in meetings to ensure alignment of the model to our services.<br><br>The **Quit programme** is now being implemented in inpatient mental health services in Barnsley. A new band 8a role working 15 hours per week for two years on secondment has been recruited. This post is currently fixed term for 2 years due to funding. A band 6 post working 15 hours per week is to be recruited along with 3 band 3 posts (2.5 wte) and a band 3 admin support role. Outstanding recruitment was put on hold due to Covid-19 as face to face contact will be limited. The band 8a will focus on setting up internal QUIT systems, processes, IT, training, data collection etc. in readiness for team recruitment and the service becoming fully operational.<br>An internal QUIT steering group is in place which is strongly linked in to the wider local and ICS wide systems.<br><br>**Bereavement support**<br>Bereavement support for the wider public and health care professionals has been set up across the ICS footprint and will be reviewed to assess impact. |

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| | **Barnsley Integrated Care update**<br>All partners across Barnsley continue to work together to develop a joined up response to Covid-19. Partnership arrangements are in place to support decision making as close to the front line as possible. Community services continue to provide care as close to home as possible working with primary care, social care and the wider CVS. The integrated Care Partnership has been resumed and is overseeing the development of the place based stabilisation and recovery plan.<br><br>**Risk Appetite**<br>This update supports the risk appetite identified in the Trust's organisational risk register. |
| **Recommendation:** | **Trust Board is asked to NOTE the update from the SYBICS and Barnsley integrated care developments.** |
| **Private session:** | Not Applicable |

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# Trust Board 30 June 2020
# Agenda item 8.2

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| **Title:** | **West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships update** |
| **Paper prepared by:** | Director of strategy<br>Director provider development |
| **Purpose:** | The purpose of this paper is to provide the Trust Board:<br>1. With an update on the development of the West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) response to Covid-19; and recovery and reset<br>2. Local Integrated Care Partnership developments in response to Covid-19 and recovery and reset |
| **Mission/values:** | The development of **joined up care and response to Covid-19** through **place-based arrangements** is central to the Trusts delivery of responsive services and support in places at this time. As such it is supportive of our mission, particularly to **help people to live well in their communities.**<br>**The way in which the Trust approaches strategic and operational developments must be in accordance with our values**. The approach is in line with our values - **being relevant today and ready for tomorrow**. |
| **Any background papers/ previously considered by:** | Strategic discussions and updates on place based plans and developments have taken place regularly at Trust Board including an update to May 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): The Trust has continued to work as a member of the partnership.<br><br>**WYH HCP recovery and reset planning:**<br>The attached presentation outlines the Partnership approach, ways of working and response to COVID-19 pandemic and update on recovery and reset planning. Significant work has been undertaken to ensure that there is a joined up response to the pandemic and recovery planning in each of our places and across the partnership.<br><br>**Mental Health, Learning Disabilities and Autism programme**<br>The Programme Board has reviewed the Programme's 8 core work streams in the context of the impact of Covid-19. The work in each work stream has been Continued, *Repurposed,* or *Paused.* The following areas of work have been prioritised as part of the |



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| | stabilisation phase; mental health secondary care pathway this includes development of a regional approach to the delivery of PICU and mapping community capacity to support flow, mutual support and recovery reset planning.<br><br>**Adult Secure Lead Provider Collaborative (LPC)**<br>The Trust is the Lead Provider for the West Yorkshire Adult Secure Lead Provider Collaborative. The project work on the LPC had been paused, though the national timetable as part of recovery planning the project work will need to resume by July 2020 to enable the programme to meet national development timescales.<br><br>**Place based response to Covid-19**<br>We continue to work with partners to develop and deliver joined up Covid-19 response and support in each of the places that we provide services. The place based work is largely directed through the multi-agency Command structure, within which the Trust is either represented directly or through the CCG representing the whole health community (as in Wakefield Gold Command). We also continue to contribute to placed based recovery and reset planning.<br><br>**Risk Appetite**<br>The development of the partnerships response to Covid-19 and the development and delivery of place-based arrangements and response is in line with the Trust's risk appetite. |
| **Recommendation:** | **Trust Board is asked to RECEIVE and NOTE the updates on the development of the West Yorkshire and Harrogate Health and Care Partnership and place based arrangements in response to Covid-19 and recovery and reset planning.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - update
# Trust Board 30 June 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 (WYH HCP) 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. WYH HCP recovery and reset planning

The Partnership has developed a framework to support places to develop their local recovery and reset plans. The framework was shared with Trust Board at the last meeting and is also attached for reference. Significant work has been undertaken to ensure that there is a joined up response to the pandemic and recovery planning in each of our places and across the partnership.

## 4. WYH HCP Coronavirus engagement mapping report: stabilisation and reset

Feedback has been collated to better understand the impact of coronavirus on individuals and communities. West Yorkshire Healthwatch organisations, Yorkshire Cancer Community, Carers UK and Bradford Talking Media have been engaged in collating the feedback. The report is an early draft and you can read it here**. The Trust communications, engagement and involvement team are reviewing this together with feedback from service users, carers and communities that we have received directly to inform the Trust Learning from Covid work and recovery planning.**

## 5. WYH HCP Health Inequalities and Covid-19

The partnership five year plan sets out ambitions to reduce the gap in life expectancy by five percent in the most deprived communities by 2024; reduce inequalities in life expectancy for people living with mental health conditions, learning disabilities and autism; reducing health inequalities for children living in households with the lowest incomes, and reducing suicide by

10 per cent, whilst strengthening local economic growth and improving skills. In response to COVID-19 the Partnership will continue to build on these ambitions, to target efforts towards those who need support the most. A preventative approach will be embedded across the partnership priority programmes. **The Trust is leading on the Suicide prevention programme on behalf of the partnership and as a partner in the mental health, learning disability and autism programme has contributed to the development of a bereavement support service as well as a mental health and well-being support line for the wider public.**

**6. Diverse Workforce and Leadership**

National evidence has highlighted the differential impact of Covid on staff and communities from black and minority ethnic communities (BAME). The Partnership has progressed a programme of work to increase the diversity of the workforce and leadership across the region. This work is supported by the partnership network made up of chairs of organisational BAME networks. **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.**

**7. West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative update**

The Trust Board was appraised at the previous meeting on the work that the programme board has undertaken to review the work streams in light of Covid. The Programme Board met in June 2020, where the work streams continuing either in a continued or repurposed form were agreed. The key points to highlight from the meeting are summarised as follows:

- **Collaborative Bank**

  A project is being established to progress the development of a non-medical collaborative bank across the collaborative. During the Covid-19 period, a number of MoUs have been established, successfully increasing the flow of workforce to support neighbouring organisations and care homes, quickly and effectively. These are short term solutions to meet the needs of Covid-19, but they do represent a considerable positive step forward in collaborative working. A key enabler to this work will be a common approach to Prevention management of violence and aggression (PMVA), and a project is being established to progress this.

- **MH Secondary Care Pathways work stream**

  This is an important work programme which was endorsed by the Programme Board, particularly in the context of the WY&H Mental Health, Learning Disability & Autism Strategy 2019/2024. It brings together previous projects into one work stream, underpinned by a set of principles for working collaboratively across mental health in-patient services. The two main components comprise:

  - Development of a regional approach to the delivery of PICU.
  - Mapping community capacity to support flow.

- **Transformation Funding, new 2020/21 approach**

  The collaborative is planning on the assumption that there is no new transformation funding in 2020/21. However, there is £700k carried forward from 2019/20. Approximately £250k of this is pre-committed, therefore there is £450 to utilise in 2020/21. A process was agreed at the Programme Board which involved allocating indicative sums of money against each work stream, subject to submission and agreement of work stream plans for spending the allocation.

- **Adult Secure Lead Provider Collaborative (LPC)**

The *NHS Long Term Plan Implementation* sets out the expectations for specialised mental health services and learning disability and autism services managed through NHS-led provider collaboratives over the next five years. The Trust is the Lead Provider for the West Yorkshire Adult Secure Lead Provider Collaborative. The Trust Board was appraised on 28 April 2020 that the majority of the project work on the LPC had been paused, though the national timetable for *further development track* sites (which includes our Adult Secure LPC) is still aiming for 'go live' from 1 April 2021. The national timetable for *fast track* sites has been adjusted to 1 October 2020 at the soonest (this will apply to Adult Eating Disorder LPC in WY), and for *development track* sites adjusted to 1 April 2021 (this will apply to CAMHS LPC in WY). In order to achieve 1 April 2021 'go live', the resumption of all Project Plan work on the Adult Secure LPC will need to be made by July 2020 at the latest. This has been discussed and supported by all partners in the LPC, and arrangements have been made for the resumption of the work. A further more detailed report will be presented to the Trust Board at its July meeting.

- **New grief and loss support service for West Yorkshire and Harrogate**

A new support and advice service is being launched to help people across West Yorkshire and Harrogate through grief and loss. The free service, commissioned by West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP), will be delivered by West Yorkshire and Harrogate Independent Hospices Consortium, Bradford Bereavement Services Consortium and Leeds Mind, and will be launched on June 29th 2020. The practical and emotional support and advice service will be available 7 days a week.

## 8. Local Integrated Care Partnerships - key developments

We continue to work with partners to develop and deliver joined up Covid-19 response and stabilisation approach in each of the places that we provide services. The place based work is largely directed through the multi-agency Command structure, within which the Trust is either represented directly or through the CCG representing the whole health community (as in Wakefield & Kirklees Gold Command).

### 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**
    - **Local integrated Care partnerships - Calderdale, Wakefield and 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

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 30 June 2020
# Agenda item 9.1

| | |
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| **Title:** | **Internal meetings governance framework update** |
| **Paper prepared by:** | Director of Finance and Resources<br>Corporate Governance Manager |
| **Purpose:** | To review the Trust's internal meeting governance structures to ensure they support the delivery of the Trust's mission and values, strategic objectives and legal requirements and provide the Trust Board and committees of the Board with the required levels of assurance. |
| **Mission/values:** | Good internal meeting governance provides a framework for the continuous development of systems and processes to support assurance, compliance and risk management in support of the delivery of the Trust's mission and strategic objectives. |
| **Any background papers/ previously considered by:** | Previous version received by Trust Board 30 April 2019.<br>Draft update was considered by the Executive Management Team (EMT) and comments included as applicable. |
| **Executive summary:** | Trust meeting structures should enable the Board to:<br>➢ Meet its statutory duties.<br>➢ Aid good decision making.<br>➢ Ensure timely escalation of issues.<br>➢ Share learning.<br>➢ Provide assurance on delivery and compliance with legislation.<br><br>The internal meetings' governance framework identifies the first and second line assurance reporting into the formal sub-committees of the Board. The terms of reference for each committee continue to be reviewed annually as part of the Audit Committee Annual Report to Trust Board (last reviewed and approved in April 2020).<br><br>The framework has been updated to reflect changes that have taken place in the last year, including:<br>➢ Addition of the Finance, Investment and Performance Committee.<br>➢ Amendment to the name of the West Yorkshire Mental Health, Learning Disability & Autism (WYMHLDA) Services Collaborative Committee-in-Common (formerly West Yorkshire Mental Health Services Collaborate (WYMHSC)).<br>➢ Addition of the Clinical Ethics Advisory Group (CEAG) established in April 2020 and reporting to the Clinical Governance & Clinical Safety Committee.<br>➢ Addition of the Extended Executive Management Team (EMT), |

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| | the Risk Panel and the Corporate Policy, Procedure and Risk Group providing assurance to EMT.<br>➢ Amendment to the Safety & Resilience TAG reporting to the Clinical Governance & Clinical Safety Committee (formerly the Health & Safety and Emergency Preparedness TAG), and removal of the HSEP sub-group (South and West) that formerly reported to this TAG.<br>➢ Safeguarding Link Practitioner Forum replaces the Safeguarding Children Operational & Practice Group and the Safeguarding Adults TAG, reporting to the Safeguarding Strategic Group.<br>➢ Removal of the Eliminating Mixed Sex Accommodation Group (formerly reported to the Patient Safety Strategy Group).<br>➢ Addition of the Reducing Restrictive Physical Intervention TAG (replaces the Managing Violence and Aggression TAG), the Clinical and Professions Standards Group and the Clinical Policies and Procedures Group, reporting to the Patient Safety Strategy Group.<br><br>It should be noted that the internal meeting governance framework is that which exists substantively in the Trust. Since the beginning of the Covid-19 pandemic a small number of temporary arrangements have been put in place for some meetings to enable focus to be placed on responding to the pandemic. Any such arrangements relating to Committees of the Trust Board have already been communicated to and agreed by the Trust Board.<br><br>**Risk Appetite**<br>The delivery of the internal meetings' governance framework supports the Trust in providing safe, high quality and equitable services within available resources through an integrated approach to delivery, management of risk and the provision of assurance at the right level. Improving the Trust's efficiency and effectiveness in line with the Trust's Risk Appetite Statement. |
| **Recommendation:** | **Trust Board is asked to RECEIVE the update to the internal meetings' governance framework.** |
| **Private session:** | Not applicable. |

# Internal governance structures – 3 lines of assurance

*Board are required to ensure appropriate risk management processes are in place.*
*Executive Management Team are responsible for the delivery of the strategy and plans within the organisation which are managed through the 1st line (green).*

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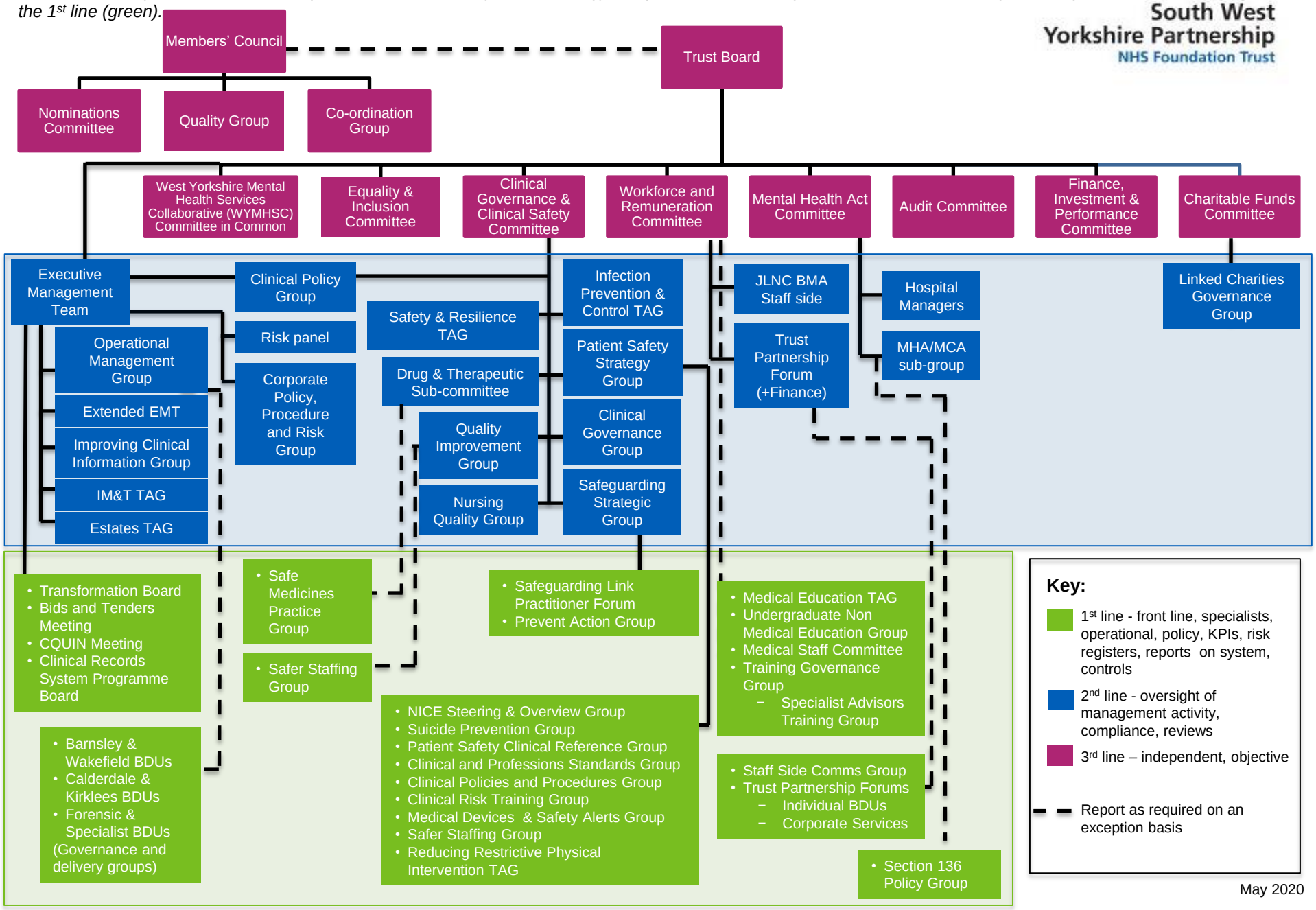


May 2020

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 30 June 2020
# Agenda item 9.2

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|---|---|
| **Title:** | **Executive Management Team (EMT) Terms of Reference** |
| **Paper prepared by:** | Director of Finance and Resources |
| **Purpose:** | To inform the Trust Board of the Terms of Reference for EMT which have recently been updated. |
| **Mission/values:** | Good internal meeting governance and structure supports assurance, compliance and risk management in support of the delivery of the Trust's mission and strategic objectives. |
| **Any background papers/ previously considered by:** | Reviewed and updated by the Executive Management Team (EMT) |
| **Executive summary:** | ➢ The Executive Management Team (EMT) has reviewed how it operates and developed some updated Terms of Reference.<br>➢ EMT is made up of the directors of the Trust and is responsible for overseeing all matters of the Trust. It is an essential component in providing executive action across the organisation.<br>➢ EMT is a forum where directors can discuss important Trust matters. It has decision-making powers in line with the Trust's scheme of delegation and will make decisions based on a collective understanding of its members. Although not required to report formally, it has a direct relationship with the Trust Board, other Committees of the Board and with the Extended Executive Management Team (EEMT).<br>➢ The Terms of Reference of EMT are attached for Trust Board information. |
| **Recommendation:** | **Trust Board is asked to RECEIVE the Terms of Reference for EMT** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# EXECUTIVE MANAGEMENT TEAM (EMT)
## Terms of Reference
***Approved by the Executive Management Team on 04 June 2020***

The Executive Management Team (EMT) is made up of the directors of the Trust and is responsible for overseeing all matters of the Trust. It is an essential component in providing executive action across the organisation.

EMT is an executive only forum where directors can discuss important Trust matters. It has decision-making powers in line with the Trust's scheme of delegation and will make decisions based on a collective understanding of its members. Although not required to report formally, it has a direct relationship with the Trust Board, other Committees of the Board and with the Extended Executive Management Team (EEMT). EMT updates EEMT on Trust Board matters and drives that agenda. **Appendix A** shows the position of EMT in the internal governance structure.

## Purpose
As directors of the organisation with extensive skills and experience, EMT's purpose is to:

- Role model the tone & culture of the organisation by operating within the agreed Trust values
- Advise the Board on the Trust's future direction with responsibility for the delivery of the strategy and plans that follow
- Support horizon scanning and innovation to enable the Trust to work in the changing context of health and care
- Ensure quality and delivery of Trust services
- Provide leadership and oversight of the risk process and to provide assurance ensuring the Trust governance processes provide for the three lines of assurance
- Oversee and provide direction on opportunities for the Trust, responding to key issues and leading the development of solutions
- Oversee the performance management processes of the Trust ensuring service provision meets high performance standards and identifying issues at an early stage enabling mitigating actions to be taken
- Take and oversee executive actions in the Trust
- Take reports/oversee work from other meetings & groups
- Oversee the reporting of and actions & learning taken from incidents
- Drive and adopt learning and good practice
- Represent staff and reflect the views of services and stakeholders
- Deliver key information to be cascaded throughout the Trust via appropriate methods
- Set the tone and respond to unprecedented changes/events as appropriate in conjunction with the command and control structure
- Feed information to and help shape EEMT

## Membership
EMT is chaired by the Chief Executive (or delegated to the Deputy Chief Executive or other Executive Director when the Chief Executive is unable to attend). The Deputy Chief Executive oversees the coordination of meetings and business.

Membership currently consists of:
- Chief Executive
- Director of Nursing & Quality/Deputy CEO
- Director of Human Resources, Operational Development & Estates
- Director of Finance & Resources
- Medical Director
- Director of Operations
- Director of Strategy
- Director of Provider Development

With **all of us** in mind.

## Attendance

Other members of staff and/or external partners may be invited to present depending on the agenda. The Chair and Non-Executive Directors do not attend EMT. Deputies are invited to attend if a Director is themselves unable to. Administrative support is provided by the Chief Executive's Office with notes and actions being recorded and tracked.

## Quorum

The quorum will be four executive directors. Members are expected to attend all meeting wherever possible. Certain decisions can only be made when the key accountable director is present and must be made within the scheme of delegation.

## Frequency of meetings

EMT will meet approximately 24 times per year. These are scheduled twice monthly with two separate agendas. EMT Risk, Assurance & Opportunities falls first in the month and is scheduled the week following the Trust Board meeting to follow up any actions. EMT Quality and Delivery is scheduled the week before the Trust Board meeting in order to pick up any business to feed into the Board.

The meeting is held at Fieldhead Hospital in Wakefield, the Trust's headquarters. Fieldhead is the home base for most directors, therefore ensuring cost effectiveness. EMT has switched to digital meetings during Covid-19, face to face meetings are encouraged outside of the pandemic.

## Duties

Members of EMT will focus on, but are not limited to the following:

- To attend EMT wherever possible or seek suitable deputy cover when unable to attend
- To feed into the agenda and produce papers in a timely manner for distribution
- To champion developments as senior leaders of the organisation
- To be solutions-focused and overcome challenges
- To support collective conversation of matters of mutual importance
- To lead and support work required to make progress outside of meetings
- To effectively represent staff, services and teams.
- To cascade decisions/information to services and teams as appropriate

EMT will focus on, but is not limited to the following:

- Performance management of the Trust including key trends from the Integrated Performance Report
- Operational excellence including reporting from the Operational Management Team meeting (OMG)
- Clinical risk scan and ensuring appropriate actions are taken as a result
- To receive and review key reports as required
- Contracting risks, bids & tenders and delegation of authority as appropriate
- Business developments within the Trust and relationships with partners
- Equality, Inclusion, Engagement and Involvement
- Priority programmes reflecting the strategic direction of the Trust
- Policy register and policies/procedure approval
- To review the Trust Board, EEMT and Members' Council agendas
- To ensure good governance practice is followed within the Trust

## Reporting to Trust Board

Any issues that EMT feels should be escalated will be discussed between the Chief Executive and Chair, and escalated to the Trust Board if required. Routine reports through the Integrated Performance Report and the schedule of governance reports will provide assurance to Board.

**These terms of reference will be reviewed annually.**

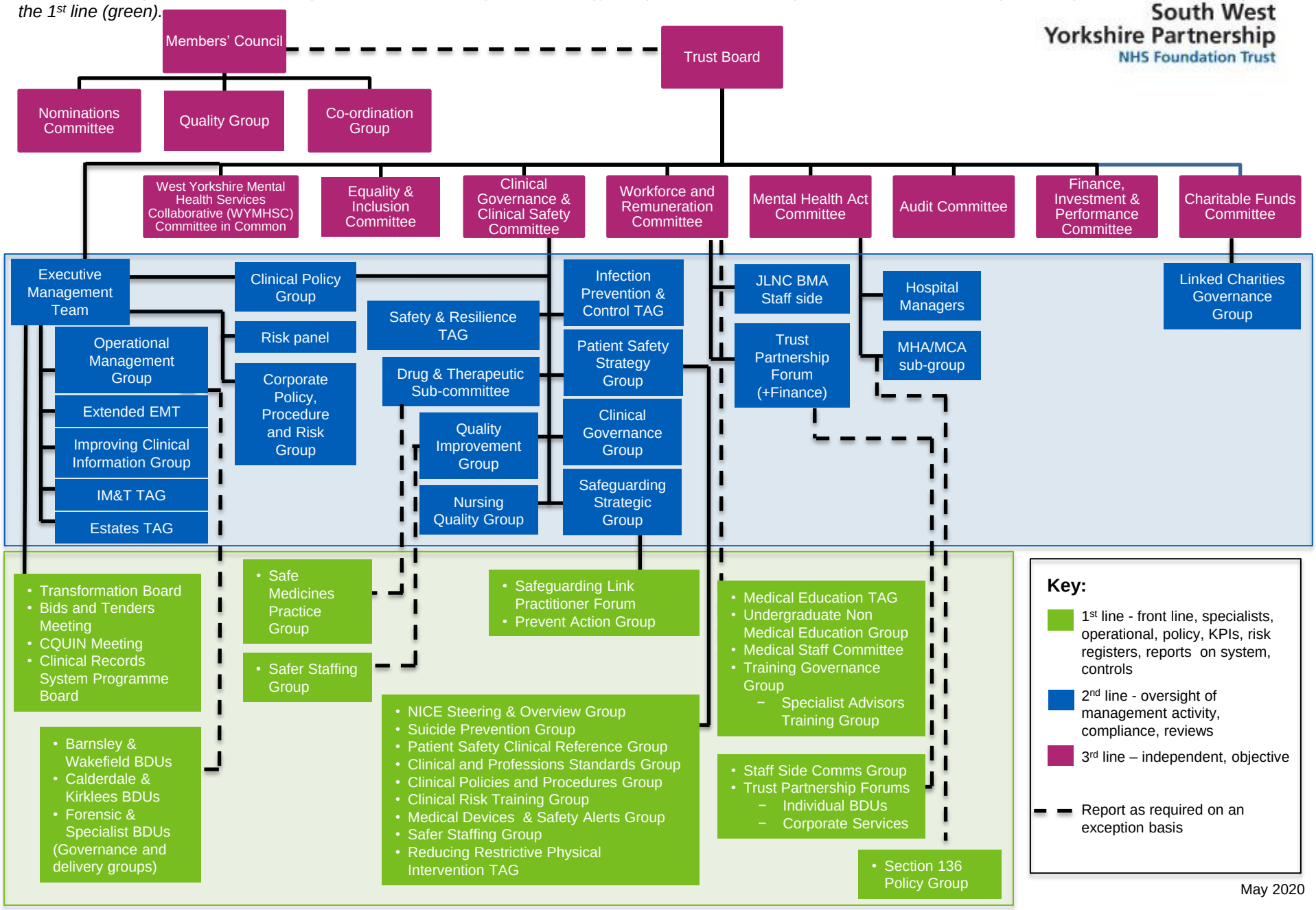
*Supported by the Trust Board on 30 April 2020.*

# Internal governance structures – 3 lines of assurance

Appendix A

*Board are required to ensure appropriate risk management processes are in place.*
*Executive Management Team are responsible for the delivery of the strategy and plans within the organisation which are managed through the 1st line (green).*

NHS South West Yorkshire Partnership NHS Foundation Trust




May 2020

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 30 June 2020
# Agenda item 9.3

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| **Title:** | **Covid-19 – Emergency Preparedness Resilience and Response (EPRR) Arrangements** |
| **Paper prepared by:** | Director of Human Resources, Organisational Development and Estates |
| **Purpose:** | This paper updates the Board in respect of the Covid-19 EPRR arrangements in response to the coronavirus outbreak. |
| **Mission / values:** | The EPRR work stream is in place to ensure that the Trust can operate safely in a period of uncertainty and looks at key areas which could be affected. The work is part of wider planning at national level. |
| **Any background papers / previously considered by:** | Executive Management Team (EMT) and Operational Management Group (OMG) are receiving updates from the command groups. |
| **Executive summary:** | The Trust whilst continuing to operate a major incident plan approach to managing the Covid-19 outbreak, has now started to consider the reset and recover phase. This in addition to the reduction of the national COVID-19 alert level from 4 (A COVID-19 epidemic is in general circulation; transmission is high or rising exponentially) to 3 (A COVID-19 epidemic is in general circulation) has led to discussions at Gold Command regarding the transition back to normal operational and governance arrangements.<br><br>The Trust reviews the Operational Pressure Escalation Level (OPEL) on a weekly basis and it remains at Level 2. However, in the Barnsley system they have reduced their OPEL to 1 and other areas are looking at reducing their OPEL.<br><br>Silver Command arrangements have moved from a daily Monday to Friday meeting to two meetings a week on Monday and Thursday. Gold Command has also reduced from three meetings a week to two on Wednesday and Friday. The Bronze Command arrangements have not been changed and are reviewed at an operational level.<br><br>Risk assessments on both Estate and Workforce continues to be a high priority area of work. The Trust's buildings are all being risk assessed in line with national guidance and in a partnership approach with Estates and Facilities and Service managers. The Estates risk assessments have been based on the social distance measures in place at the current time of two metres.<br><br>Workforce risk assessments have been ongoing and Black, Asian and Minority Ethnic staff have been prioritised, in line with the growing evidence, with a timescale for completion by 12 June 2020. The next priority workforce group will be Shielded Staff following changes to the shielding arrangements. |

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| | There have been discussions at national level with the Health and Safety Executive and NHS Employers regarding Reporting of Injuries, Diseases and Dangerous Occurrences Reporting (RIDDOR) for COVID-19 illness. There has been further guidance produced by the Health and Safety Executive which has been considered by the EMT. The current reporting arrangements in the Trust are consistent with Health and Safety Executive guidance. The Trust has made no COVID-19 related RIDDOR submissions.<br><br>**Risk Appetite**<br>This plan is in line with the Trust's risk appetite for both clinical services and emergency planning. |
| **Recommendation:** | **Trust Board is asked to NOTE the contents of the report.** |
| **Private session:** | Not applicable |

South West Yorkshire Partnership NHS Foundation Trust

# COVID-19: Emergency Preparedness Resilience and Response (EPRR) Arrangements Update

## Trust Board: 30 June 2020

## 1. Introduction

This paper provides and update for the Trust Board on the ongoing arrangements within the Trust in response to COVID-19 and the key developments.

## 2. Command Arrangements

In line with the Trust's major incident plan a series of command arrangements were introduced. These arrangements are reviewed on a regular basis in line with the activity and action required to keep staff, service users and services safe. A decision has been taken to reduce the number of Gold and Silver Command meetings based on the current impact of COVID-19 and actions and decisions required.

Silver Command has moved from five days a week, Monday to Friday, to two days a week on Monday and Thursday. To align with the new Silver Command arrangements, Gold Command has reduced to two days per week, Wednesday and Friday. Bronze Command arrangements are reviewed at operational level and have not changed.

The reduction in Command meetings reflects the UK Government COVID-19 alter level being reduce from 4 (A COVID-19 epidemic is in general circulation; transmission is high or rising exponentially) to 3 (A COVID-19 epidemic is in general circulation).

As part of the reset and recovery phase there will need to be a discussion regarding the transition back to the normal leadership and management, and governance arrangements.

NHS Improvement and England Incident Level remains at 4 (an incident that requires NHS England national command and control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.)

## 3. Operational Pressure Escalation Level (OPEL)

The Trust reviews the overall OPEL level on a weekly basis using the individual service reviews of their OPEL level. Currently the Trust's OPEL is 2 although some services within the Trust have reduced to 1.

The Barnsley system HAS reduced their OPEL to 1 and a number of other partners are reviewing their levels.

The OPEL reporting is defined as:

- **OPEL one - Low levels of service pressure**
- **OPEL two - Moderate levels of service pressure**
- **OPEL three - Severe levels of service pressure**
- **OPEL four - Extreme levels of service pressure**

## 4. Risk Assessments

In line with national guidance risk assessments of the Trust's estate are being undertaken and a programme based on service needs has been developed. These risk assessments are based on the two metre social distancing and it is not proposed to reduce this at this point in time.

A risk assessment for Black, Asian and Minority Ethnic Staff and other vulnerable staff groups has been developed and being rolled out. In light of the growing evidence of the impact of COVID-19 on the BAME communities, the Trust set an objective that all BAME Staff including bank and agency should have a completed risk assessment by the 12 June 2020.

The guidance on shielding is changing from the 4 July and again on the 1 August and in response to this all Shielded Staff will have a risk assessment completed by the end of July at the latest.

## 5. Reporting of Injuries, Diseases and Dangerous Occurrences Reporting (RIDDOR)

Updated guidance has been issued by the HSE regarding the reporting of COVID-19 related incidences under RIDDOR. This guidance does point out that it is difficult to establish the link to meet the threshold for reporting staff who have contracted Covid-19 under the RIDDOR requirements.

Currently the Trust has not reported any cases where it can be established that it is attributable to an occupational exposure as opposed to exposure within the general public exposure. Within the Regional NHS safety advisors network, a response from 15 other trusts has also identified that there has been no incidents where reliable evidence would indicate occupational exposure.

One possible factor that could highlight a potential occupational exposure could be related to Personal Protective Equipment (PPE) but in all instances SWYPFT has followed PHE guidance as the baseline of requirements in the appropriate areas.

The issue of what PPE is available and the appropriate use within the relevant areas has been continuously monitored and any issue identified followed up and dealt with. The Trust has been able to maintain supplies of appropriate PPE for the relevant areas and other aspects such as fit-testing and at no point has it allowed a lower standard to be adopted.

Each potential case still needs to be examined on an individual basis but the test of it being “more likely than not” attributable to work activities still is difficult to prove without continuous mass testing of staff.

As the number of cases within the general public subsides, over time there may be such a case where this can be established but with SWYPFT the exposure within the workplace also appears to be reducing in respect of the exposure of staff.

The advent of testing all staff and antibody testing may highlight additional information that could be used for considering future cases but this cannot be applied retrospectively and so the number of cases that could be reportable should still be relatively low.

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# Trust Board 30 June 2020
# Agenda item 9.4

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| **Title:** | **Trust Board self-certification (FT4) – corporate governance statement 2019/20** |
| **Paper prepared by:** | Director of Finance & Resources<br>Corporate Governance Manager |
| **Purpose:** | To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider license. |
| **Mission/values:** | Good governance supports the Trust to deliver its mission and adhere to its values. |
| **Any background papers/ previously considered by:** | The operational plan for 2020/21 approval has been deferred due to Covid-19.<br>The Trust Board reviewed compliance with NHS Constitution on 28 January 2020.<br>The first part of the required self-certification (G6/CoS7) was approved by Trust Board on 28 April 2020.<br>The attached document has been reviewed by the Executive Management Team. |
| **Executive summary:** | **Background**<br>NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.<br>As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations. The Trust Board approved the first self-certifications (G6/CoS7) on 28 April 2020 in relation to:<br>➢ The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence)<br>➢ If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence).<br>Further self-certifications (FT4) are required by 30 June 2020: |



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| | ➢ The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence) (appendix 1 – Corporate Governance Statement)<br>➢ The training of Governors (as required by s151(5) of the Health and Social Care Act 2012) (see below).<br><br>**Self-certification - part two (FT4)**<br><u>Draft Corporate Governance Statement 2019/20</u><br>The attached paper (appendix 1) sets out the statements (numbered 1-6) Trust Board is required to make and the assurance to support self-certification against the statements. From the assurance provided, Trust Board is asked to certify that it is satisfied with the risks and mitigating actions against each area of the required six areas within the Trust's Draft Corporate Governance Statement. The rationale for this assurance is set out in the accompanying detailed statement.<br><br><u>Training of Governors</u><br>Starting in 2013, the Trust has developed, through the Members' Council Co-ordination Group, a programme of training and development to ensure governors have the skills and experience required to fulfil their duties. The Trust has supported the training and development of governors in a number of ways:<br>➢ Each new governor had an induction meeting with the Chair and all other governors had an annual review meeting to discuss individual performance and training and development needs. Governors are also provided with a comprehensive induction pack to support them in their role.<br>➢ The Trust offered 1:1 support and 'buddying' as part of the induction programme for new Governors.<br>➢ Attendance at national GovernWell training modules was also encouraged and the Trust facilitates attendance.<br>➢ Most formal Members' Council meetings include a discussion item or development session, which allows governors, with the support of Trust Board, to look at a particular area of Trust services or activity in more detail.<br>➢ Each governor has an annual performance review which includes attendance at meetings and training requirements.<br><br>In 2014, the Members' Council signed up to the principle that there should be a level of minimum commitment and contribution from Governors at two levels:<br>*Required*<br>➢ Attendance at a minimum of three out of four formal Members' Council meetings.<br>➢ Attendance at the annual evaluation session.<br>➢ 1:1 introductory meeting with the Chair. |

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| | ➢ Annual review meeting with the Chair.<br>➢ Attendance at the Annual Members' Meeting.<br>*Desirable*<br>➢ Attendance at Trust Board meetings.<br>➢ Attendance at training and development sessions organised by the Trust.<br>➢ Attendance at the Foundation Trust Network's GovernWell modules.<br>➢ Membership of formal groups (currently Members' Council Co-ordination Group, Quality Group and Nominations Committee).<br>From the assurance provided, Trust Board is asked to certify this it "***is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.***" |
| **Recommendation:** | **Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to:**<br>➢ **the Corporate Governance Statement 2019/20**<br>➢ **the training for Governors 2019/20** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 30 June 2020
# Corporate Governance Statement 2019/20

**1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.**

The Trust continues to implement, develop and improve its arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board undertook a well-led governance review during 2015, which has been followed up by CQC well led reviews in each of 2017, 2018 and 2019.

The most recent CQC well review provided a rating of **good**. Review and scrutiny of the Trust's governance arrangements took place as part of the well-led review, which included interviews with the Trust Board and staff. The review concluded that the Trust Board and leadership team had the appropriate range of skills, knowledge and experience, and showed integrity on an ongoing basis. The report also highlighted that there was a robust and realistic strategy for achieving Trust priorities and effective internal governance structures, systems and processes in place to support delivery of the strategy. Following publication of the CQC report in August 2019, the Trust Board received a summary of key findings and the action plan containing 12 'must do' and 27 'should do' actions in September 2019, including a governance structure to monitor the progress and management of the action plan. This continues to be regularly reviewed by the Clinical Governance & Clinical Safety Committee.

In 2019/20, internal audit completed a governance and risk audit which received **significant assurance**. As part of the audit, the Trust's strategic priorities were reviewed, taking account of the 'make SWYPFT a great place to work' objective which was adopted in 2019. Indicators defined in the Trust strategy relating to all strategic priorities are reviewed within the Integrated Performance Report (IPR) which is received at key governance groups across the Trust, including the Trust Board. As part of the review the auditors also considered the Trust's approach to the identification, escalation and management of risk, and the alignment of the Board Assurance Framework (BAF).

*Risks*
*The Trust does not apply or applies inconsistently good corporate governance. Mitigated by robust scrutiny through the Trust's governance and assurance processes.*

The most recent Care Quality Commission (CQC) rating overall is **good** (which includes a rating of **good** for the well-led domain). The Board undertook a structured development programme, using the NHSI framework, which ran throughout 2019/20.

There are a number of areas to provide assurance that the Trust applies the principles, systems and standards of good corporate governance.

- The Trust's Constitution, based on Monitor's model constitution, underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution. A review of the Trust's Constitution began in December 2019, including consultation with governors and Board members. Amendments and areas of further review / investigation were approved at Trust Board in December 2019 and Members' Council in January 2020, with further work to be completed in 2020.
- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. The annual self-assessment was presented to Trust Board in January 2020.
- Each committee of the Trust Board is required to prepare an annual report, which is presented to the Audit Committee. The Audit committee reviews overall effectiveness of committee structure. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.
- Each group and committee of the Members' Council is required to prepare an annual report and review of the terms of reference, which is reported to the Member's Council annual in April / May and provides assurance that each group / committee is meeting its terms of reference and work programme.
- The Trust undertakes an annual assessment of compliance against NHS Improvement / Monitor's Code of Governance which is reported to Trust Board.
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors are proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration. All members of Trust Board and the Executive Management Team have disclosure and barring (DBS) checks in place.
- All elections made to the Members' Council are held in accordance with the Model Election Rules in the Trust's Constitution. Elections are overseen by an external organisation (currently Civica Election Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2013. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence.

*Risk*

*The outcome of the inspection required some areas that require improvement. Mitigated by an action plan to address areas for improvement.*

The Care Quality Commission (CQC) action plan covers the 12 'must do' and 27 'should do' actions highlighted in the most recent CQC report, published in August 2019. The Board received a first draft of the action plan in September 2019. Progress against the action plan continues to be regularly reviewed by the Clinical Governance & Clinical Safety Committee.

In addition, actions identified from each of the internal audits are allocated a lead within the organisation and tracked through an online web portal 'Pentana'. Progress updates and supporting information is be uploaded to the tracker which are reviewed by auditors and action leads, and once complete they are closed by the auditor. The audit actions are tracked through updates to the Audit Committee.

*Risk*
*The Trust does not comply with the requirements of its Licence. Mitigated by ongoing review of Trust compliance and reporting to Trust Board as part of the NHS Improvement / Monitor requirements.*

The following also provide assurance to Trust Board that the Trust has good corporate governance arrangements in place and complies with its Licence:

- The Head of Internal Audit Opinion for 2019/20 provides **significant assurance** on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.
- As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in NHS Improvement's Foundation Trust Annual Reporting Manual. The Statement for 2019/20 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust's annual report and accounts.
- The Trust's Board assurance framework and risk register have been assessed as appropriate as part of an internal audit of the risk and governance in 2019/20 which received **significant assurance**.
- The Trust Board reviews compliance with the NHS Constitution annually, last reviewed in January 2020.
- The Trust Board receives annual self-certifications of compliance with the NHS Provider Licence (April) and corporate governance statement (June).

*Risk*
*The Trust does not continue to have good corporate governance arrangements in place. Mitigated by submission of financial and performance metric data on a monthly basis, through ongoing review of internal governance processes and through internal audit processes.*

This is further supported by the amendments to governance arrangements that the Trust was required to adopt in response to the Covid-19 pandemic. In line with national guidance, the Chair, Chief Executive and Company Secretary regularly reviewed the governance arrangements to allow business to continue during the pandemic. Examples include:

- In line with point 4.17 of the Standing Orders of the Trust Board, the Chair agreed to exclude members of the public and press from the March 2020 Trust Board meeting for special reasons pertaining to health and safety following guidance in relation to social distancing. At the time of the March 2020 Trust Board meeting, the Trust did not have the appropriate level of technology tested to support members of the public or press joining a meeting remotely, however this was fully functional by the April 2020 Trust Board meeting.
- It was acknowledged at the beginning of the pandemic that any changes to the running of the Trust Board, or requirement to suspend the Standing Orders of the Trust Board would be agreed in line with the Trust Constitution.
- During the Covid-19 pandemic, the Trust Board and Committee agendas and papers have been reduced to focus on delivery of the national Covid-19 plan, business continuity and any other business believed to be essential to the Trust.
- It was agreed that areas of focus for the Committees of the Trust Board during the pandemic would be staff wellbeing and staffing changes, delivery of clinical services, and reporting and management.
- Interim measures relating to IT systems and information governance continue to be reviewed regularly by the Improving Clinical Information Group, and it has been agreed by Trust Board t that the Standing Financial Instructions and Scheme of Delegation would be reviewed regularly throughout the pandemic, with any interim approvals being logged and reported.
- The Trust emergency response command structure (bronze, silver and gold) has been in place since March 2020 which receives instruction / guidance from regional and national bodies and determines what action needs to be taken, with all decisions and actions logged for information, ratification or approval on a weekly basis.

- The Non-Executive Directors have been updated on a weekly basis since March 2020 on all decisions and actions taken.
- The Members' Council have been updated regularly by the Chair and Corporate Governance Team and successfully held a virtual Council meeting on 1 May 2020. In addition, Q&A sessions have been in place for governors following Trust Board meetings since April 2020.
- In April 2020, the Executive Management Team (EMT) included a number of risks relating specifically to Covid-19 onto the organisational risk register, which are reviewed regularly alongside the impact of Covid-19 on existing risks.
- The Trust is fully engaged in each integrated care system (ICS) it works in and the Trust Board receives regular updates from executive director leads with regard to programmes of work in each ICS.

**2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time-to-time.**

The Accounting Officer and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from NHS Improvement, an assessment of the Trust's immediate position is undertaken and any action or development required to ensure compliance is initiated.

*Risk*
*Trust does not have regard to guidance. Mitigated by the Company Secretary having oversight of the systems and processes in place to ensure guidance is identified, captured, assessed and implemented.*

**3. The Board is satisfied that the Trust implements:**
**a) effective board and committee structures**
**b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees**
**c) clear reporting lines and accountabilities throughout its organisation.**

Trust Board is clear that its role is to set the strategic direction and associated priorities for the organisation, ensure effective governance for all services and provide a focal point for public accountability. The general duty of Trust Board, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for members of the Trust as a whole and the public. Trust Board is clear of its accountability and responsibility.

Trust Board and committee structures in place are effective and meet the requirements of the Trust's Constitution. Committees are supported by terms of reference and annual work plans and have clear reporting mechanisms to Trust Board. The Trust Board has a work programme and agenda is drawn up with reference to the board assurance framework, and cycle of meetings. The Trust has seven committees:

- Audit Committee
- Clinical Governance and Clinical Safety Committee
- Equality and Inclusion Committee
- Finance, Investment and Performance Committee (established as a Forum in June 2019 and a Committee from November 2019)
- Mental Health Act Committee
- Workforce and Remuneration Committee
- West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Committees-in-Common
- Charitable Funds Committee (Committee of the Corporate Trustees)

The Committees are chaired by a Non-Executive Director and, with the exception of the Audit Committee, have Non-Executive and Executive Director membership. The Audit Committee membership comprises exclusively of Non-Executive Directors. Agendas, which are risk-based, are compiled and agreed by the chair of the committee in conjunction with the lead Director. Each committee has an annual work programme, which is incorporated into agendas as appropriate. Lead Directors are responsible for ensuring, with the Company Secretary and lead PA for each meeting, that papers are commissioned to meet the requirements of the committee, to provide assurance that risk is mitigated within the Trust and to provide assurance that the Trust is working to deliver and continuously improve the services it provides whilst achieving value for money and best use of resources.

The membership of committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors. The committee structure is reviewed for appropriateness from time-to-time by the Chair, with support from the Chief Executive and Company Secretary. An update to the internal meeting governance framework will be agreed at Trust Board in June 2020 (previous review April 2019).

Each committee is required to prepare an annual report, which is presented to the Audit Committee. The Audit committee reviews overall effectiveness of committee structure. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.

The Executive Management Team's (EMT) role is to ensure that resources are deployed to support the delivery of the Trust's plan, to ensure that the Chief Executive can discharge their accountability to best effect through effective delegation and prioritisation of work, to support each other to find appropriate linkages and synergies, to ensure performance is scrutinised and challenged, both Trust-wide and by Business Delivery Units (BDUs), and to ensure the work of the EMT is aligned with that of Trust Board.

Trust Board is supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. The Members' Council is clear that its role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public. The Members' Council continues to develop its skills and experience in its ability to challenge and hold Directors to account for the Trust's performance. The Members' Council holds an annual session specific to holding the Non-Executive Directors to account. This is supported by a training session to enable the governors to develop their skills to run the session successfully.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within BDUs, deputy directors provide operational leadership and management allowing BDU Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. BDUs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

BDUs are supported by corporate directorates, which provide co-ordinated support services linked to the accountabilities of executive directors. There are six domains comprising financial management, information and performance management, people management, estates management, compliance, governance and public involvement and engagement, and service improvement and development.

*Risk*
*The Trust does not have effective structures at Trust Board level. Mitigated by annual committee review process, independent review by internal audit of effectiveness, clear view of roles and responsibilities, and clear approach to leadership and management throughout the Trust.*

**4. The Board is satisfied that the Trust effectively implements systems and / or processes:**
- **a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively**
- **b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations**
- **c) to ensure compliance with healthcare standards binding on the Licence holder, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions**
- **d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and / or processes to ensure the Licence holder's ability to continue as a going concern)**
- **e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Trust Board and Committee decision-making**
- **f) to identify and manage (including, but not restricted to, manage through forward plans) material risks to compliance with the conditions of its Licence**
- **g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and, where appropriate, external assurance on such plans and their delivery**
- **h) to ensure compliance with all applicable legal requirements.**

As part of its annual audit, the Trust's external auditor, Deloitte, was satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in 2019/20. There were no issues identified to report in this regard in the audit opinion.

*Risk*
*The Trust does not have the systems and processes to ensure compliance with its Licence. Mitigated by performance reporting arrangements to Trust Board, including exception reports on areas of risk or concern, quarterly exception reports, robust committee arrangements in place providing assurance that the systems and processes in place are effective.*

The Trust's internal audit plan is risk-based to enable the Trust to identify areas where improvement is sought and to learn from best practice. The Audit Committee approved the internal audit plan for 2019/20. The plan included core reviews to inform the Head of Internal Audit Opinion relating to core financial controls, governance and risk management, which included a focus on Board committee arrangements, policy monitoring and data security and protection toolkit. This was supported by a number of cyclical and risk reviews covering cost improvement process and reporting. Cyber security, data quality framework, performance management framework, patient experience (focus on complaints) and compliance with legislation. The conclusions and recommendations from all internal audit reports are reported into the Audit Committee and if deemed appropriate the Audit Committee will seek further assurance and updates on actions being taken

The Trust continues to develop and implement service line reporting, which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. Further work will be undertaken in the coming year to use the information to benchmark internally and learn from best practice.

Trust Board receives an Integrated Performance Report (IPR) on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and quality performance targets. Other reports to Trust Board and its committees provide further assurance that the Trust is fulfilling its purpose in an

effective and efficient manner.

The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust has a robust process in place to ensure that it meets the requirements of its registration. Action plans were developed in response to recommendations included in the most recent inspection reports published in 2019. For 2019/20 the Trust's programme of visits to services focused on areas 'requiring improvement' in the reports and completing recommended 'must' and 'should' do actions. Mental Health Act visits occur regularly and, following each visit, an action plan is submitted to the CQC to address any issues raised. The action plans and progress against these are monitored and scrutinised by the Mental Health Act and Clinical Governance and Clinical Safety Committees. Local actions have also been implemented in relation to any identified concerns arising from the Trust's own unannounced visit programme.

Based on evidence provided by finance and performance reports, the Trust's draft operational plan for 2020/21, the temporary financial arrangements in place for the first four months of 2020/21 and a favourable cash position, supported by Audit opinion, the Trust will remain a going concern. As part of its accounts audit for 2019/20, the Trust's external auditor was able to agree with management's view that the Trust could account on a going concern basis. The coming year presents a challenge and greater operational and financial uncertainty to the Trust given the impact of Covid-19. Trust Board will regularly review the Trust's position and it is planned to introduce a finance committee during the year.

*Risk*
*The Trust is unable to meet the requirements of its operational and financial plans. Mitigated by regular review at finance, investment and performance committee to ensure its plans provide sufficient investment in services and to consider the planned end-of-year outturn position.*

The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.

**5. The Board is satisfied that:**
- **a) there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided**
- **b) Trust Board's planning and decision-making processes take timely and appropriate account of quality of care considerations**
- **c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care**
- **d) Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care**
- **e) the Trust, including Trust Board, actively engages on quality of care, with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources**
- **f) there is clear accountability for quality of care throughout the Trust, including, but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to Trust Board where appropriate.**

The Trust continues to regularly review processes against governance best practice, including:

- policies developed, reviewed and in place
- governance systems
- the assurance framework and risk register presented to Trust Board quarterly
- audits undertaken both internally and externally
- the programme of unannounced visits

- reports submitted to Trust Board and its Committees, as well as the Members' Council.

The Trust's Quality Account publication for 2019/20 has been deferred due to Covid-19, but will provide a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The report is normally externally audited, but this requirement is not in place for the 2019/20 report given the impact of Covid-19. Internally controls are in place to ensure that the content is in line with the Annual Reporting Manual 2019/20 issued by NHS Improvement.

The process introduced by the Director of Nursing and Quality to assess risk to and impact on quality and safety of the cost improvement and efficiency savings proposed by BDUs was again applied in 2019/20. The Quality Impact Assessment process, led by the Director of Nursing and Quality and undertaken in conjunction with clinical and general management within BDUs, provides assurance throughout the process to the Executive Management Team (EMT) and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements do not have an adverse effect on Trust services. In 2019/20, assessment of the impact of substitutions or mitigating action are included in the process as well as cost pressures.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. Reporting processes and mechanisms through Trust Board, its committees, EMT and through to BDUs and their governance processes reflects this approach. Accountability for quality is also clear through the leadership and management arrangements within the Trust. BDUs continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making.

The Trust's approach to clinical quality improvement is based on continuous service improvement, working in innovative ways to meet local priorities, to ensure compliance with national standards and external regulation, adoption of lean systems thinking, and making the most of shared learning opportunities across the healthcare system, using quality to deliver best value. The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services. The approach also links to the national Quality, Innovation, Productivity and Prevention (QIPP) agenda.

Trust Board receives regular reports, directly and through the Clinical Governance and Clinical Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, reducing restrictive practice, and information governance, are being addressed. Where the Clinical Governance and Clinical Safety Committee identify an area of concern which has been raised at a particular time, it is scrutinised on behalf of the board by receiving regular reports for a period.

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators (KPIs) relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality. This includes surveys, consultations and engagement events. The Trust's approach to insight and service user experience is set out in its Communication, Engagement and Involvement Strategy, which is currently under review and will form part of the Involving People Strategy in 2020. Regular meetings are also held in community and ward settings to

receive service user and carer feedback. The Trust continues to look for innovative ways to capture service user and carer feedback at the point of contact.

The Trust is compliant with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection (Hygiene Code). The Trust has an Infection Control Strategy in place and the infection control annual plan and annual report are considered by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Trust Board monitors infection control through the monthly performance reports and the quarterly compliance report. Hygiene and quality of environment are maintained through cleaning schedules and through service level agreements and regular visits to clinical areas by the Director of Nursing and Quality, include checks for cleanliness.

The Trust publishes information in relation to the Friends and Family test for service users and staff.

The Trust actively engages with its service users, their carers, staff and stakeholders on the quality of its services through the development of its Quality Accounts and in the development of its services.

The Trust has a whistleblowing policy in place, which sets out clearly staff responsibility to raise concerns and how they can do this. The policy is clear on the escalation process and who concerns should be reported to. The policy is supported by information on the Trust's intranet and in associated documentation, such as the fraud and bribery act policy, safeguarding policies, and serious incident reporting and management policy. Arrangements are scrutinised by the Audit Committee. The Trust has also appointed a network of Freedom to Speak Up Guardians (FTSUG), which includes staff governors from the Members' Council, rather than one individual due of the diverse nature of services and large geographical spread of the Trust, the FTSUG provide staff with another way to raise concerns at work. Trust Board has also identified the Deputy Chair as the Senior Independent Director.

*Risk*
*The Trust does not have the capacity and capability at Trust Board level. Mitigated by quality performance reporting to Trust Board, annual quality report, customer services processes and ongoing engagement with stakeholders, service users / carers and staff, clear process in place for whistleblowing and raising concerns, and processes in place for recruitment and selection of Trust Board members.*

**6. Trust Board effectively implements systems to ensure that it has in place personnel on Trust Board, reporting to Trust Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the Trust's NHS provider licence.**

Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The Chair and Non-Executive Directors have a broad base of skills and experience, including financial, commercial, marketing, legal, community engagement, and health and social care. It is the role of the Nominations Committee to assess the mix of skills and experience across Trust Board annually and when appointing Non-Executive Directors to the Board and to ensure a balance is maintained with skills complementing those of Executive Directors. To inform this process and to ensure Trust Board retains a balance of skills and experience to operate effectively as a unitary board, a review of Trust Board skills and experience will be undertaken as part of the Trust Board development plan. The recruitment process for new members of the Trust Board incorporates testing against the values of the organisation and discussion panel including staff (with representation from staff equality networks), governors and service users / carers.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors, Governors and stakeholders. Trust Board undertakes ongoing Board development, using external expertise where required. During 2019/20 a structured development programme was followed using the NHS Improvement framework.

The Chief Executive is subject to formal annual appraisal by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members. The outcome of the Non-Executive Director appraisals is reported to the Members' Council.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. This process of assessing the organisation's readiness for medical and nursing re-validation has been scrutinised both by Trust Board and by the Clinical Governance and Clinical Safety Committee.

Trust Board satisfies itself that the management team has the necessary skills and competencies to deliver the Trust's strategic objectives. Where gaps are perceived, the Chief Executive will seek to address Trust Board concerns, supported by the Workforce and Remuneration Committee.

All appointments to senior management positions are subject to rigorous and transparent recruitment processes. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation and wider NHS and succession planning. Professional and clinical leadership is devolved into the organisation under the leadership of the Director of Nursing and Quality, and the Medical Director.

The Trust also has various leadership and management development pathways in place including a programme for all managers within the Trust at bands 7 and above, Middleground, which aligns effort and resources to shared organisational goals, ensures all effort and initiatives link together to create added value, ensures behaviours and actions are aligned to the organisational vision, values and goals, and ensures behaviours help produce performance, assurance and improvement at individual, team and organisational level.

*Risk*
*The Trust does not have suitably qualified individuals at all levels of the organisation. Mitigated by recruitment and selection processes for Trust Board, Director-level appointments and staff at all levels.*

For non-medical professional qualifications, all nursing, Allied Health Professionals and psychology registered professional staff are subject to revalidation arrangements through their professional bodies. The Trust provide a monitoring and reminder system to all registered professional staff to ensure that registration is maintained. The revalidation process is also monitored by nominated professional leads with routine reporting into Clinical Governance and Clinical Safety Committee around compliance. The report in February 2020 showed that since 2016 approximately 1800 nurses have revalidated (many will have now revalidated twice), nobody has ever failed to revalidate and no time has been lost due to failure to revalidate.

For the recruitment of medical staff, doctors are assessed during the application and interview process to ensure they have the relevant qualifications and experience to fulfil the post. Medical HR will meet with the doctors to verify their ID and complete the Disclosure and Barring Service (DBS) check. The Medical Directorate request information relating to the doctor's last appraisal date, whether there are any concerns about the doctor's practice, conduct or health and if there are any outstanding investigations. The information received is checked by the Trust's Responsible Officer (RO), prior to final offer being made. Where this information is not received prior to the final offer being made, the offer remains subject to satisfactory RO information or satisfactory Annual Review of Competence Progression (ARCP) outcome for those doctors joining the Trust straight from a training programme.

Once a doctor joins the organisation, they are connected to the Trust on the General Medical Council (GMC) connect and added to the appraisal system, L2P. They have an induction meeting with the Associate Medical Director (AMD) of Appraisal and Revalidation and after this are appraised in line with their dates. All appraisals are reviewed by the AMD and RO, before being passed or returned to the individual. There are regular meetings between AMD,RO and business manager and any issues are raised in these meetings. In addition there is a Responding to Concerns Action group (RtCAG), whose membership comprises of RO, AMD, Medical Director, Director of Nursing & Quality and Director of HR, OD & Estates, where any issues about a doctors fitness to practice are raised, including reviewing any complaints with a named medic.

From the 2018/19 appraisal and revalidation report, 92% of doctors appraised successfully and the 8% of those that did not, there was an acceptable reason approved by the AMD and RO. The report for 2019/20 was cancelled due to Covid-19 , however, the appraisal and revalidation groups still meet and RtCAG continues, which provides oversight of all potential issues.

NHS
South West
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# Trust Board 30 June 2020
# Agenda item 9.5

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| **Title:** | **Annual Report and Accounts - 2019/20** |
| **Paper prepared by:** | Director of Finance and Resources |
| **Purpose:** | ➢ To confirm the submission of the 2019/20 Annual Accounts and Annual Report.<br>➢ To explain the process undertaken to generate these submissions and provide assurance regarding the governance of the process.<br>➢ To publically table the reports generated by the external auditors Deloitte LLP following their annual audit. |
| **Mission/values:** | The Annual Report and Accounts form part of the Trust's governance arrangements, which support the Trust's mission and values. The Annual Report provides a summary of the Trust's performance against its mission and in line with our values and the accounts demonstrate financial probity. |
| **Any background papers/ previously considered by:** | ➢ Given the impact of the Covid-19 pandemic on the NHS, the deadline for submission of the Annual Report and Accounts has been extended to 25 June 2020. Trust Board delegated authority for approval to the Trust Chair and Chief Executive at its meeting on 21 May 2020.<br>➢ The draft Annual Governance Statement was reviewed and agreed by the Trust Board on 28 April 2020 with the final draft reviewed and approved at Trust Board on 21 May 2020. The final draft was included in the Annual Report reviewed by the Audit Committee on 2 June 2020 and approved by the Trust Chair and Chief Executive on 3 June 2020.<br>➢ The draft Annual Report had input from executive directors and other senior managers and stakeholders, and was shared with four non-executive directors including the Trust Chair for comment and feedback. The final draft was reviewed by the Audit Committee on 2 June 2020 and approved by the Trust Chair and Chief Executive on 3 June 2020.<br>➢ The Annual Accounts were reviewed in detail by the Director of Finance & Resources and the two qualified accountants on the Audit Committee. The Annual Accounts were then reviewed in full and recommended for approval by the Audit Committee on 2 June 2020 and approved by the Trust Chair and Chief Executive on 3 June 2020.<br>➢ A separate paper was provided to the Trust Board on 21 May and Audit Committee on 2 June explaining the change in process and extended timescales for completion of the Quality Account. |

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| **Executive summary:** | ➢ In accordance with Department of Health and Social Care Group Accounting Manual 2019/20, the Annual Report and Accounts is not able to be published until after the document is laid before parliament which is due to take place in July 2020. It will be formally presented at the Annual Members' Meeting on 28 September 2020.<br>➢ All documents were submitted to NHS England & Improvement ahead of the submission deadline.<br>➢ Each document was subject to significant Board scrutiny and oversight.<br>➢ With regard to the accounts, Deloitte issued an unmodified audit opinion with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.<br>➢ A copy of the audit report for the accounts is attached to this paper. |
| **Recommendation:** | **Trust Board is asked to:**<br>➢ **NOTE the update and make any further COMMENTS on the process relating the annual report and accounts process and submissions; and**<br>➢ **RECEIVE in public the external audit report relating to the annual accounts and comment accordingly.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# 2019/20 Annual Report, Annual Accounts and Quality Account

## Introduction

In line with statutory requirements the Trust has submitted an annual report and its annual accounts to parliament and to NHS England & Improvement (NHSE&I). Each of these has been subject to internal scrutiny and governance, and to external audit. The documents become publicly available documents once laid before parliament, which is due to occur in July 2020 and will be formally presented at the Annual Members' Meeting in September 2020. This document explains the process undertaken and provides the external audit reports.

Board members are reminded that given the impact of Covid-19 timescales for the submission of these documents has been extended this year. The annual report and accounts need to be completed and submitted by 25 June and the quality account by 15 December. Given the timings of the year-end, required time to audit the accounts and report remotely delegated authority was given by the Trust Board on 21 May for the Trust Chair and Chief Executive to approve the annual report and annual accounts.

## Annual Governance Statement

The Annual Governance Statement (AGS) was produced in line with guidance and instructions provided by NHSE&I based on Treasury requirements. The draft AGS was approved by the Trust Board on 28 April and the final draft was further reviewed and approved by Trust Board on 21 May. The final version was reviewed and recommended for approval by the Audit Committee on 2 June before being approved by the Trust Chair and Chief Executive on the 3 June 2020. The AGS contained the Head of Internal Audit overall opinion of significant assurance.

## Annual Accounts

The annual accounts were produced in line with international accounting standards (IFRS) and followed guidance and instruction provided by NHSE&I. The draft accounts were shared with the members of the Audit Committee (which includes two qualified accountants) for comment and feedback. Responses were provided to all questions raised and where appropriate amendments were made to the accounts (typically within the notes to the accounts). They were also shared with members of the Executive Management Team (EMT) for comment and feedback.

The accounts were subject to audit by Deloitte LLP and to a review at the Audit Committee on 2 June. The Audit Committee recommended them for approval and they were subsequently approved by the Trust Chair and Chief Executive on 3 June 2020. Electronic

signature took place on 3 June. A log was kept of all adjustments made from version to version. The accounts were then submitted to parliament and NHSE&I three weeks ahead of the required deadline.

**Annual Report**

The production of the annual report was co-ordinated by the head of business development and included contributions from appropriate executive directors and other senior managers. The annual report was shared with non-executive directors and the lead governor for comments. As with the annual accounts, the annual report was reviewed at the Trust Board on 21 May and then at the Audit Committee on 2 June. The Audit Committee recommended the annual report for approval and it was approved by the Trust Chair and Chief Executive on 3 June 2020. Electronic signature again took place on 3 June 2020. The report was then submitted to parliament and to NHSE&I

**Quality Account**

As previously reported to the Trust Board there is no requirement to complete and external audit of the 2019/20 quality account. In addition the deadline for submission has been extended to 15 December 2020.

**Conclusion and Recommendation**

In conclusion the Trust met all its submission deadlines associated with its statutory returns covering the annual accounts and annual report. Input and feedback was regularly sought from all Board members and a range of other key stakeholders. External Audit provided an unmodified opinion in relation to the accounts.

Trust Board is asked to note the submission of the statutory returns, process undertaken to generate the accounts and reports and the assurance provided by our external auditors.

Deloitte.

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# South West Yorkshire Partnership NHS Foundation Trust

Report to the Audit Committee on the 2019/20 audit

# Contents

## 01 Final report



## 02 Appendices

# Director introduction
## The key messages in this report

Audit quality is our number one priority. We plan our audit to focus on audit quality and have set the following audit quality objectives for this audit:

- A robust challenge of the key judgements taken in the preparation of the financial statements.
- A strong understanding of your internal control environment.
- A well planned and delivered audit that raises findings early with those charged with governance.

I have pleasure in presenting our final report to the Audit Committee for the 2019/20 audit.
I would like to draw your attention to the key messages within this paper:

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| **Status of the audit** | Our audit is complete.<br>Our Independent Examination of EyUp! Is underway and we have agreed a timetable with management to have these ready for signing for the September Charitable Funds meeting. |
| **Conclusions from our testing** | • The key judgements in the audit process related to the Modern Equivalent Asset Valuation Alternate Site design (page 8);<br>• We have issued an unmodified audit opinion on the financial statements with the inclusion of a key audit matter on property valuations referring to a material uncertainty identified by your property valuers (page 8);<br>• We have identified a finding in respect to our work regarding management override of controls (page 9);<br>• We did not identify any significant audit adjustments or disclosure deficiencies; and<br>• We have not identified any inconsistencies between the financial statements and the TACs (Trust Accounts Consolidation schedules). |
| **Financial sustainability and Value for Money** | • The Trust reported a surplus for the year of £8.5m before other comprehensive income and expenditure, which is ahead of the planned surplus of £1.5m. This includes £1.8m of payment from the Provider Sustainability Fund (PSF) notified at the year-end.<br>• CIP (Cost Improvement Plan) delivery was £10.6m against a £10.6m target, meaning that the Trust has achieved the target in year. This comprised of £5.5m in recurrent CIP, an underachievement of £1.8m (plan £7.3m), offset by an overachievement of £1.8m in non-recurrent CIP (plan £3.2m v actual £5m).<br>• The Trust has a Use of Resources rating of 1 and a Single Oversight Framework segmentation of 1 which are in line with the planned rating. It is not currently subject to any regulatory action from either NHSI (NHS Improvement) or the Care Quality Commission (CQC).<br>• Our response to Value for Money is set out on page 10. |

# Director introduction

## The key messages in this report (continued)

Audit quality is our number one priority. We plan our audit to focus on audit quality and have set the following audit quality objectives for this audit:

- A robust challenge of the key judgements taken in the preparation of the financial statements.
- A strong understanding of your internal control environment.
- A well planned and delivered audit that raises findings early with those charged with governance.

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| **Annual Report & Annual Governance Statement** | • We have reviewed the Trust's Annual Report & Annual Governance Statement to consider whether it is misleading or inconsistent with other information known to us from our audit work. Based on our review, we consider that the Trust has followed the format prescribed by the Foundation Trust Annual Reporting Manual. |
| **Impact of Covid-19** | • The impact of Covid-19 has led to a material uncertainty being identified by the Trust's property valuer regarding the valuation of properties (page 12). This is described as follows:<br>*The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on 11 March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries.*<br>*Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.*<br>*Our valuation(s) is / are therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of this property / these properties under frequent review.*<br>The above material uncertainty statement is based on guidance from RICS. As a result we expect to refer to this in our opinion in the key audit matter on property valuations.<br>• There are no other significant impacts of Covid-19 on the Trust's Accounts and Annual Report identified at this time. |
| **Accounting performance** | • The finance team have been proactive in raising matters for audit consideration during the year. The quality of working papers to support the financial statements audit has been of a very high standard as in previous years. We would like to take this opportunity to thank management for their assistance during the audit. |

Paul Hewitson
Audit Director

# Our audit explained

## We tailor our audit to your business and your strategy

**Identify changes in your business and environment**

In our planning report we identified the key changes in your business and articulated how these impacted our audit approach. We have not identified any subsequent changes which have impacted our audit approach.

**Scoping**

We have performed our risk assessment in line with current NHSI requirements.

**Other findings**

As well as our conclusions on the significant risks we are required to report to you our observations on the internal control environment as well as any other findings from the audit. These are set out on page 13 of this report.


**Determine materiality**

When planning our audit we set our Group materiality at £4.506m based on approximately 2% of forecast income. Materiality has increased slightly since our planning assessment to £4.857m (PY: £4.269m) as total income for the year has increased against the plan. We report to you in this paper all misstatements above £243k (PY: £225k).

**Significant risk assessment**

In our planning report and update reports we explained our risk assessment process and identified significant audit risks in relation to Management Override of Controls and the Modern Equivalent Asset Valuation alternate site assumptions. We report our findings and conclusions on these risks in this report. No additional risks have been identified since our Audit Plan.

**Conclude on significant risk areas**

We draw to the Audit Committee's attention our conclusions on the significant audit risks. In particular the Audit Committee must satisfy themselves that management's judgements in relation to income are appropriate.

**Our audit report**

We have issued an unmodified audit opinion with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.

# Central Funding – Provider Sustainability Funding (PSF)

The Trust had a planned allocation of PSF of £1.8m, with a control total of £1.5m, or £(0.2)m before PSF income.

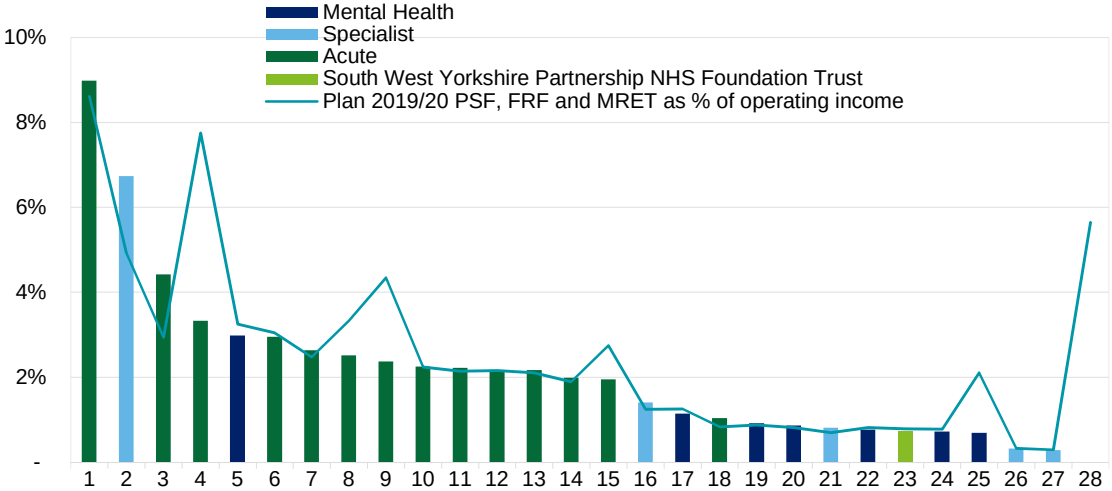
The Trust has recognised £1.8m of PSF income, in line with plan.

The Trust exceeded its underlying control total by £1.3m.

On average, trusts we audit received 96.1% of planned PSF, FRF and MRET income, and £0.3m of additional 2018/19 income allocated in 2019/20.

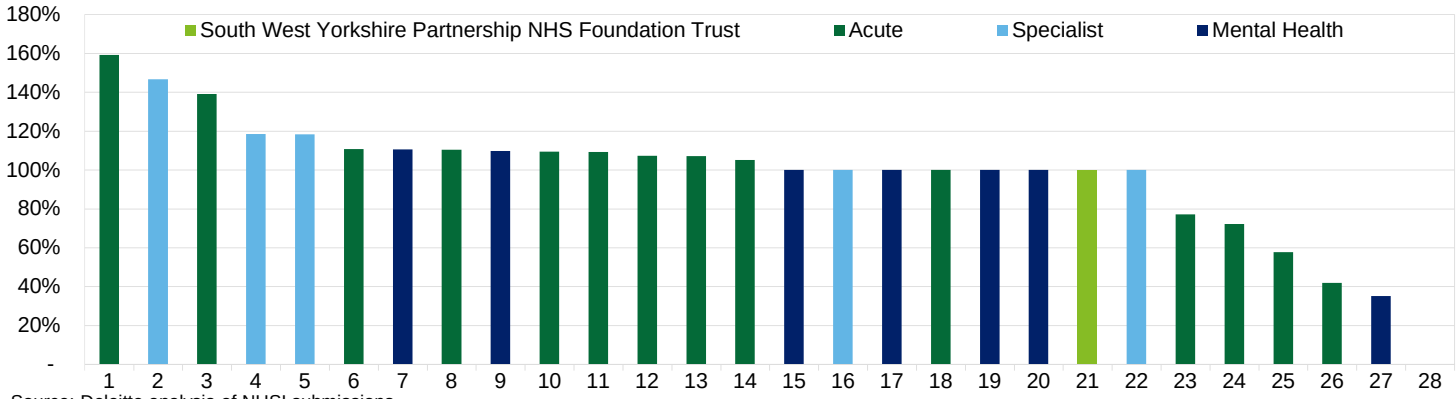
These income streams were 0.7% of the Trust's operating income for the year, compared to an average of 2.3% for all trusts we audit and 1.0% for Mental Health trusts.

**PSF, FRF and MRET funding as a percentage of operating income**




Source: Deloitte analysis of NHSI submissions

**PSF, FRF and MRET as a percentage of plan**




Source: Deloitte analysis of NHSI submissions

# Significant risks
## Dashboard

| Risk | Fraud risk | Planned approach to controls | Controls conclusion | Consistency of judgements with Deloitte's expectations | Expected to be a key audit matter in our audit report | Slide no. |
|---|---|---|---|---|---|---|
| Modern Equivalent Asset Design | ✓ | DI | Satisfactory | ● | ✓ | 8 |
| Management Override of Controls | ✓ | DI | Weakness identified | ● | ✗ | 9 |

Overly prudent, likely to lead to future credit ⊖ ⊖ ● ⊕ ⊕ Overly optimistic, likely to lead to future debit.

**Controls approach adopted**

- DI Assess design & implementation
- OE Test operating effectiveness of relevant controls
- S Involvement of IT specialists

# Significant audit risks (continued)

## Modern Equivalent Asset Valuation Alternate Site design

| | |
|---|---|
| **Risk identified** | Under Auditing Standards there is a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. In line with the prior year, we do not consider this it be a significant risk for South West Yorkshire Partnership NHS Foundation Trust, as there is unlikely to be an incentive to fraudulently recognise revenue. Therefore, we consider the fraud risk to be focussed on management's judgements in respect of the Modern Equivalent Asset Valuation – Alternate Site (MEAV-AS) design and its appropriateness in view of any service changes and any changes to the Trusts capital programme, as this could impact the Trust's Public Dividend Capital and depreciation charges.<br><br>In 2018/19 the Trust commissioned the District Valuer (DV) to perform a full revaluation of the estate and to implement amendments to the previous MEAV-AS design. For 2019/20, our discussions with management indicated that the Trust planned to use the existing MEAV-AS design to procure a desktop valuation for the current year. There is judgement in relation to the use of the MEAV-AS design should this not accurately reflect the current service potential and future estate's strategy for the Trust. |
| **Deloitte response** | • We have examined the preparation of MEAV-AS assumptions and the management controls within the Trust surrounding the review and communication of the MEAV-AS assumptions;<br>• We have reviewed the MEAV-AS assumptions used by management and validated that these are the same as the ones adopted in the 2018/19 valuation;<br>• We have tested a sample of the MEAV-AS assumptions to the Trust's current estates strategy and also the current service potential of assets; and<br>• We have reviewed minutes of the Estates TAG and Trust Board meetings to check for any changes to the Trust's estate that has not been reflected in the MEAV-AS design.<br><br>No significant issues have been identified as a result of the testing performed. |
| **Audit report findings** | We included this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.<br><br>We included in our audit report a key audit matter due to the material uncertainty identified by the DV in relation to the valuations as at 31 March 2020 due to the impact of Covid-19 on the property market. |

# Significant audit risks (continued)

## Management override of controls

| | |
|---|---|
| **Risk identified** | In accordance with ISA 240 (UK) management override is a significant risk. This risk area includes the potential for management to use their judgement to influence the financial statements as well as the potential to override the Trust's controls for specific transactions.<br>We consider that in the current year there is a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. This is due to the increasingly tight financial circumstances of the NHS and the incentives to meet or exceed control totals to receive PSF funding. |
| **Deloitte response** | • We have risk assessed journals and selected a sample of items for detailed follow up testing. The journal entries were selected using data analytics to focus our testing on higher risk journals with characteristics of audit interest.<br>• We have tested the appropriateness of journal entries recorded in the general ledger, and other adjustments made in the preparation of financial reporting.<br>• We have reviewed accounting estimates for biases that could result in material misstatements due to fraud.<br>• We have obtained an understanding of the business rationale of significant transactions that we become aware of that are outside of the normal course of business for the entity, or that otherwise appear to be unusual, given our understanding of the entity and its environment. |
| **Conclusion** | We have not identified any significant bias in the key judgements made by management.<br>We have raised an insight in respect to the review of journals, on page 13. |
| **Audit report findings** | We did not include this risk in our audit report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team. |

# Value for money

**Value for money**

We are required to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Value for money is assessed against the following criterion, and three sub-criteria (informed decision making, sustainable resource deployment, and working with partners and other third parties):

"In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people."

Our work takes account of the Annual Governance Statement and the findings of regulators. We are required to perform a risk assessment through the course of our audit to identify whether there are any significant risks to our value for money conclusion, and perform further testing where risks are identified.

**Key judgements**

As part of our risk assessment, we have considered how the Trust's performance compares to plan and prior year.

| | Actual 2019/20 | Plan 2019/20 | Variance | Prior year 2018/19 |
|---|---|---|---|---|
| Surplus (before impairments) | £8.5m | £1.5m | £7.0m | £3.2m |
| EBITDA margin (as a % of related income) | 4.7% | 4.2% | 0.5% | 4.4% |
| CIP target and identified to date | £10.6m | £10.6m | (£0.0m) | £10.6m |
| Single Oversight Framework segmentation (finance rating) | 1 | | | 1 |
| CQC report conclusions | Good | | | Good |

The Trust reported a surplus for the year of £8.5m before other comprehensive income and expenditure, which is ahead of the planned surplus of £1.5m. This includes £1.8m of payment from the Provider Sustainability Fund (PSF) notified at the year-end. CIP (Cost Improvement Plan) delivery was £10.6m against a £10.6m target, meaning that the Trust has overachieved the target in year. This comprised of £5.5m in recurrent CIP, an underachievement of £1.8m (plan £7.3m), offset by an overachievement of £1.8m in non-recurrent CIP (plan £3.2m whereas actual £5m).

**Deloitte response**

As part of our risk assessment we have considered information from a combination of:

- Review of high level forecasts and CIP plans;
- Consideration of the Trust's year end and forecast cash position;
- High level interviews with management;
- Review of the Trust's draft Annual Governance Statement;
- Consideration of issues identified in our audit work;
- Consideration of the Trusts' financial results, including CIP delivery, and the 2019/20 plan;
- Review of any Care Quality Commission Reports issued in the year;
- Review of NHSI's risk ratings;
- Benchmarking of the Trust's performance.

**Draft audit report findings**

We have identified no specific risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

# Area for monitoring in relation to our Value for Money Conclusion

| | |
|---|---|
| **Area of monitoring** | As part of our planning work and discussions with the Trust we noted the delivery of the CIP programme as an area for monitoring that may potentially have been relevant to our Value for Money conclusion. |
| **Conclusion** | We monitored this area throughout the year, and based on our work, did not consider that this crystallised into a specific risk and therefore there are no issues identified that would have an impact on the Value for Money conclusion. |

# Coronavirus (Covid-19) outbreak

## Impact on the annual report and audit

The current crisis is unprecedented in recent times. The NHS is most directly exposed to the practical challenges and tragedies of the pandemic, and is undergoing major, rapid operational changes in response.

The uncertainties and changes to ways of working also impact upon the reporting and audit processes, and present new issues and judgements that management and Audit Committees need to consider. NHS Improvement has issued *"NHS providers: COVID-19 related considerations for 2019/20 annual reports and accounts disclosures"* to assist in making relevant disclosures. We summarise below the key impacts on reporting and audit:

| Impact on Trust annual report and financial statements | Impact on our audit |
|---|---|
| The Trust need to consider the impact of the outbreak on the annual report and financial statements including:<br>• Principal risk disclosures;<br>• Change in the funding regime for 20/21;<br>• Waiting list backlog;<br>• Property valuation material uncertainty;<br>• Impairment of non-current assets;<br>• Allowance for expected credit losses;<br>• Fair value measurements based on unobservable inputs;<br>• Onerous contracts and any potential provisions;<br>• Going concern; and<br>• Events after the end of the reporting period. | Covid-19 has fundamentally changed the way we have conducted our audit this year including:<br>• Teams are primarily working remotely with workarounds needed in respect to accessing 'physical' documentation and on site access to Trust staff.<br>• The teams have had regular status updates to discuss progress and facilitate the flow of information.<br>• Consideration of impacts on the areas of the financial statements and annual report listed has been included as part of our audit work in the current year and comments have been included where appropriate within this report.<br>• In conjunction with the Trust, we will continue to consider any developments for potential impact up to the finalisation of our work in June 2020. |

# Internal control and risk management

## Findings

During the course of our audit we have one internal control and risk management finding, which we have included below for information.

| Area | Observation | Priority |
|---|---|---|
| **Journal review** | During the year we note, in line with Internal Audit findings, that the review of journals ceased and there is no review of journals completed. Deloitte recommend that journals are reviewed at least on a monthly basis, or journals with specific characteristics or a random selection of journals are reviewed. | High |

The purpose of the audit was for us to express an opinion on the financial statements. The audit included consideration of internal control relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. The matters being reported are limited to those deficiencies that we have identified during the audit and that we have concluded are of sufficient importance to merit being reported to you.

Low Priority

Medium Priority

High Priority

# Purpose of our report and responsibility statement

## Our report is designed to help you meet your governance duties

### What we report

Our report is designed to help the Audit Committee and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under ISA (UK) 260 to communicate with you regarding your oversight of the financial reporting process and your governance requirements. Our report includes:

- Results of our work on key audit judgements and our observations on the quality of your Annual Report.
- Our internal control observations.
- Other insights we have identified from our audit.

### What we don't report

As you will be aware, our audit was not designed to identify all matters that may be relevant to the board.

Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.

Finally, our views on internal controls and business risk assessment should not be taken as comprehensive or as an opinion on effectiveness since they have been based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

### The scope of our work

Our observations are developed in the context of our audit of the financial statements.

We described the scope of our work in our audit plan.

### Use of this report

This report has been prepared for the Board of Directors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

We welcome the opportunity to discuss our report with you and receive your feedback.

**Deloitte LLP**

Newcastle | June 2020

# Sector Developments

# COVID-19 implications for 2019/20 Annual Report and Accounts

## There are a number of areas where the current crisis and related uncertainties will impact on the 2019/20 reporting process.

**Issue**

The current crisis is unprecedented in recent times. The NHS is most directly exposed to the practical challenges and tragedies of the pandemic, and is undergoing major, rapid operational changes in response.

The uncertainties and changes to ways of working also impact upon the reporting and audit processes, and present new issues and judgements that management and Audit Committees need to consider. NHS Improvement has issued *"NHS providers: COVID-19 related considerations for 2019/20 annual reports and accounts disclosures"* to assist in making relevant disclosures.

- **Timetable:** NHS Improvement has given providers the option to delay submission of draft accounts to a choice of either 27 April or 11 May (compared to original deadline of 24 April), with signed accounts due by 25 June rather than 29 May.
- **Financing and funding**: The Government has undertaken to provide the NHS with the funding required to address the current crisis. All providers have moved to block contracts for at least the first four months of 2020/21, with additional funding for the incremental costs of COVID-19 and an undertaking to ensure that where this does not cover costs additional funding will be provided to ensure providers achieve break-even. Unlike many other organisations, this removes short-term uncertainty over finances and going concern, income is significantly below normal. Trusts will still need to assess the appropriateness of the going concern assumption for at least 12 months from the signing of the financial statements, and we understand that the Department and NHS Improvement will be issuing guidance on assumptions that providers should make about the remainder of 2020/21 and start of 2021/22.
- **Valuation**: The Royal Institute of Chartered Surveyors have issued guidance to valuers, highlighting that the uncertain impact of COVID-19 may cause a valuer to conclude there is a material valuation uncertainty. This does not preclude a valuer giving an opinion on value, but highlights additional uncertainty over the valuation. Our understanding is that at 31 March 2020 most, if not all, valuations will include a "material valuation uncertainty" paragraph. NHS Improvement have given guidance, both for trusts with 2020 valuations and for those not undertaking valuations in year, that this should be disclosed in the Key Sources of Estimation Uncertainty note, with the disclosure reflecting specific circumstances of the Trust. Where this is the case, then this will also be expected to need to be referred to in the audit opinion. The Trust's valuation included a material valuation uncertainty paragraph.
- **Reporting requirements:** The Quality Accounts no longer need to be prepared alongside the Annual Report and have to be submitted by 15 December 2020, and independent assurance from the auditor is no longer required. The requirement to include a performance analysis section in the Annual Report has been removed, as has the requirement to disclose sickness absence data.
- **Annual Report:** NHS Improvement have suggested areas where disclosures are likely to need to refer to COVID-19, albeit with the main focus of the Annual Report on 2019/20 as a whole. This would include: forward looking disclosures; discussion on finances, operational performance and work force; the annual governance statement and how the trust responded to this (including any required changes in control environment or business continuity issues; and risk and uncertainties disclosures.
- **Inventory:** In some cases, trusts were unable to perform planned inventory counts, or to have these audited. There may also be circumstances where unusual stock levels have occurred around year-end, some items may be impaired (due to reductions in some services) or judgements may be needed over the ownership of centrally procured stock. The Trust's stock balance is immaterial, as such this has not presented an issue for the 2019/20 audit.
- **Financial instruments:** The wider impact of the crisis may impact on measurement or disclosure of financial instruments, for example by changing expected credit loss provisions.

# COVID-19 implications for 2019/20 Annual Report and Accounts (continued)

## There are a number of areas where the current crisis and related uncertainties will impact on the 2019/20 reporting process.

**Next steps**

- Our Foundation Trust Annual Reporting Manual and DHSC Group Accounting Manual checklist which we have shared with management includes specific considerations for matters highlighted by NHS Improvement and other interested bodies, which have been considered in reviewing the Annual Report and Accounts.
- We have reviewed key areas of impact with management as part of our year-end audit work.
- The Trust are progressing in line with plan to sign their accounts and annual report by the 25 June 2020 deadline.

# Respond – Recover – Thrive: Governing NHS boards through COVID-19

## How is your board coping?

Overview by the Deloitte Board Advisory Practice

Over the last few weeks the COVID-19 crisis has unfolded at extraordinary pace, causing everyone to fundamentally rethink priorities and to redefine ways of working. The Boards of NHS provider organisations are no exception and have responded with urgency. From our discussions with a number of providers around the country, it is clear that there has been a rapid response to bring about new ways of working during these unprecedented times.

Commonly adopted initiatives include: moving to video-conferencing for board and committee meetings, along with defining revised protocols for board etiquette; revisiting agendas and forward plans to determine what is absolutely necessary; minimising the number of additional attendees/presenters invited to the meetings, and in some instances redefining meeting quoracy; and revising Standing Financial Instructions (SFIs) and Standing Orders (SOs) to ensure they enable sufficient autonomy to the executive team at a time when pace is key.

### Sharing Best Practice

Despite the commonly adopted initiatives described above, it is apparent from our discussions with NHS provider boards, as well as those in other sectors, that there is no blueprint for governance in these times. As a result, providers are developing a number of innovative approaches devised to increase flexibility, whilst also maintaining rigour. Outlined below is a brief overview of these approaches.

1. **Board led change:** A number of providers have formally set out the options for changing governance arrangements during COVID-19 in a paper to their board for discussion and approval.
2. **Consent Agenda**: Under this approach, some of the board papers are placed onto a separate section of the agenda ("the Consent Agenda") with a working assumption that they will not be subject to any detailed debate during the meeting unless specifically requested.
3. **Meeting efficiency:** There are a number of ways in which efficiency can be improved. Examples include: inviting board members to submit questions in advance of board or committee meetings and holding a preparatory call with Non-Executive Directors (NEDs) a few days in advance.
4. **Post-board briefings:** Some are endeavouring to publish a summary of the key matters on their website immediately after the board meeting to maintain communication with the public, patients, governors, and stakeholders.
5. **NED briefings**: We are aware of providers who have placed a lot of emphasis on this. Examples include: NED/Executive Director (ED) buddy systems; weekly virtual meetings between each committee chair and their relevant ED, with a summary of pertinent points shared by the committee chairs
6. **COVID-19 Risk Register**: Risk management continues to play a crucial role in managing the current crisis, and many have moved to maintaining a COVID-19 Risk Register and updating their Board Assurance Framework (BAF) for COVID-19 related strategic risks, including reputational risk.
7. **Consolidating committee meetings:** Many providers have moved to consolidate or reduce meeting frequency, balancing the time input required with ensuring that key issues are regularly reviewed.
8. **Decision Logs:** Trusts are maintaining a list of significant operational and strategic decisions taken during these revised measures, which can subsequently be shared with their board to ensure that visibility and transparency is maintained.
9. **Ethics Committees:** many trusts are establishing board level Ethics Committees (or modifying the Terms of Reference of existing forums).
10. **Board visibility:** Board visibility is more important than ever to boost the morale of staff that are under constant pressure, as well as to provide visible leadership to external stakeholders, and many have turned to technology based solutions.

# Respond – Recover – Thrive: Governing NHS boards through COVID-19 (continued)

## How is your board coping?

**Next steps**

- It is vital that boards take time to plan ahead for the "new normal", given the wide ranging implications for patients, staff and finances beyond the current situation. The full article can be found here: https://www2.deloitte.com/uk/en/pages/public-sector/articles/governing-nhs-boards-through-covid-19.html**. We will be arranging a number of future webinars around these aspects**. If you would like to be included in these sessions, please contact: **Jane Taylor, Lead Director,** jataylor@deloitte.co.uk or **Lucy Bubb, Associate Director,** lbubb@deloitte.co.uk **from the Deloitte Board Advisory Practice**.

# National Audit Office updated Code of Audit Practice

## The National Audit Office has issued the new Code of Audit Practice applicable for 2020/21 audits onwards

**Issue**

The National Audit Office issued the new Code of Audit Practice for 2020/21 onwards. The Code is applicable to NHS Trusts and Foundation Trusts, CCGs, and Local Authorities.

The Code remains aligned (where relevant) with generally accepted auditing standards, with the intention that this will allow the Code to adapt to any changes arising as a result of the wider debate within the audit profession (such as the Brydon Review and the Redmond Review).

The most significant changes are around Value for Money (the arrangements to secure economy, efficiency, and effectiveness in the use of resources), which:

- Change the approach away from the auditor performing a risk assessment, and then only performing further work if a significant risk were identified, to specifying procedures that will need to be undertaken in each of three areas. This will require a minimum level of work at every local public body, with additional risk based work where relevant.
- Moving the focus of reporting to providing public narrative commentary on each of criteria considered for all bodies. This will be included in a separate "Annual Auditor's Report", which will be a public narrative report, which for NHS bodies will be issued alongside the audit opinion.
- The audit opinion will continue to include reporting by exception where the auditor is not satisfied in respect of arrangements in place (which is a change from the initial proposals consulted upon).

The three criteria that would be considered in Value for Money work would be:

- **Financial sustainability:** How the body plans and manages its resources to ensure it can continue to deliver its services.
- **Governance:** How the body ensures that it makes informed decisions and properly manages its risks and finances.
- **Improving economy, efficiency and effectiveness:** How the body uses information about its costs and performance to improve the way it manages and delivers its services.

Where the auditor identifies significant weaknesses in VfM arrangements, the Code includes an expectation that the auditor will issue recommendations to the audited body, and considers whether to do so when identified.

Other proposed changes include:

- Giving the NAO the ability to specify whether auditors should issue 'enhanced' auditor reports (as is already done for NHS Foundation Trusts);
- Clarifying expectations on reporting by introducing key principles for effective reporting, so that auditors ensure that any reporting is as effective and transparent as possible and promotes local improvement.

We note that the changes are likely to increase the scope of work required for audits, both in required procedures on Value for Money and in the need for an additional public report each year.

The NAO will now move forward in developing supporting guidance on the detail of what will be required.

# Appendices

# Audit adjustments

## Unadjusted misstatements

The following uncorrected misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Auditing standard on Auditing (UK). The net impact of these is a decrease of £0.131m in the deficit for the period.

| | | Debit/ (Credit) income statement £m | Debit/ (Credit) in Net Assets £m | Debit/ (Credit) in reserves £m |
|---|---|---|---|---|
| **Misstatements identified in current year** | | | | |
| Revaluation – update to valuation | [1] | | 0.273 | (0.273) |
| | | | | |
| **Aggregation of misstatements individually < £0.243m** | | | | |
| Misstatements less than £0.243m | | (0.131) | 0.131 | |
| | | | | |
| **Total** | | **(0.131)** | **0.404** | **(0.273)** |

(1) Judgemental difference noted on revaluation movement indices between the valuation date (31 December) and year end (31 March).

As part of the agreement of balance work, we note that there is a range of uncertainty. Whilst all differences are clearly trivial, on the debtors and creditors, there is a margin of uncertainty of £1.099m and on income and expenditure there is a margin of uncertainty of £2.555m. This is not raised as an error but is noted here as a range of uncertainty as a result of the agreement of balance process.

# Audit adjustments (continued)

## Disclosures

**Disclosure misstatements**

The following uncorrected disclosure misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK).

| Disclosure | Summary of disclosure requirement | Quantitative or qualitative consideration |
|---|---|---|
| We have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management. | | |

# Fraud responsibilities and representations

## Responsibilities explained

**Responsibilities:**

The primary responsibility for the prevention and detection of fraud rests with management and those charged with governance, including establishing and maintaining internal controls over the reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations. As auditors, we obtain reasonable, but not absolute, assurance that the financial statements as a whole are free from material misstatement, whether caused by fraud or error.

**Required representations:**

We have asked the Board to confirm in writing that you have disclosed to us the results of your own assessment of the risk that the financial statements may be materially misstated as a result of fraud and that you are not aware of any fraud or suspected fraud / you have disclosed to us all information in relation to fraud or suspected fraud that you are aware of and that affects the entity or group.

We have also asked the Board to confirm in writing their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

**Audit work performed:**

In our planning we identified the risk of fraud in revenue recognition and management override of controls as a key audit risk for your organisation.

During course of our audit, we have had discussions with management and those charged with governance, as well as with Local Counter Fraud and Internal Audit.

In addition, we have reviewed management's own documented procedures regarding fraud and error in the financial statements.

# Independence and fees

As part of our obligations under International Standards on Auditing (UK), we are required to report to you on the matters listed below:

| | |
|---|---|
| Independence confirmation | We confirm that we comply with FRC Ethical Standards for Auditors and that, in our professional judgement, we and, where applicable, all Deloitte network firms are independent and our objectivity is not compromised. |
| Fees | Details of the fees charged by Deloitte for the period have been presented below. |
| Non-audit services | In our opinion there are no inconsistencies between FRC Ethical Standards for Auditors and the Trust's policy for the supply of non-audit services or of any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary. We have not carried out any non-audit services in the period 2019/20. |
| Relationships | We have no other relationships with the Trust, its directors, senior managers and affiliates, and have not supplied any services to other known connected parties. |

The professional fees earned by Deloitte in the period from 1 April 2019 to 31 March 2020 are as follows:

| | Current year | Prior year |
|---|---|---|
| Audit of Trust (including WGA) | £46,672 | £46,672 |
| **Total audit** | **£46,672** | **£46,672** |
| Quality Accounts (1) | 2,500 | £5,000 |
| Independent Examination of the Charity | £828 | £828 |
| **Total fees** | **£50,000** | **£52,500** |

(1) The quoted fee for the Quality Accounts work was £5,000. NHSI in response to the covid-19 pandemic removed the requirement for auditors to complete the limited assurance procedures. However, prior to this announcement, a substantial amount of the indicator work had already been undertaken. We have agreed with management that the fee for the work undertaken will be £2,500.

# Our audit report

## We will provide an overview of our audit approach

Here we discuss the items that we intend to comment on in our audit report. Our audit report includes comment on materiality and scoping, including how this has changed from last year. We also comment on the key audit matters which have been the focus of our time and efforts on the audit.

**Materiality**

We will disclose materiality, and the basis for how we determined it. We will also provide our reporting threshold and the component materiality ranges used in the audit.

**Key audit matters**

Key audit matters are those which were of most significance in the audit. We have indicated in the slides above which significant risks and other matters we determined to be key audit matters.

**Irregularities and fraud**

We will explain the extent to which we considered the audit to be capable of detecting irregularities, including fraud.

In doing so, we will describe the procedures we performed in understanding the legal and regulatory framework and assessing compliance with relevant laws and regulations. We will discuss the areas identified where fraud may occur and any identified key audit matters relating to fraud.

**Material uncertainty related to going concern**

We have not identified a material uncertainty related to going concern and will report by exception regarding the appropriateness of the use of the going concern basis of accounting.

# Sector benchmarking

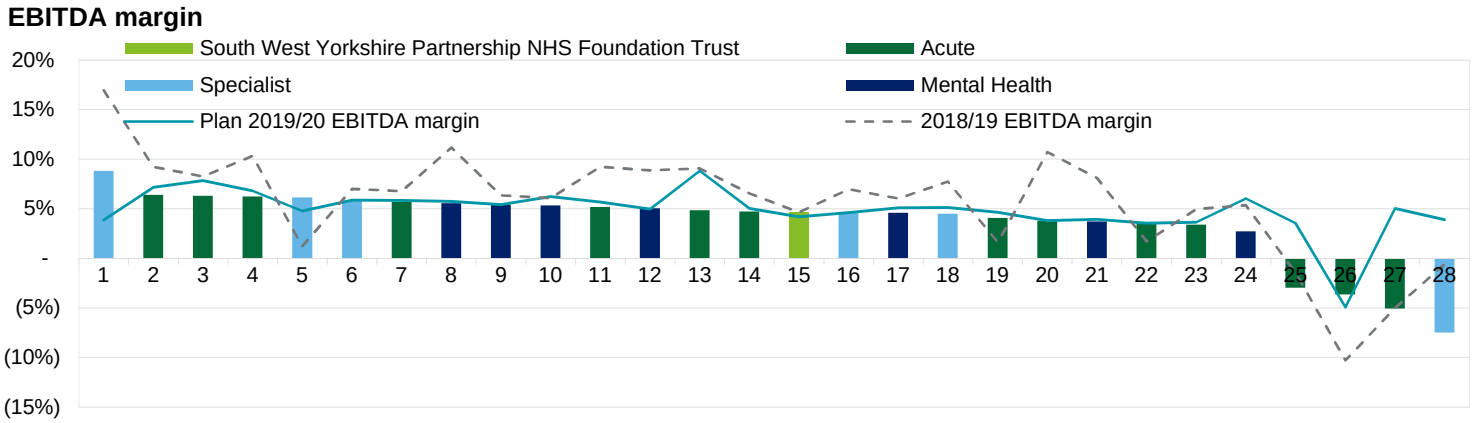
## We have reviewed the Trust's performance to 31 March 2020.

Our audit process includes an on-going assessment of internal and external factors affecting the Trust. This includes considering the Trust's actual and planned performance on financial, quality and other governance metrics compared to its peers, to enable us to identify and understand risks specific to the Trust. We have summarised for the Audit Committee below some of the comparisons we have performed as part of our concluding analytical procedures, comparing the Trust's performance to 31 March 2020 to other trusts we audit.

The table below shows how the Trust's results compare to other trusts we audit:

| (£m) | Trust Actual | Trust Plan | Trust Variance | Mental Health Trusts average Actual | All Trusts average Actual |
|---|---|---|---|---|---|
| Operating income | 243.0 | 225.3 | 17.7 | 211.8 | 473.2 |
| EBITDA | 11.4 | 9.5 | 0.1 | 10.0 | 17.2 |
| EBITDA margin (%) | 4,7% | 4.2% | 0.5% | 4.7% | 3.6% |
| Surplus / (deficit) | 8.5 | 1.5 | 7.0 | (2.3) | (5.7) |
| Performance against control total | 2.8 | 1.5 | 1.3 | 1.8 | (3.8) |

The chart below shows EBITDA margin for trusts we audit, compared to plan. The Trust's EBITDA of £11.4m compared to plan of £9.5m gives an EBITDA margin of 4.7%. This compares to an average margin for mental health trusts of 4.7% and all types of trust of 3.6%



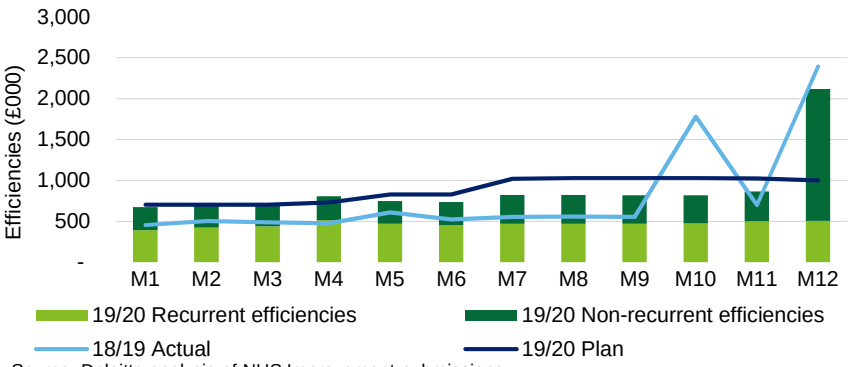

Source: Deloitte analysis of NHSI submissions

# Sector benchmarking (continued)

## The sector is behind plan on delivery of efficiency savings. The Trust is £0.2m behind the planned level of savings for the year and has a high level of non-recurrent savings.

Nationally, providers delivered £1.1 billion of savings through efficiency savings (cost improvement programmes (CIPs) and revenue generation schemes) during the first two quarters of the year. Overall, the sector forecast to finish the year £135m behind plan with £3.1bn of savings (95.9% of plan), an increase on the first two quarters.

**Efficiencies**

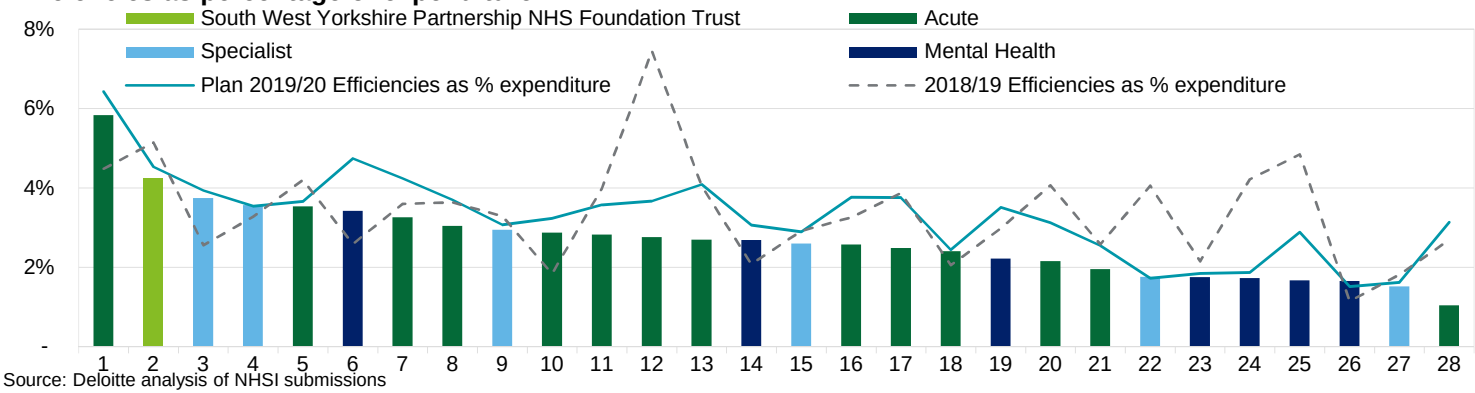



Source: Deloitte analysis of NHS Improvement submissions

| Efficiencies (including revenue generation schemes) %/£m | Trust 2019/20 | *Mental Health* 2019/20 | All Trusts 2019/20 |
|---|---|---|---|
| Planned efficiencies | 10.6 | 6.7 | 15.4 |
| Actual efficiencies | 10.6 | 6.1 | 13.5 |
| Actual as % of plan | 100.0% | 90.1% | 87.5% |
| | | | |
| Recurrent efficiencies as % of total | 52.2% | 51.8% | 69.0% |
| | | | |
| Planned efficiencies as % of operating expenses | 4.5% | 3.4% | 3.3% |
| Actual efficiencies as % of operating expenses | 4.2% | 2.8% | 2.7% |
| | | | |
| Pay efficiencies as % total | 39.7% | 48.6% | 31.1% |
| Non pay efficiencies as % total | 40.4% | 37.3% | 38.0% |
| Income efficiencies as % total | 19.9% | 14.0% | 31.0% |

On average, the trusts reviewed had planned to achieve efficiencies of 3.3% of operating expenses in 2019/20 (the Trust planned savings of 4.5%). Actual average savings have been below this at 2.7% (the equivalent of £1.9m higher spend). The Trust has achieved efficiencies of 4.2% of operating expenses, in line with plan.

**Efficiencies as percentage of expenditure**




Source: Deloitte analysis of NHSI submissions

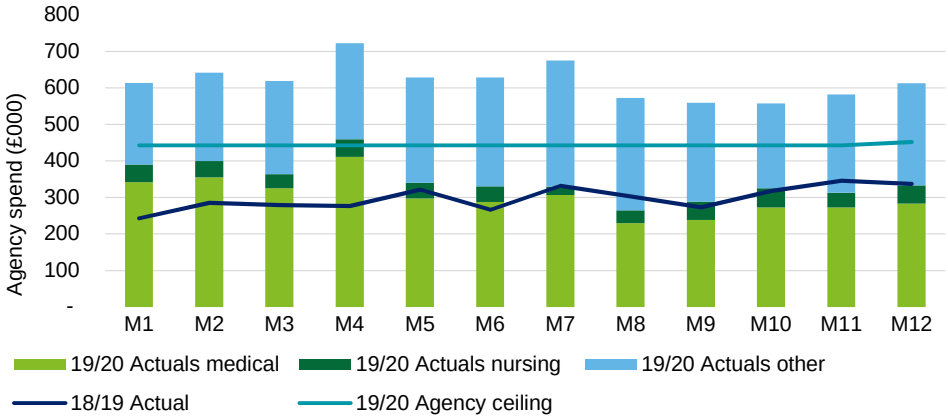
# Sector benchmarking (continued)

## Most trusts have not delivered their planned pay savings. The Trust has achieved 72.1% of planned pay savings.

The main contributor to spending variances nationally are higher than planned pay costs. On average, trusts we audit achieved 83.7% of planned pay efficiencies compared to 72.1% for the Trust (£4.2m achievement of plan of £5.9m).

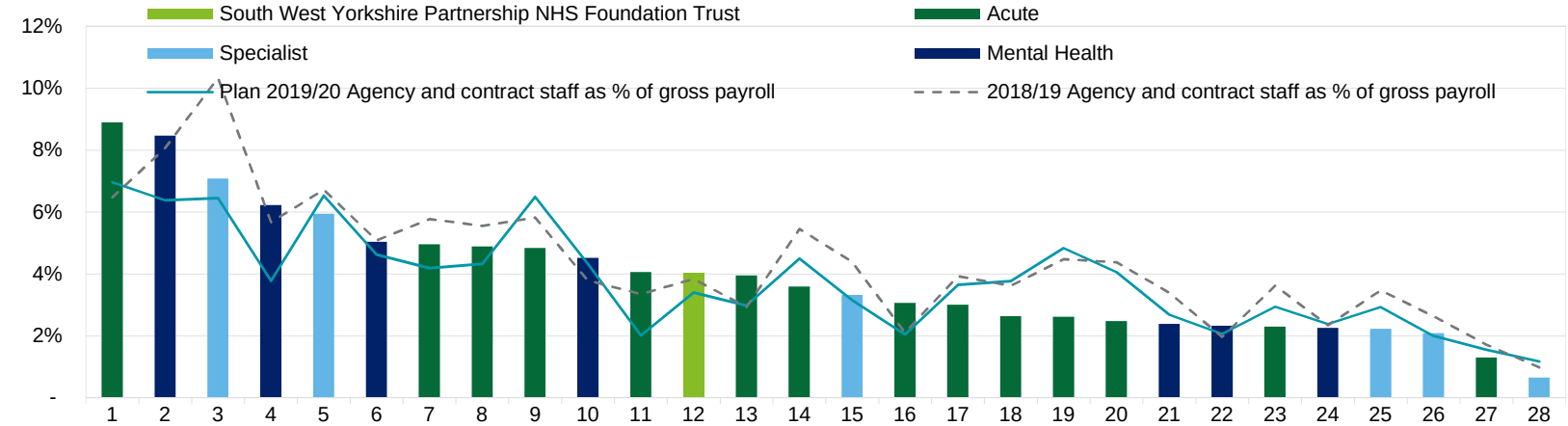
The Trust's agency costs of £7.4m year to date compared to an agency ceiling of £5.3m and plan of £(5.9)m (126.5% of plan). On average Mental Health trusts we reviewed spent 124.7% of plan (all trusts 98.5% of plan).

**Agency spend**




Source: Deloitte analysis of NHS Improvement submissions

**Agency and contract costs as a percentage of gross payroll costs**




Source: Deloitte analysis of NHSI submissions

# Sector benchmarking (continued)

## Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.

The Trust's year-end cash balance was £36.4m, £17.5m above plan of £18.9m and £8.6m above 31 March 2019 balance of £27.8m.

Although the sector has experienced increasing working capital pressures, on average Mental Health trusts were £5.3m behind plan, and all trusts we reviewed were £11.1m ahead of plan.

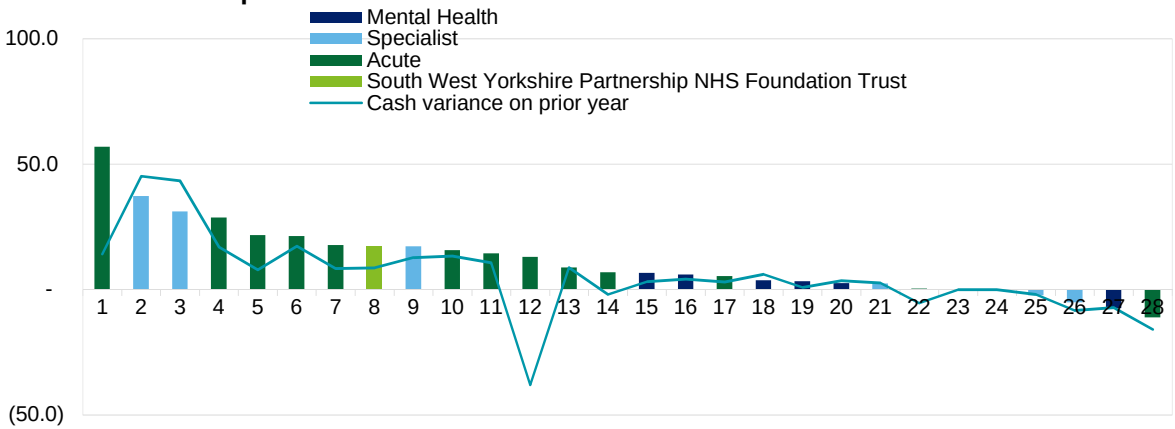
The Covid-19 funding changes have reduced working capital pressures for early 2020/21.

The Trust debtor days at 31 March 2020 were 18 days compared to an average mental health trusts of 20.2 and for all trusts reviewed of 31.8 days.

The Trust creditor days at 31 March 2020 were 167 days compared to an average for mental health trusts of 186.9 and for all trusts reviewed of 152.3 days.

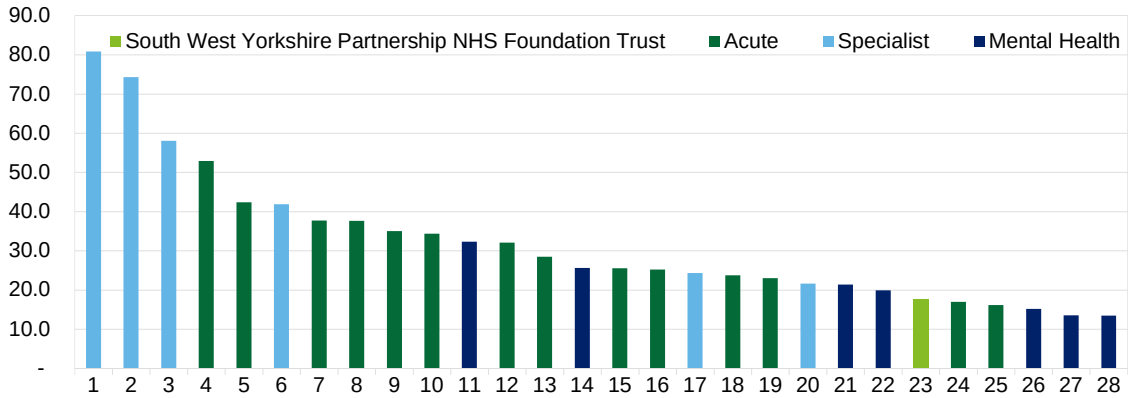
*Debtor and creditor days figures are using NHS Improvement's calculation methodology.*

**Cash variance to plan**




Source: Deloitte analysis of NHSI submissions

**Debtor days**




Source: Deloitte analysis of NHSI submissions

# Sector benchmarking (continued)

## The Use of Resources risk rating for the Trust reflects the Trust's overall compliance with the key NHS Oversight Framework metric targets.

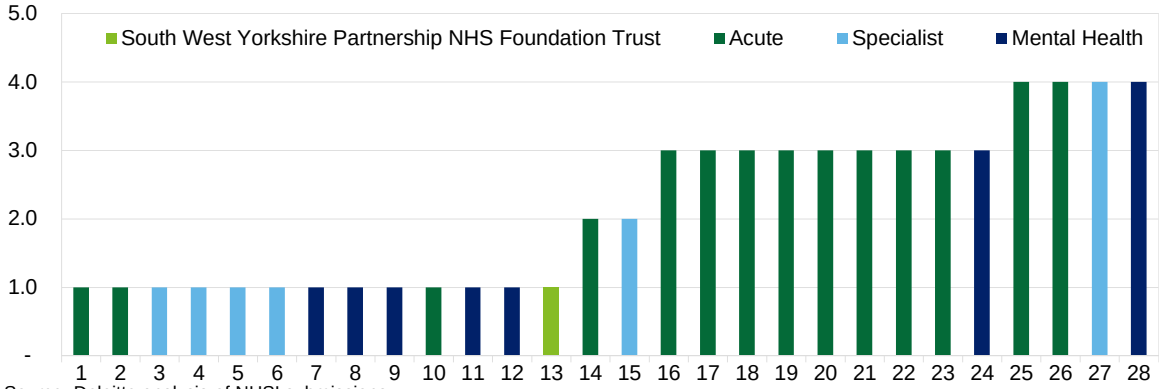
### NHS Oversight Framework Risk Rating

The Trust has a risk rating at 31 March 2020 of 1. The table and chart below show how this compares to other trusts we audit.

Use of Resources

| Single Oversight Framework Use of Resources metrics | Trust | Trust | *Mental Health* | *All Trusts* |
|---|---|---|---|---|
| As at 31 March 2020 | Plan | Actual | *Actual* | *Actual* |
| Capital service cover metric | 1.0 | 1.0 | 1.9 | 2.1 |
| Liquidity metric | 1.0 | 1.0 | 1.6 | 2.1 |
| I&E Margin metric | 2.0 | 1.0 | 1.6 | 2.0 |
| I&E Variance from plan metric | | 1.0 | 1.4 | 1.8 |
| Agency staff use vs provider cap metric | | 3.0 | 2.6 | 2.0 |
| **Overall rating (before overrides)** | | **1.4** | **1.8** | **2.0** |
| **Rating after overrides** | | **1.0** | **1.6** | **2.1** |

**Use of Resources Risk rating**




Source: Deloitte analysis of NHSI submissions

Deloitte.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# Trust Board 30 June 2020
# Agenda item 9.7

| | |
|---|---|
| **Title:** | **2020/21 Planning** |
| **Paper prepared by:** | Director of Finance and Resources |
| **Purpose:** | To provide the Trust Board with the current status of planning for the remainder of 2020/21 |
| **Mission/values:** | Use of resources |
| **Any background papers/ previously considered by:** | Regular review at the Financial Investment & Performance Committee<br>Regular review at Trust Board |
| **Executive summary:** | • The planning process for 2020/21 was suspended across in March following the outbreak of the Covid-19 pandemic.<br>• For the period covering April to July temporary financial arrangements are in place with the use of a calculated block payment each month together with allowable reclaims for reasonably incurred Covid-19 costs and a further top-up of income to enable trusts to break-even. The Trust requires this additional top-up primarily because not all of its income is covered by the block payment.<br>• It is likely for the remainder of 2020/21 there will be a continuation of some form of block contracting arrangements, but with stronger financial control.<br>• Formal guidance is expected at the end of June/early July with tight deadlines for completion of a plan for the remainder of the year envisaged.<br>• There is increased input and requirement from ICSs and NHSE&I.<br>• Initial information for activity, revenue costs and capital costs is being requested ahead of the guidance being provided.<br>• Within the Trust it is expected there will be ongoing costs as a consequence of the Covid-19 response. Examples include the potential need for out of area beds, staff absence cover, testing, enabling staff to work from home, additional cleaning, increased digital technology costs. It is also expected that costs will increase as the year progresses compared to the first part of the year as demand returns to at least normal levels, staff begin to take leave, increased digital technology costs come into effect and additional service requirements become clearer.<br>• At this point in time it is unclear what arrangements will be put in place in relation to the mental health investment standard for 2020/21.<br>• An exercise is taking place within each integrated care system (ICS) to review and prioritise Covid-19 capital requirements. |

| | |
|---|---|
| | • The Trust is commencing a more detailed planning process in readiness of the formal guidance being provided.<br>• Once available the formal guidance will be formally communicated to all Board members via the executive management team meeting (EMT) and weekly non-executive directors' meeting. Once timescales for submission are known. arrangements can be put in place to ensure Trust Board is suitably involved with an approval process in place for draft and final submissions. |
| **Recommendation:**<br>. | **It is recommended the Trust Board NOTES the update in terms of the planning process and potential changes to the financial arrangements after July, and the work the Trust is carrying out in terms of developing an operational plan for the remainder of the year**. |
| **Private session:** | The paper relates to matters that are commercial-in-confidence. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 30 June 2020

## Agenda item 10 – Assurance from Trust Board committees

### Audit Committee

| | |
|---|---|
| **Date** | 2 June 2020 |
| **Presented by** | Laurence Campbell, Non-Executive Director (Chair of Committee) |
| **Key items to raise at Trust Board** | ➢ There were no items to raise at Trust Board. The Audit Committee agenda was condensed to approve the annual accounts |
| **Approved Minutes of previous meeting/s for receiving** | ➢ Minutes of the Committee meeting held on 14 April 2020 will not be approved until July meeting. |

### Clinical Governance & Clinical Safety Committee

| | |
|---|---|
| **Date** | 9 June 2020 |
| **Presented by** | Charlotte Dyson, Deputy Chair (Chair of Committee) |
| **Key items to raise at Trust Board** | ➢ Review of Committee related risks with focus on Covid 19 related risks. (Action for workforce committee)<br>➢ Key Clinical Risk focus on Covid-19 including impact on Workforce / Staff wellbeing / Delivery of clinical services / Patient Safety / Patient experience.<br>➢ Update on CQC Action Plan<br>➢ Assurance reports taken<br>o Serious Incidents Quarterly Report and Annual LeDer<br>o RRPI Annual report<br>o D&T Annual Report<br>o Safeguarding Annual Report |
| **Approved Minutes of previous meeting/s for receiving** | ➢ Minutes of the Committee meeting held on 7 April 2020 attached. |

## Equality & Inclusion Committee

| | |
|---|---|
| **Date** | 2 June 2020 |
| **Presented by** | Charlotte Dyson, Deputy Chair (Chair of Committee) |
| **Key items to raise at Trust Board** | ➢ Trust wide equality impact assessment<br>➢ Feedback BAME and Disability networks<br>➢ Feedback from C&K Forum<br>➢ Representation of BAME staff in decision making / command structures<br>➢ Revised timetables for strategy development<br>➢ Review of Committee related Risks |
| **Approved Minutes of previous meeting/s for receiving** | ➢ Minutes of the Committee meeting held on 3 March 2020 attached. |

## Finance, Investment & Performance Committee

| | |
|---|---|
| **Date** | 26 May 2020 |
| **Presented by** | Chris Jones, Non-Executive Director (Chair of Committee) |
| **Key items to raise at Trust Board** | ➢ Reporting break even position, this assumes £241k of additional income via the 'true-up' process<br>➢ Strong cash position<br>➢ Finance working hard on 7 day payment of suppliers and challenges that come with that<br>➢ Return of financial planning framework in future<br>➢ Agreed to get more detail on CAMHS performance, building on existing data<br>➢ Approval of business case for new finance ledger system |
| **Approved Minutes of previous meeting/s for receiving** | ➢ Minutes of the Committee meeting held on 23 January, 27 February and 23 April 2020 attached. |

## Mental Health Act Committee

| | |
|---|---|
| **Date** | 12 May 2020 |
| **Presented by** | Kate Quail, Non-Executive Director (Chair of Committee) |
| **Key items to raise at Trust Board** | ➢ The Coronavirus act 2020 made provision to amend the Mental Health Act 1983 (as amended 2007), however at this time the Mental Health Act remains unchanged. A range of Trust actions have been taken and provisions put in place should they be needed, these include: amending and preparing internal documents, providing training for the Mental Health Act administration team, and working with AMHP and other colleagues.<br>➢ Whilst the Mental Health Act has not changed, temporary changes have been made In respect of the use and application of the MHA/MCA and DoLS due to Covid19. These changes were taken through MHAC and are all recorded in the Trust's Covid19 Governance Decision Log.<br>MHAC will continue to receive feedback from Hospital Managers, AMHPs, Acute Trust colleagues on any impact of these changes on service users, families, staff and partnership working.<br>As part of its ongoing QI focus, MHAC will monitor and learn from the impact of these changes.<br>➢ The CQC introduced remote MHA visiting in April using Microsoft Teams. The focus is on speaking with the ward manager and |

| | |
|---|---|
| | interviewing patients. Feedback is given to the ward manager and MHA Administrator at the end of the day. (A letter follows to the Chief Executive as usual.) Ward Managers and MHA Administrators report this new process of real time, direct CQC feedback to be highly effective in enabling them to take speedy, immediate action and resolve issues as necessary.<br>➢ Ethnicity recording – improvement sustained. Significant reduction in the number of patients where ethnicity is recorded as 'Unknown'. (E.g. 2019/20 Quarter 4, 1844 (5.5%) of service users accessing services did not have ethnicity recorded or the patient 'refused to disclose'. This is down from 3911 (13%) at the same period last year.)<br>➢ A 9% reduction in the use of the Mental Health Act this Quarter (Q4). The drivers for this significant reduction are not yet fully understood, though are likely be related to Covid19. Q1 data may facilitate this understanding. |
| **Approved Minutes of previous meeting/s for receiving** | ➢ Minutes of the Committee meeting held on 12 November 2019 and 10 March 2020 attached. |

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

| | |
|---|---|
| **Date** | 23 April 2020 |
| **Presented by** | Angela Monaghan, Chair (Chair of Committee) |
| **Key items to raise at Trust Board** | ➢ The programme has reviewed its role and which elements continue, are repurposed or pause<br>➢ We are developing some specific WY&H offers including on bereavement, keeping people connected, supporting cohorting arrangements, learning lessons and planning for a post COVID response<br>➢ We will continue the dialogue with TEWV on the possibility of developing a subsidiary organisation to provide care packages for complex individuals with learning disabilities and autism<br>➢ All organisations have well implemented business continuity plans; the role of the collaborative has been in testing these from a WY&H footprint perspective and sharing good practice |
| **Approved Minutes of previous meeting/s for receiving** | ➢ Minutes of the Committee meeting held on 21 January 2020 were presented at Trust Board 31 March 2020 |

*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 7 April 2020 Via MS Teams (COVID -19)

| | | |
|---|---|---|
| **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:** | | |
| **In attendance:** | Mike Doyle (MD) | Deputy Director of Nursing & Quality |
| | Sarah Harrison (SH) | PA to Director of Nursing and Quality (author) |
| | Carol Harris (CH) | Director of Operations |
| | Laurence Campbell | Non Executive Director |

## CG/20/28 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting and acknowledged the situation and the convened meeting by Microsoft Teams. The revised agenda was also acknowledged due to COVID-19. It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

## CG/20/29 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 2020 or subsequently.

## CG/20/30 Minutes of previous meeting held on 11 February 2020 (agenda item 3)

Minutes of the previous meeting were agreed.

**It was RESOLVED to APPROVE the minutes of the meeting held on 11 February 2020.**

## CG/20/31 Matters Arising (agenda item 4)

Due to the current situation of COVID-19 the Committee agreed to 3 of the actions from the action log.

CG/19/133 Transformation & Priority Programmes update – Deferred
CG/19/139 CAMHS - Deferred
CG/19146 Whistleblowing and Freedom to Speak up Guardians update – Deferred
CG/20/08 CQC Action Plans – improvement Plan - To be discussed at agenda item 7.

**CG/20/32 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)**

TB advised the Committee that the ORR was last reported to the Trust Board before COVID19 pandemic.

Tim Breedon (TB) informed the Committee that a paper is being taken into EMT this week considering additions to the Trust wide register regarding COVID 19. The discussion at EMT will inform the paper taken to board later in the month for review. *It is assumed that some of the identified risks will be assigned to CGCS after that discussion has taken place. Committee can then consider the risk controls and actions in the normal way*.

Laurence Campbell (LC) noted that Trust Board is not until the end of April and other Committees will have also taken place and suggested that early sight of the thinking would be helpful TB said that he would take the suggestion into the EMT discussion and AM advised that it could be included in the forthcoming NED briefing later in the week..

The Committee members asked for an understanding of the key clinical risks and would like a high level summary view of the position.
TB described the key headline risks as;

- Risk of staff and patients contracting Covid19 whilst at work
- Risk of insufficient staff as a result of high levels of suspected or positive cases in the workforce
- Increased demand on services as a result of anxiety of contracting Covid19, with particular reference to apparent suicides
- Late presentation from those who require intervention/ support, leading to poor outcomes

A discussion then followed regarding the emerging risks and their current mitigation.
TB informed the Committee that there is a revised approach to QIA in the event of repurposed services to ensure that our responses do not lead to unintended consequences.
CH advised that there has been a reduction in demand through SPA from GP surgeries which could be a worrying indicator and noted that our new 24/7 helpline should be starting later this week.
TB reported that there has been a plethora of policy guidance issued and we will need to keep a close watch on interpretation of issues across the system as differing approaches can undermine staff/user confidence. A system has been established via the command structure.

The Committee agreed that the management of public confidence in our services and safety of services remains paramount.

Subha Thiyagesh (SThi) informed the Committee of further clinical risks in relation to Personal Protective Equipment (PPE) and the issues with availability and delivery. SThi informed that clinically there is no risk this trust at the moment but supply issues are anticipated, and we are already planning for this eventuality. In addition revised national

guidance on step up and steps down into acute settings (Covid pathway) will be available by the weekend.
IM&T also advised that in terms of Information Governance, Clinicians are now using new methods including using video consultations to ensure a quality service is maintained, this has been subject to governance review. The Mental Health Act Team are as prepared as they can be and are sighted on potential MHA revisions.

Kate Quail (KQ) queried what work is happening regarding Covid19- related workforce succession planning.

KQ asked if there may be a possible increase in suicide and self harm linked to the Covid 19 situation. CH informed that this is being monitored.

Alan Davis (AD) highlighted issues and risk in the approach to workforce and at the moment and new processes have been fast tracked and the risks clarified. Arrangements for staff health & wellbeing were discussed including the issues around PPE. Staff testing arrangements are in place to support people back to work if asymptomatic and it was noted that the Trust is now in a good position regarding testing.

Flexible arrangements are in place to support staff but AD also reinforced that the Trust are learning as they go due to the current situation.

AM queried as to whether the Trust can adequately quality impact assess service offer alterations. Carol Harris (CH) informed the Committee that at the moment there is uncertainly around the quality of mental health care ~~to~~ due to the pace and this cannot be measured at the moment. However patient safety was key and staff always put the patients first and foremost.

LC/AM raised a question around LD/ Autism and the frailty assessments and whether there was a risk about the application of revised guidance. SThi informed the Committee that there were initial concerns but that the GMC guidance was helpful in allaying anxieties.
It was noted that the work preparing for the flu pandemic has been helpful in managing our response and the fact that we established silver command arrangements in the first week of February has been beneficial.
The committee noted the significant work that had already taken place in response to the pandemic and asked that their thanks be shared with everyone involved.

The Committee reiterated that they would like to receive the outcome of the overarching COVID-19 clinical risks from the Executive Management Team on 9th April as soon as possible. TB advised that he will take this to EMT.

**Action: TB**

**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. The committee noted the work to date in mitigating the Covid19 risks.**

## CG/20/33 Quality Accounts (agenda item 6)

Mike Doyle updated the Committee on the position in relation to the Quality Accounts.
The changes in response to COVID-19 were highlighted as follows;-

- The Quality account deadline has been extended with no new date published as yet.
- Section 2b (indicators and assurance section is no longer required- this has been withdrawn for this year).
- No longer require external audit of the quality account.
- Local and mandated indicators will not be tested.
  SWYPFT plan:
- To continue to collate the report once staff have been identified to undertake critical tasks, once complete we will determine capacity and allocate resource accordingly.
- First draft is now likely for June (COVID-19 dependent) – the report is 75%-80% complete.
- Conversations will take place with Deloitte once the emergency planning work has decreased.

**It was RESOLVED to NOTE the position on the production of the Quality Account.**

## CG/20/34 Care Quality Commission Improvement Plan (agenda item 7)

MD informed the Committee that good progress has been made, however due to the impact of Covid-19 it has been recommended nationally that ongoing quality improvement initiatives will be put on hold until further notice. The committee received the update summary identifying good progress to date. The update report also shows where initiatives are delayed, this is also being shared with the CQC.

Because of COVID 19 the Trust will not be requesting CQC Improvement plan updates during April and May, in line with removing the burden recommendations from NHSI/NHSE but are intending to request these again starting from June 2020. This will be reviewed in line with the developments of the pandemic.

The impact of the coronavirus is impacting on teams being able to complete their actions within their given timescales. It is recommended that these timescales be extended by six months.

Due to the issues identified above, the RAG ratings have not been changed in March 2020, so remain as they were within the February 2020 monthly update.

AM queried as to whether there were any safety issues due to the delay and if they are picked up elsewhere and also if the Trust can shorten the deferment or delay. CD also added a query regarding risk reporting and care plans and to ensure that work continues on this for patient care and safety. MD confirmed that all hotspots are raised through OMG and will continued to be monitored through OMG and the IPR process.

It was noted that the CQC engagement meetings are continuing and TB will be speaking with Jo Walkinshaw (CQC) within the next couple of weeks to ensure that the current position is understood.

**The Committee NOTED the update and supported the revised arrangements due to Covid19**

## CG/20/35 Update on COVID -19 (agenda item 8)

### 8.1 NHSE/I Correspondence

TB gave a brief overview to the Committee of the action that the trust has already taken in response to the two letters received to the Trust from Simon Stevens, NHS Chief Executive and Amanda Pritchard NHS Chief Operating Officer. TB highlighted the following:-

- Free up maximum inpatient and critical care capacity
  - Repurposed Barnsley community support
  - Focussed upon keeping people out of hospital
  - Provision of technology to support remote consultations/contact
- Prepare for Covid -19 positive patients
  - PPE guidance issued in line with national guidance and currently working on aligning supply and demand, no immediate issues
  - Training for staff to support patients who are Covid19 positive or suspected, this is provided via our IPC team
  - Preparations underway for cohorting patients and implementation of IPC rules regarding isolation etc.
  - Flu pandemic plan in operation
- Supporting staff
  - Testing plan in place, drive through options available
  - Guidance for staff issued
  - Use of technology
  - New support line available 7 days a week
  - Return to practice and student nurse plans implemented
- Supporting the system
  - As per command
- Checking our Business Continuity Plans
  - Stress tested all plans
  - Highlight from burden letter
  - Reviewed CGCS agenda
  - Suspended clinical audits
  - Q Accounts suspended
  - Ethics committee development plan initiated

Amanda Pritchard letter: - reducing burden and releasing capacity

- Quality accounts as above
- CGCS continuation in line with request

## 8.2 Business Continuity Plans

This has already been already submitted to Trust Board. The stress testing has taken place and shown the planning to be in a good position.

## 8.3 Governance Arrangements, including command and control structures

AM queried as to whether the implementation of the governance arrangements and control structures were clear and if this is working for the Trust. TB confirmed that the Trust was quick of the mark and stakeholder mapping took place very quickly, however challenges will still remain. Silver command has been in place since the 4th February 2020, and continued challenges remain in keeping pace with what other Partners are doing. Gold, Silver and Bronze commands within SWYPFT are working effectively and contact with partners is working well.

CH reiterated that the Trust is well linked to the Gold and Silver commands with partners which has led to positive achievements.

## 8.4 Example – Revised Directorate Support Offer

TB advised that this paper had been provided to illustrate the level of detailed planning that has already taken place in response to the pandemic. AM noted that this paper was very comprehensive. CD agreed, however had a slight concern in relation to the Safeguarding position and would like this to be looked at due to the partial service comment. TB informed the Committee that this is in relation to our contribution to the system wide work e.g. boards and sub groups and that no dilution in advice or guidance to our services has taken place. TB added that in terms of QIA there has been no dilution to the approach but more focus on COVID-19.

CH added that all wards will remain as they at present however identified cohort wards will be in place for Covid-19 positive patients should this be needed.

TB informed the Committee that revised Quality surveillance arrangements are in place through desktop review and usual clinical risk review at panel and OMG

**The Committee NOTED the update and SUPPORTED the revised arrangements**

## CG/20/36 Safer Staffing Report (agenda item 9)

MD apologised for the fact that the version of the paper submitted for circulated was sent in error and the correct paper had now been circulated.

CD thanked MD for this paper and acknowledged the need to concentrate as a Committee on the Trust current position on staffing and any pressure points should the Trust have a surge in sickness.

Although the current COVID-19 outbreak has impacted on the safer staffing agenda, the national commitment to safer staffing is ongoing and SWYPFT need to maintain the progress already made in delivering safer staffing as well as being engaged in the national development of the mental health safer staffing tool and related initiatives.

We are engaging nationally, regionally and locally with a number of forums, considering a variety of interventions and developing our response to the COVID-19 outbreak, as discussed within the report.

The Trust currently meets its safer staffing requirement overall, although there is regularly a shortfall in registered nurses and in some areas difficulty in sustaining sufficient numbers in times of increased demands.

**New plans for Quarters 1 and 2 2020/21 include the items below; however, due to COVID -19, re-prioritisation of these actions may take place.**

- Relaunch the pilot implementation of staffing judgement tool within community teams (delayed due to COVID -19)
- Finalise staffing models within older peoples transformation project
- Support the Forensic BDUs establishment and skill mix review
- Embed the MHOST within our inpatient wide establishment review (currently being piloted within the Forensic BDU)
- Complete the tender process for both nursing and AHP master vendor
- Participate and support the collaborative bank project

- Ensure establishment of SLAs with our neighbouring acute trust banks to provide reciprocal specialist support
- Continue to review the Medical Bank capability and assist in registering everyone on e-roster
- 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
- Support the introduction of the acuity staffing management tool, *SafeCare,* and implement pilot project plan(delayed due to COVID -19)
- 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
- 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

MD highlighted page 19 of the report detailing COVID-19 response, and noted that they are very much in involved in helping services develop business continuity and service plans and repurposing of certain staff including corporate and support services. A redeployment exercised has been mobilised and relocating people into unfamiliar services is happening at a very fast pace. Business continuity plans have stood up to the test and the Trust has maintained safe staffing.

MD informed the Committee that the Trust is at Opel Level 2 at the moment and are looking at changes in activity and performance i.e. staffing sickness etc which are being monitored. Between 350-400 staff are being isolated at any 1 time and 90 shielded staff which is being monitored daily.

Testing is now being introduced to enable staff to get back in to work and exception reports are being received every day.

The Trust Bank is rapidly expanding and people are starting to return to practice and the Trust has also confirmed that they are to pay overtime.

MD informed the Committee that as a Trust we are standing up to the test and do not need to escalate from Opel 2 to 3.

The Committee acknowledged the staffing pressures already within the Trust before the pandemic hit and asked if there was a surge if there was the flexibility to manage. MD informed that staff have been told to restrict to critical functions straight away which frees up staff which is why the Trust has not felt the impact as yet. This is being monitored daily and work continues with individual BDU's.

The Committee agreed to read the updated document and any comments will be sent back to Mike Doyle.

**Action: MD**

CD queried whether the IPR had been revised in relation to measuring and recording and TB informed this will be discussed this Thursday at EMT. AD also highlighted that a daily sitrep report is being sent every morning. MD also added that in relation to community safer staffing that staff are now working in different roles to prop up the critical functions.

**The Committee RECEIVED and NOTED the update including the work to support the Covid19 response**

## CG/20/37 Staff Wellbeing (agenda item 10)

TB gave a brief to the Committee and noted some basic measures that are in place.

1. COVID-19 psychological support line in place available 8am-8am Mon-Fri and 8am-4pm at weekends.
2. Carers support line available Monday to Friday
3. Wellbeing Apps have been provided free to NHS staff - Head Space / Unmind / Daylight
4. Focus placed on regular Comms and Command Structures.

It was noted that people are well versed in looking out for each other and CH added that in the Community, Whatsapp groups have been set to keep in touch with positive contact and teams feel like they are pulling together. CH noted that staff reported that they feel happy with the new PPE guidance.

AM informed the Committee that Rob Webster noted at Trust Board that they would like to receive staff stories at the next meeting to draw on the positive examples being heard.

Committee noted the huge amount of work that has been undertaken and acknowledged the resounding support of teams within the Trust.

**The Committee RECEIVED and NOTED the update**

## CG/20/38 Delivery of Clinical Services (agenda item 11)

CAMHS

CH updated the Committee with regard to CAMHS services and noted that appointments are being managed over phone and the service has moved to working 7 days within crisis teams. All age liaison was in consultation but this may move at a different pace. Core services are being provided by telephone/ video. ASC/ADHD waiting list work being completed as far as possible by phone. This means service is 'stacking' observation work necessary for final diagnosis. Teams are looking to capture learning from each service area in relation to telephone/video interventions for the future. All areas now have 7 days a week crisis/IHBT cover and this is 'critical' within continuity plans. Staff will be redeployed from core pathways as required. Consultations regarding all-age liaison has been stalled indefinitely. Options are being considered as part of continuity plan to develop a revised PLT offer (to include CYP) e.g. Mid Yorkshires push to take MH assessment work off the hospital site. Wetherby/Adel Beck CAMHS maintaining minimum onsite staffing levels for urgent work. Lockdown at Wetherby means CYP only allowed out of cell for 1 hour per day so limited opportunities for therapeutic work

Forensics

Staffing challenges still remain and work is still ongoing on key elements of the forensic plan that relates to safety, e.g. chair / searches. S17 leave has been stopped due to COVID-19. Recruitment is continuing at pace with SKYPE interviewing being used.

Barnsley Community

Thanks have been received from BHFT for support provided by Sue Stansfield and Sue Wing. Services are being maintained to provide care at home and early discharge from hospital and support to care home patients and staff. Bed capacity under review. Discussions have taken place with the CCG regarding Mapleton Court who are leading work regarding the potential of a 60 bedded unit. The Trust have incorporated a number of BHFT therapy staff with ours to facilitate relevant speedy discharges. The Trust continues to undertake priority 1 and 2 visits in NNS and have a range of patients with COVID symptoms and also confirmed cases. Staff swabbing in Barnsley will be joint with Primary care/ GP Federation and Alison Thomas is working with James Barker. The numbers are on the daily weekend update.

New Service Requirements

All services are being maintained and all service users are RAG rated, maintaining contacts through innovative means or face to face when necessary. Business continuity plans are reviewed daily and updated weekly and are cascaded to partners. All community team staffing remains green and all functions are operational using phone and online contact where appropriate. Teams are providing a high level cross cover and support across all areas and IT coming through which is really helpful. Good use of Skype and MS teams for staff meetings and MDT's. Use of video conferencing for clinical work and staff are exploring AirMid. SPA in Wakefield has developed a case load of their own as a step before IHBT as often people previously known to MH where problems are increasing and they are being maintained by assertive phone contact. 51% reduction in routine calls from primary care to SPA in Wakefield. In C&K SPA are showing further reductions in referrals, 55% lower than average for last week and all services are continuing to function at the present time with 'hot spots' being managed locally. In C&K IAPT have developed a broad range of guided self-help tools for COVID-19 related referrals and have developed a pathway for supporting staff with our OH teams

Any New Services
No - on hold at the moment.
Recruitment for SCFT continuing but will be constantly reviewed as to if/when staff are moved into the new team.

LD
Some pressures are being experienced by various community teams where vulnerabilities of individuals have been increased due to the withdrawal of other services e.g day care, domiciliary. These have been escalated through tactical silver. Our staff have been supported to prioritise need and escalate. Also as part of LYPFT contingency plan there ATU has moved to a rehab environment with no seclusion facility. This may add a system wide pressure in LD.

Committee noted the great work undertaken by all services.

**The Committee RECEIVED and NOTED the update**

## CG/20/39 Reporting and Management (agenda item 12)

**Agree CGCS key IPR domains**

TB introduced the item explaining that it would be helpful to have a committee view on the revisions required to the IPR in current circumstances
TB noted a review of the IPR which is going to EMT this week. A vast majority of the quality domain will remain.

Maintain
- Incident reporting
- PU, falls & restraint, EOL, IPC (MRSA & CDIFF)
- Complaints against revised offer
- Safer staffing
- IG breaches
- Safeguarding
- IPC

Remove
- CQUIN
- Smoking cessation
- EMSA
- FFT
- Supervision
- CPA care plan

Query
- Doc
- Meds omissions
- Risk assessments
- MHA

CD noted that the locality reporting was helpful and would like this to remain.
LC highlighted the staff testing issue and that Neds have discussed having sight of the testing plans as they are being implemented and their coverage. TB noted for inclusion in the workforce section.
The Committee would like to receive an update in the IPR including staff figures.

**Action: TB**

The following areas of action were then addressed at the request of committee

**Training (specific to COVID -19)**
- Testing – swabbing, training being provided to non frontline staff
- Enhanced physical health skills being provided - initially via our community teams in Barnsley
- Revised mandatory training arrangements have been approved via silver command

**Clinical Recording**
- All positive cases recorded via systmone and IPC provide a daily report into silver command, incident management scan for covid-19/corona and alerted to spot trends which are reported into clinical risk scan.

Establishing new ethics committee, as a quick response is needed to meet clinical queries and an advisory group will be established plus an oversight group to govern decision making process. Dr Adrian Berry has developed TOR for the group to initially respond to requests and then establish the committee TOR. AM advised that she is able to sit in on this and has experience. All agreed that the Committee is required beyond this current situation so careful constitution is required. It was noted that the advisory group is separate from exec members and will be a three tier style. TB to circulate the Ethics Committee TOR
The Committee noted that if this was to be a formal Committee it will need sign off from Trust Board and discussion will be required to establish this. SThi informed that a rapid turnaround will be needed to highlight the clinical links.

**Action: TB**

The committee was asked to note that that the introduction of the FIRM risk assessment has been delayed until sept 2020

**The Committee RECEIVED the summary report, NOTED the actions being taken and supported the introduction of an clinical decisions advisory group**

## CG/20/40 Quality Impact Assessment (agenda item 13)

MD updated the Committee on the position and informed that the Quality Improvement and assurance team has no QIAs currently awaiting a challenge panel.

There are a number of further CIP work-streams underway which have yet to receive the completed CIP forms, a list of outstanding ones are in the document.

There are currently no red and amber rated QIAs that require further discussion within the operational managers group.

There has also been nine service quality impact assessment completed. We expect this to increase before the end of the financial year.

There has also been QIAs on five capital bids

**Next steps**

- ✓ Quality impact challenge panels will be established and will continue as new CIPs are received by QIAT as per SWYPT Standing Operating Procedure.
- ✓ The Operational Management Group will be monitoring progress in achieving CIPs and overseeing CIPS that have been rated as 'red' and 'amber'.
- ✓ Cost improvement plans are discussed monthly at Executive Management Team (EMT)
- ✓ There is a need for new services and service changes to be subject to a QIA.
- ✓ QIAT to continue to undertake service change quality impact assessments when documentation is received.
- ✓ To ensure clear process for capital bid QIAs for 2020/21 by working with estates and facilities

**The Committee RECEIVED and NOTED the progress, plans and areas of risk.**

## CG/20/41 Internal Audit Report – Complaints Audit Review (agenda item 14)

TB provided a brief summary of the position and confirmed that 360 had now conducted their follow up review and confirmed that the actions are complete. They have also made some helpful suggestions for improvement that will be adopted once the current pandemic has concluded.

**The Committee REVIEWED and NOTED the improvements made to provide assurance on the customer services process.**

## CG/20/42 Sub-groups – exception reporting (agenda item 15)

TB informed the committee that the RRPI, Safeguarding and IPC groups all remain in situ.

**Drug & Therapeutic**

SThi informed the Committee that this meeting is still taking place virtually. Guidance in terms of medication and prescribing are being monitored along with clinical queries.

**It was RESOLVED to NOTE the report.**

**Safety & Resilience**
TB to check with AD for update.

**Action: TB**

**It was RESOLVED to NOTE the report.**

**Infection Prevention and Control**
Received and noted

**It was RESOLVED to NOTE the report.**

**Safeguarding adults & children**
Report received and noted

**It was RESOLVED to NOTE the report.**

**Reducing Restrictive Physical Interventions Group**
An increase on assaults on staff have been noted however robust processes are in place and this is high priority on the groups agenda.

**It was RESOLVED to NOTE the report.**

**Improving Clinical Information Governance Group**
No update.

**It was RESOLVED to NOTE the report.**

**Physical Health**
SThi highlighted PPE guidance and resuscitation guidance which is available.
Also Physical Health strategy has now been completed and went to EMT last week. SThi to circulate to the Committee.

**Action: SThi**

**It was RESOLVED to NOTE the report.**

## CG/20/43 Serious Incidents Update (agenda item 16)

TB informed the Committee the due to COVID-19 the Coroners are no longer meeting so work is adapting to this situation.

Sancus – we have responded to the report and await response

TB advised that Risk panels are still in place virtually and all SI's are seen through that meeting. The team are looking at how these are being managed at present.

## CG/20/44 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 17)

Issues were identified as:

- **Risk Register**
- **COVID 19 Assurance and Response**

- **Safer Staffing**

**CG/20/45 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 18)**

- Discussion at EMT and update to NEDs

**CG/20/46 Work Programme (agenda item 19)**

Noted the items that have been deferred and all items have been logged due to COVID-19

19.1 record of deferred items from 7 April 2020 was noted.

**CG/20/47 Date of next meeting (agenda item 20)**

The Committee discussed the frequency of Committee meetings due to COVID-19 and agreed that the meetings should and need to still take place however a revised agenda may be discussed nearer the time of the Committee. The Committee agreed to cancel the meeting scheduled for May 2020 (Quality Account) given the extension. The next meeting will remain June 2020.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# Minutes of Equality & Inclusion Committee held on 3 March 2020 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 |
| | Alan Davis (AD) | Director of Human Resources, Organisational Development and Estates |
| **Apologies:** | Members | |
| | Chris Jones (CJ) | Non-Executive Director |
| | Rob Webster (RW) | Chief Executive |
| | Others | |
| | Dr Subha Thiyagesh (SThi) | Medical Director |
| | Mohammad Navsarka (MN) | Activity Coordinator |
| | Elaine Shelton (ES) | Unison Branch Secretary |
| | Tim Mellard (TM) | Matron/LGBT+ staff network |
| | Sean Rayner (SR) | Director of Provider Development |
| | Sue Threadgold (ST) | Deputy Director |
| | Chris Lennox(CL) | Deputy Director |
| | Sam Jarvis (SJ) | General 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/BAME staff network |
| | Dawn Pearson (DP) | Marketing, Communications, Engagement & Inclusion Lead |
| | Aboobaker Bhana (ABB) | Manager (Public Engagements Lead) Partnerships Team |
| | Claire Hartland (CH) | HR Business Manager |
| | Christine Symonds (CS) | Senior Finance Manager/Disability staff network |
| | Laurence Campbell (LC) | Non-Executive Director |
| | Amanda Miller (AM) | General Manager (attending for Chris Lennox) |

## EIC/20/01 Welcome, introductions and apologies (agenda item 1)

The Chair Angela Monaghan (AM) welcomed everyone to the meeting and noted apologies. Laurence Campbell (LC) was also in attendance as an observer in his role as Audit Committee Chair.

## EIC/20/02 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/20/03 Minutes of previous meeting held on 10 December 2019 (agenda item 3)

Minutes of the previous meeting were agreed.

**It was RESOLVED to APPROVE the minutes of the meeting held on 10 December 2019**

## EIC/20/04 Matters arising (agenda item 4)

Actions from the meeting held on 10 December 2019 were noted and the action log was updated as appropriate.

- EIC/19/50 – Organisational Risk Register - RISK ID 1157 was formally agreed by Trust Board to be aligned to the Equality and Inclusion Committee (EIC) and is also included in the risk paper at item 5.

- EIC/19/51 Equality Standards Update - RACE forward. Alan Davis (AD) advised the committee that Tim Breedon (TB) is the lead Director and noted that work now needs to be accelerated. AD reminded the committee that this is not just a forensic services' concern but is a trust-wide issue. AM noted the point and that it is also to be discussed at the Workforce and Remuneration Committee (WRC). AD stressed that this has to be clinically led and driven and committee agreed that the action should sit with the EIC. TB confirmed that this needs to be sighted across both EIC and WRC, however EIC is the key committee for oversight. This is to be noted at WRC. AM queried as to whether the full plan needs to be circulated. The committee suggested a possible standing item for RACE Forward to be added within the Inclusive Leadership and Development Programme Update item and also a service user / staff story could also be shared at EIC under the Performance section.

  **Action: Alan Davis/Tim Breedon**

- EIC19/54 Performance Dashboard. Bullying & Harassment. TB noted that the data was not ready for this version of dashboard and work is underway on this for the next report in June.

- EIC/19/54 Performance Dashboard. BDU attendance. AM wanted to ensure that the attendance message is getting out about EIC into specialist services. AD noted that Sue Threadgold (ST) could address gap.

  **Action: Sue Threadgold**

## EIC/20/05 Consideration of items from the organisational risk register relevant to the remit of the Equality & Inclusion Committee (agenda item 5)

TB reminded the committee that RISK ID 1157 has now been formally aligned to the EIC from Trust board.

TB asked if the committee felt there was anything additional to highlight in the risk description. Dawn Pearson (DP) noted the equality impact assessments (EIA) link to the actions in the risk. AM advised this is included within the EDS2 action plan. Also RACE Forward and bullying and harassment should be updated and included within the action plan, including dates.

**Action: Tim Breedon**

TB queried the need for a new risk around access to services.

Erfana Mahmood (EM) queried whether SystmOne could help with any data on service access issues and TB informed that the system does help.

AM highlighted that there is a data and analysis gap and more work and discussion is needed before we can decide if another risk is required.

TB suggested that the access issue could be included in the risk for poor user experience. this will be considered and will be subject to risk review at EMT and then come to committee before Trust Board. TB to discuss at EMT

**Action Tim Breedon**

**The Committee DISCUSSED and commented on the current Trust-wide corporate/ organisational level risk, relevant to this Committee and ASSURED themselves that the current risk level, although above the Trust risk appetite, given the current environment is appropriate.**

## EIC/20/06 Equality Standards updates (WRES, WDES) (agenda item 6)

Claire Hartland (CH) gave an overview of the paper to the committee update on progress since December on the WRES and WDES action plans

WRES Action Plan Update
**Indicator 2:** To ensure that the relative likelihood of BAME staff being appointed from shortlisting across all posts is the same as that of white staff.
**Indicator 5:** To reduce the numbers of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
**Indicator 6:** To reduce the numbers of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months

WDES Action Plan Update
**Indicator 1:** Improve the declaration rates on the electronic staff record (ESR) to reduce the number of null/not known categories
**Indicator 2:** Increase the relative likelihood of disabled staff being appointed from shortlisting across all posts compared to non-disabled staff.
**Indicator 4:** Reduce the numbers of disabled staff experiencing harassment, bullying or abuse from i) Patients/service users, their relatives or other members of the public. ii) managers. iii) other colleagues.
**Indicator 6:** Presentism To ensure that adequate and reasonable adjustments are made to enable disabled staff to carry out their work.
**Indicator 8:** Ensure that adequate and reasonable adjustments are made to enable disabled staff to carry out their work.

CH highlighted an event that is taking place on the 30 March around care planning, which is focusing on front line staff and also a showcase event later in the year involving the change network.

The national report has indicated that our trust is performing well in WRES indicator 8 which is positive and as a result of our focused work in this regard.

AD discussed what was needed to drive the 2020/21 agenda and links into trust priorities areas. He noted that we have good foundations but we have to drive ambitions.

DP raised a query regarding the disability perspective and whether we do have reasonable adjustments in place e.g. training and times, and noted that there are barriers in place. CH advised that there is work underway around reasonable adjustments with Paul Brown (as noted above). Christine Symonds (CS) informed that the disability network is pushing policies and guidance through at the moment and that changes are being made. CS also informed that Disability Policy is making slow progress as it is a large document which is being thoroughly checked. AM queried whether it would help to bring the policy through the committee to see the progress and committee agreed. SH to contact CS and place on agenda for June.

**Action: Sarah Harrison**

DP has discussed the role of Peer Support Workers with CH and consideration is being given to getting these posts in place within the Trust. AD advised that this needs to be service driven and not HR driven and that further work needs to be undertaken.

AM noted the plans to scope delivery of New Horizons again in Batley Girls School during Autumn 2020.

EM informed the Committee that she had attended the school and it was well received but noted that resources and time is an issue. EM suggested it would be worthwhile scaling up these events if possible. Aboobaker Bhana (ABB) informed the committee that 6 sessions had taken place and the committee queried if this was helping applications. CH informed that the position is looking positive. DP suggested that work could be undertaken to see if they could increase the scale. AD noted that this is a broader issue.

ABB highlighted to the Committee that one girl who was part of the school discussion is now going to be working with SWYPFT as an apprentice as a result of this initiative.

AM noted that we are delivering against the objectives but queried if the right level of support and resources in place. CH noted the comments and agreed to review the plans.

Further analysis and national comparisons will be available for the next committee.

**Action: Claire Hartland**

**The Committee NOTED the update and COMMENTED on the 2021 action plan.**

## EIC/20/07 Equality Impact Assessments (EIA) updates (agenda item 7)

AB gave a brief overview to the Committee advising that not all EIAs are progressing well as they are not being undertaken by the service/team and policy authors in a timely manner, despite ongoing advice and the offer of support from the Equality and Engagement Managers.. EIC support is needed to ensure improvement.

Support service functions, i.e. policy development, is now an area of focus for the 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. TB confirmed that this system is now being developed with the corporate governance team

ABB went on to inform that issues have been highlighted with the unknowns and discussions with Mike Garnham are taking place where clinicians can assist.

Overall quality is improving year on year with EIAs, however it is the annual reviews that are still an issue. Local forums are having some impact with dealing with this.

TB noted a discussion that had taken place at Extended EMT on the 27 February, led by DP, on the importance of EIAs which was received well. . DP informed the meeting that Paul Foster is to create a Digital Strategy and has discussed the EIA with DP from the discussion at Ext EMT which is a positive move.

AM noted the link to quality improvement (QI) and noted the progress in other areas, and asked if a QI approach would assist. TB noted that previously the issue was on the need for completion whereas this has shifted and is now on the quality of the action plan and measuring progress.

DP suggested whether positive recognition could be given to completed EIAs that are excelling standards as a means of promoting the impact of the work. It was agreed that good practice examples would be promoted and A Miller supported this approach.
DP to identify good practice examples.

**Action: Dawn Pearson**

**The Committee RECEIVED and COMMENTED on the update and SUPPORTED the ongoing work and future focus.**

## EIC/20/08 Equality Delivery System 2 update (agenda item 8)

Zahida Mallard (ZM) gave a brief overview to the committee.

The CCGs' Equality and Diversity Team for Calderdale, Kirklees and Wakefield, who have to date coordinated the EDS 2 workshops on behalf of the local health economy partners, informed us of their decision to no longer coordinate EDS grading events in 2020. This decision has been made due to capacity issues in the CCGs' Team. We have worked alongside them to arrange the events for March 2020 in these three geographical areas.

We have agreed to work on the external facing goals for EDS2 together as health economy partners as a market place event, with grading undertaken on the same day this year.

We have a joint event plan in place and SWYPFT will produce an engagement report following the completion of all four events across the Trust footprint.

The proposed approach of the CCG's in future is that, they would be hold bi-monthly meetings with equality leads from the respective health economy partners to discuss statutory and contractual obligations for assurance purposes and will include AIS (accessible information standard), WDES and WRES data in the reporting.

The whole process will be complete for the next meeting in June where an update will be given.

**The Committee NOTED the update and SUPPORTED the actions identified.**

## EIC/20/09 Performance Dashboard (agenda item 9)

TB reminded the committee of the 3 strands that comprise the performance dashboard:-

Workforce – The committee agreed that this now includes a good and helpful narrative.
Corporate – The committee agreed that EIA could support this more.
Service user experience – The committee queried how this can be shown more effectively.

The committee noted that the single point of access (SPA) data perspective was useful as was the information regarding access into services that was tabled, and this will be included in the next dashboard. TB noted this will be more valuable once mature.

Local place-based population data versus trust data is the challenge at present.

EM noted that statistical process control (SPC) charts could be applied to access, acuity and patient experience to improve the dashboard as a lot of data has already been collected. DP to ask Mike Garnham for assistance.

**Action: Dawn Pearson**

DP suggested that fuller explanations of what is needed would help to build the dashboard and suggested more comms explaining why data is being asked for would be helpful.

AD added that a drill-down into recruitment is needed for the next dashboard e.g. barriers, bands & peer reviews.

**Action Claire Hartland**

The Committee recognised that a lot of work has been done and this is still a work in progress. AM thanked everyone for the report and noted the progress made.

**The Committee DISCUSSED the development of the dashboard and NOTED the data and trends to be reviewed.**

## EIC/20/10 Staff Survey Results (agenda item 10)

AD gave a brief overview to the committee of the staff survey results and informed that work will commence looking at the data about how people are feeling, which is all part of 'making SWYPFT a great place to work' and senior leadership forum. Committee will receive action plans at a later date.

**The Committee NOTED the results and the UPDATE.**

## EIC/20/11 Feedback from Staff Equality Networks (agenda item 11)

**Disability**

CS provided an update to the committee on the work of the disability staff network:

- She started by giving a "story" from a network meeting which took place in Folly Hall. CS took a colleague who has difficulty walking to the meeting. The meeting was on the lower-ground floor, however there was an issue with the lift as this did not go down to the room. Only stairs went down to the room. They received little help from staff. The disabled colleague was asked by staff to go outside in the rain for access though fire doors. When they finally arrived in the meeting room there were no hearing loops, or hearing loops were not in use, and staff were unaware of how to use these. CS wrote to Folly Hall regarding the lack of help and information. It was

pointed out that the chair of the meeting should have made arrangements for disabled staff to access the meeting. Hearing loops have now been switched on however there are issues with them.

AD is aware of the issues and these are being addressed. AM queried whether this will be an issue at other sites. ZM highlighted an issue regarding training and staff are possibly unaware of how to use hearing loops.

CS advised of two access audits which have been scheduled for Fieldhead and Kendray and a meeting with Nick Phillips has been arranged. CS noted the group would like to be involved in the progress of these issues.

AM would like the audit actions back to EIC and Nick Phillips to attend and give the committee an update on this.

**Action: Sarah Harrison**

- Attendance is very low at network meetings so comms are involved to highlight and raise awareness. Paul Brown is helping with disclosure and getting people involved. AD noted that we need to show it makes a difference having the networks.

- It was noted that progress is slow at the moment.

**BAME**

Cherill Watterston provided an update to the committee on the work of the BAME staff network:

- A lot of work is being undertaken regarding recruitment.
- Pushing RACE Forward through clinical teams and getting them engaged.
- Engaged with the Mental Health Act Committee (MHAC) on work in forensics and on community treatment orders (CTOs).
- Recruiting allied health professionals (AHPs) from wider geographic locations.
- Staff network day 13th May, all networks to be involved.
- Face to face training recommended.
- More comms is needed re EIA.s

Committee is supporting the approach and noted the work taken place

**LGBT+**

Tim Mellard provided a brief to the Committee prior to the meeting.

- 300 pledges have now taken place and the network will be out and about within the Trust.
- SWYPFT are involved in research with York University and SWYPFT appear to be in one of the highest returning Trusts which shows a high level of engagement.

EM askedwhat was happening with the working carers' network and AD noted the carers' passport and that support is progressing. Committee agreed not to lose sight of the carers' network.

**The Committee RECEIVED and NOTED the updates from the staff networks.**

## EIC/20/12 Inclusive Leadership and Development Programme update (agenda item 12)

AD gave a verbal update to the committee and informed that the Moving Forward programme is progressing and is positive.

The Tavistock Institute position on phase 2 of the Building Leadership for Inclusion programme is now agreed and this is being rolled out across inpatient areas.

**The Committee RECEIVED the update.**

## EIC/20/13 Feedback from BDU Equality Forums (agenda item 13)

**Calderdale and Kirklees (C&K) BDU**

Amanda (AM) Miller gave a brief update to the committee and advised of the primary care network (PCN) work in Calderdale in relation to needs assessments.
There is also an ongoing Literature review for asylum seekers.

IAPT – AM reported that there is under representation of BAME communities accessing services and work is underway on this.

**Barnsley and Wakefield (B&W) BDU**

Focus is on EIAs and getting the action plans and making sure they are measureable.

**Forensics BDU**

No update received.

AM asked that the attendees for the committee note which group they are representing, e.g. network reps, staff side, BDUs, etc.

**Action: Sarah Harrison**

Committee felt assured that these meetings are taking place.

## EIC/20/14 National & Regional Issues and Impact Locally (agenda item 14)

Tim Breedon provided a verbal update to the committee.

- Nothing new to report on EDS3.
- Peer review for carers. It was noted that work was happening across the West Yorkshire and Harrogate Health and Care Partnership around carers. Work is alsocunderway with others Trusts around mental health and Keir Shillaker is leading on this.
- Carers' passport is progressing around public audiences.
- Joint action plan for carers.

## EIC/20/15 Committee Annual Report (agenda item 15)

As part of this process of assurance to Trust Board and as part of development of the Annual Governance Statement (AGS) annually, Trust Board committees are required to produce an annual report and an annual work programme, undertake an annual self-assessment, and review their Terms of Reference (TOR) for relevance and appropriateness

**Annual Report**

The committee's annual report 2019/20 outlines the membership and attendance and reviews the committee's activities during the year.

AM noted the agenda and discussions have changed, evolved and improved over the year.

Committee also noted the significant change from a forum to a Committee.

**TOR**
There were no changes to the ToR.

**Self Assessment**
The Committee were happy with the self assessment

**Work plan**
The Committee were happy with the work plan and made slight additions as outlined at item 18.

**The Committee REVIEWED and APPROVED the Annual Report 2019/20, Self-Assessment, Terms of Reference and Work Programme for 2020/21.**

## EIC/20/16 Equality Strategy update and Communication, Engagement & Involvement Strategy update (agenda item 16)

The purpose of the paper is to describe an update on progress of the Communication, Engagement and Involvement Strategy 2016-2019 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

In addition the strategy will now align membership as an integral part of the strategy and progress is being made and as with other areas a website page will be created to support this work. Mapping of approaches is also taking place along with external stakeholder views being reviewed this month.

DP went on to inform that a lot of ground work is being undertaken on wards and that action plans will be ready for June.

DP highlighted the fact that there has been some concern expressed around the approach to integrate the equality strategy within the above. Some people have suggested that it dilutes the importance of the equality strategy and others remain content with the revised approach. DP asked for guidance from the committee.

DP advised that the Equality Strategy has links with other strategies e.g. workforce and the committee felt that this is making sense in that it is cross-cutting and links well to values. However it could be broader and more visible. DP advised that gathering information will be guided by the committee if further developments are needed.

CW commented that the network members reported that they feel that, with a combined strategy, things could be lost.

TB reminded the meeting the original decision was taken as the work is all so closely aligned and that it was felt to provide a more coherent approach. He suggested that maybe the strategy could continue as planned with clear communications around the key domains but stressing the importance of the equality agenda.

AM suggested that equality should be shown as a key pillar in the strategy. Something symbolic and equality pillar and keep separate. Statutory obligations around equality.

It was noted that discussion is scheduled on this issue at EMT 5th March 2020 and Salma Yasmeen will feedback to DP once concluded.

**Action: Tim Breedon**

**The Committee AGREED and SUPPORTED the recommendations.**

## EIC/20/17 Items to bring to the attention of Trust Board or other Committees (agenda item 17)

- RACE Forward focus
- Equality Impact Assessments - strong focus
- Development of performance dashboard
- Staff networks – audit done on disability access; rainbow badges; reciprocal mentoring
- Strategy development

## EIC/20/18 Work Programme (agenda item 18)

Committee agreed to include an audit report section.

EDS to now be 6-monthly in September and March.

The Committee approved the work programme and noted the further meetings for 2020/2021.

**The Committee APPROVED the Work Programme**

## EIC/20/19 Date of next meeting (agenda item 19)

The next meeting will be held at 10.30 – 13.00 on 2 June 2020 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

South West Yorkshire Partnership NHS Foundation Trust

**Finance, Investment & Performance Committee (FIPC)**
**Thursday 23 January 2020**

| **Present** | **In attendance** | **Apologies** |
|---|---|---|
| Tim Breedon (TB)<br>*(entered at 12:50 mid-way through risk item 5)*<br>Mark Brooks (MB)<br>Carol Harris (CH)<br>Chris Jones (CJ) (Chair)<br>Kate Quail (KQ *(via dial in)*<br>Rob Webster (RW)<br>Sam Young (SYo) | Jane Wilson (JW) (Note taker) | None |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
|---|---|---|---|---|
| 1 | Introductions and apologies | Chris Jones (CJ) welcomed everyone to the meeting and made introductions for the benefit of Kate Quail (KQ) dialling in. | CJ | |
| 2. | Declarations of interest | None | CJ | |
| 3. | Minutes from previous meeting | The minutes from the FIP meeting held on 19 December 2019 were approved. | CJ | |
| 4. | Review of progress against agreed actions | **Action 011 – Agency Self-Certification**<br>The Committee agreed to review this action and feedback to the Board accordingly. The final document to be discussed at the FIP meeting in February. Lead confirmed as Carol Harris<br>**Action 014 – Annual work plan**<br>The Committee agreed with the draft work plan presented as a paper on the agenda<br>**Action 015 – Risks on the risk register**<br>The Committee agreed to close this action<br>**Actions 016 & 017** – Mental Health benchmarking report<br>MB suggested this be reviewed in conjunction with updated information in the model hospital which is expected in April<br>**Action 018** – 2019/20 non-pay expenditure - this action to be picked up under finance report | CH<br><br>MB<br><br>MB<br><br>MB | Action CH<br><br><br><br>Action MB |
| 5. | Review of committee related risks and any exception report as | MB stated at the Audit Committee meeting on 7 January it was agreed that some risks allocated to it for oversight and review should be transferred to the Finance, Investment & Performance Committee (FIP). He asked the committee to note that the Audit Committee had not had sight of the updated organisational risk register included in the FIP papers as this | MB | |

<table>
<tr><th>Item no.</th><th>Item/area</th><th>Progress and actions/decisions</th><th>Lead</th><th>Action</th></tr>
<tr><td></td><td>required (need to agree with Audit Committee)</td><td>
has just been updated in readiness for the Trust Board on 28 January.<br><br>
Risks identified that will come to FIP are:-
<table>
<tr><td>275</td><td>Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding.</td><td></td></tr>
<tr><td>522</td><td>Risk that the Trust’s financial viability will be affected as a result of changes to national funding arrangements.</td><td>It was agreed this risk was within appetite so should be recommended to be removed.</td></tr>
<tr><td>1076</td><td>Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support.</td><td></td></tr>
<tr><td>1114</td><td>Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.</td><td></td></tr>
<tr><td>1214</td><td>Risk that local tendering of services will increase, impacting on Trust financial viability.</td><td></td></tr>
</table>
<ul>
<li>CJ asked when emerging risks such as the risk around the forensic lead provider collaborative would be included on the risk register. MB stated it has been identified as a risk for consideration on the January Board paper and would be built up into a firmer risk during February as details and clarity of the requirements of the lead provider and potential risks increase.</li>
<li>MB stated that given the current cash balance the risk score relating to capital has been recommended for a reduction in scoring.</li>
<li>CJ asked about the impact of exceeding agency costs by more than 50% of the cap. MB stated he did not think it was an organisational risk issue as the most notable implication was on financial risk rating. He added that based on current projections it was becoming less likely this level of overspend would be reached.</li>
</ul>
</td><td></td><td></td></tr>
<tr><td>6.</td><td>Current year financial performance, full year forecast including CIP performance</td><td>
MB stated he would cover 3 reports together.<br><br>
Key highlights
<ul>
<li>Risks are being effectively managed in a number of areas.</li>
<li>A surplus was generated in December largely as a result of reducing previously identified risk meaning the Trust is in a better position to meet its full year control total.</li>
<li>The flu vaccination target of 80% has been met.</li>
</ul>
</td><td>MB</td><td></td></tr>
</table>

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
|---|---|---|---|---|
| | | • Some additional non-recurrent income has come into organisation in recent months.<br>• Effective mutual relationships cultivated with commissioners has resulted in recognition of such items as out of area bed pressures.<br>• From an operational perspective not all projected recruitment has been achieved. In some cases, agency/bank has not yet materialised to cover vacancies or short-term initiatives.<br>• Net financial risk position has improved.<br>• Whilst the position is improved this year the underlying position remains as a deficit of circa £4m for the full year. Messaging to staff needs to be carefully considered.<br>• Cash is currently healthy with in excess of £30m in the bank. The level of cash will mean interest earnings of circa £170 this year.<br>• SYo asked what the full year agency staffing cost was in relation to the cap. MB said on current projections it would be 45-48%.<br>• SYo asked if in respect of recruitment is there a lack of people to recruit. CH explained that there are a number of staff shortages both locally and nationally. CH added that different ways of attracting staff continue to be considered with a recruitment and retention plan in place. Additional resource has been recruited to support recruitment of substantive staff.<br>• MB explained that the reduction in income in recent years has been reversed this year with total income increasing compared to last year.<br>• MB stated the Trust continues to forecast meeting its control total of a £200k deficit at end of year.<br>• MB explained the contract settlement for 2020/21 is very important as growth in mental health is currently not planned to be as high beyond that year.<br>• CJ asked what effect a £6m registered staffing underspend is having on the organisation. TB stated there is some mitigation in the over recruitment into healthcare assistant posts. TB explained a Quality Impact Assessment is currently being conducted. RW felt it was important for the Trust Board to understand this issue and how it is being addressed.<br>• MB noted that the use of non-registered staff has offset two thirds of underspend on registered staff.<br>• TB added that new roles are being introduced such as trainee nurse associates.<br>• CJ referred to a continued overspend on some estates costs.<br>• MB explained the main issue in year is the increase in costs relating to 2 leased buildings which are PFIs.<br>• MB reported that energy costs are generally increasing and that to reduce these it will require focus on use and culture. MB added that he would provide a paper on the key estates costs movements and areas of opportunity at a future meeting.<br>• MB summarised by stating there has been continued improvement in financial performance over the last year, stating there are still a number of challenges to be overcome before the Trust achieves financial sustainability. CJ asked why was energy overspent and should it feature as someone's priority. MB confirmed estates are very engaged with the non-pay delivery group, stating some recent work has identified total energy cost per metre squared per building and the reasons for differences are being assessed to identify if there is anything that can be done differently.<br>• CJ asked CH to pass on the thanks of the committee to those involved with the CQUIN work. | | Action CH |
| 7. | Review of output from | TB stated there had been 9 service quality impact assessments completed, 5 on capital bids, no other quality impact assessments in relation to CIP. No amber or red incidents that require discussion with operational managers. | TB | |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
|---|---|---|---|---|
| | quality impact assessments | | | |
| 8. | Review of progress against financial sustainability plan | The updated plan is not significantly different to the plan previously presented to FIP in December 2019; however, the following progress has been made:<br>• Focus on 20/21 CIPs at the Operational Management Group (OMG)<br>• Action plans being developed for top 10 loss-making services<br>• Internal team dashboards developed and released<br>• Multi-functional device tender evaluation completed<br>• Draft estates strategy update circulated to OMG for consideration<br>• Treat well for less awareness campaign launched (drugs & medicine)<br><br>CJ asked in the context of the financial sustainability plan how do we message this effectively in that if we get it right now it will become easier in years ahead. MB felt that part of the challenge is how much financial improvement will happen naturally e.g. income growth and vacancies and how much will require real change e.g. productivity, re-structure etc. In the case of vacancies how do we ensure we are operating safely. The work being carried out on internal efficiency and productivity will be of particular help in this respect.<br>CJ stated he expected the details of the financial sustainability plan to be firmer in terms of the values of savings and when they will be achieved. MB reminded committee members that this is a three year plan and the report provided at the December meeting highlighted the significant progress made in year 1 of the plan, particularly in terms of income growth and out of area bed placements. His view was that there was not much more that could have been done at this stage other than bring in an external body to have specific key focus. There has been an in-year setback in terms of the initial assumption made regarding the use of NHS professionals. In terms of developing a data warehouse to inform internal team productivity intense resource has been applied to this, moving staff from SystmOne on to this work. He also added that unforeseen cost pressures have arisen such as CAMHS staffing costs, particularly for consultants that have added to the scale of challenge. MB suggested further work is required on effectiveness of our rostering. One option is to conduct peer reviews with other similar trusts.<br>MB added the Trust does not benchmark well in terms of corporate services with similar trusts in the north-east, Yorkshire and Humber. In some areas we appear to be an outlier in terms of cost, some of which could be explained by the geographical footprint covered. TB stated that even if we don't benchmark well this doesn't mean we are well staffed. MB added that the potential for digital driven efficiencies needs to be better understood. A recently established digital group has identified some areas for further investigation.<br>CJ stated he felt more assurance was required to convince him the financial sustainability plan could be delivered. As an example he felt there would be more savings arising from the review of the model hospital and non-pay. MB explained there is ongoing work with reference to non-pay which has delivered good levels of saving in recent years and the incremental opportunity is not considered significant. | MB | |
| 9. | IPR – learning disability service performance improvement | Key highlights were:<br>• Work has been taking place in recent weeks to understand the under-achievement against the metric '% referrals that have commenced service delivery within 18 weeks'. One of the key issues identified has been not recording correctly on the electronic patient record, issue. This is an issue that that pre dates the introduction of SystmOne.<br>• Work is being carried out to identify how data is pulled from the system to ensure that information is being pulled | CH | |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | correctly.<br>• Another issue has been the number of vacancies in these services where it has been a struggle to recruit either substantively or via agency for a number of posts.<br>• A data clean-up is taking place and it is expected that following this the target of 90% will be achieved.<br>• RW asked if in relation to this issue and other reported data quality issues, were there any other SystmOne transfer issues in other services. MB stated that typically any issues identified were being resolved as they arose. He stated that in this particular case SystmOne had helped expose it, but was by no means perfect yet.<br>• MB added that all BDUs have had issues with CPA data quality and this continues to improve as everyone becomes more familiar with the system and how it works. CH confirmed that clear guidance had gone out to all clinicians, and that there were monthly performance clinics with each of the teams, along with tailored LD documentation. CH stated she thought Wakefield BDU would hit 90% by November.<br>• KQ asked when recruitment to the Wakefield psychology post would take place. CH confirmed this was currently out to recruitment. TB stated some skill mixing had also been carried out and that we need to consider how LD services are provided and staffed across West Yorkshire.<br>• CJ questioned whether the drill down had only been carried on 18 week waiting period metric. CH confirmed it had and that the Trust Board had highlighted this as an area of focus following review of the integrated performance report at its November meeting.<br>• CJ asked what happens to all those that are not seen at 18 weeks, suggesting a need to enrich the report.<br>• KQ asked are there other standards that we measure ourselves against. TB responded yes and that these were scheduled into Clinical Governance and Clinical Safety Committee meetings.<br>• SYo asked if the committee needs a wider paper on LD performance to learn more about service. RW commented on the need to resist to ask for more stating the Board asked the committee to look at performance against this metric. | | |
| 10. | Review of operating plan guidance and process to achieve the requirements | • It is expected the Trust will need to make an initial submission early to mid-February, and is likely to include financial and workforce schedules.<br>• The Trust is working towards developing a financial plan to deliver a £0.5m surplus in line with the control total set in 2019.<br>• Contract negotiations are typically well underway with an expected timescale for final agreement of the end of March. Contract negotiation parameters are being discussed later in this meeting and agreed at the Finance, Investment and Performance Committee.<br>• Each BDU and corporate service is in the process of meeting with the Director of Finance to review their initial financial plans, including the identification of cost pressures and cost improvement projects (CIPs).<br>• Capital plans are being prioritised with the aim of meeting the target established in the five year plan submission of £7.8m.<br>• The Trust Board needs to agree the governance and approval mechanisms for the expected draft submission of operating plan schedules by early-mid February.<br><br>**Focus on Income Growth and Contract Negotiation Parameters**<br><br>The Trust has been successful this year with increasing its income base, which included some contribution in the form of demographic growth. There will be further investment in mental health services in 2020/21. | MB | |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | • SYo commented that the approach looked sensible and asked if there was anything that may be considered controversial.<br>• MB stated he did not feel there was anything considered controversial. He noted there were 2 proposed new service specifications in health and care homes which need further understanding in terms of what this means for service delivery and the Trust stating the need to ensure Trust knows what the commitments are and how they can be delivered.<br>• MB noted that consideration needs to be given to what is required under the lead provider collaborative for forensics in 2020/21. Currently, encouragement is being given to every lead provider to start recruitment in to new commissioner arrangements. We are currently unclear what resources will transfer from the specialist commissioner in this respect.<br>• MB reminded committee members that whilst the detailed planning guidance has not been provided yet the fundamentals are known from previous long term plan and 5 year planning guidance. A five year settlement for the NHS has already been agreed. He noted the Trust is working on its annual plan and expects to submit a draft plan by the end of February. MB and CH are meeting with each BDU to understand their proposed plans in greater depth. MB felt that insufficient recurrent CIPs have been identified to date, but the current run rate, largely due to vacancies, is likely to mean non-recurrent savings are achieved in the first part of the year at least. He would like to see some of the mental health growth applied to existing cost pressures, particularly the demand for inpatient beds coupled with service user acuity leading to greater safer staffing needs.<br>• The contract negotiation parameters for 2020/21 were approved. | | |
| 11. | Barnsley CAMHS | Key highlights:-<br><br>• Barnsley CCG have written to the Trust advising they didn't award a contract following the recent tender exercise and that they are undergoing a market engagement exercise shortly The letter stated the CCG is extending our current contract by 3 months. SWYPFT responded to CCG seeking some clarification and opportunity to re-negotiate the terms and conditions.<br>• RW stated his understanding the contract can only be extended once and that the 3 month extension puts staff and services at risk.<br>• TB added that any uncertainty leads to risk within the workforce.<br>• TB raised the question of what will happen if the next tender exercise does not generate a successful bidder. MB was not clear on what the outcome would be but it could mean a managed change with the incumbent provider. | MB | |
| 12. | Items to be brought to the attention of Trust Board/Committees | • CJ reported the committee were pleased with the continued good financial performance, noting the underlying deficit.<br>• Continue to receive updates on financial sustainability plan and to clarify objectives.<br>• Assurance that there is an upturn in LD service referrals that have had a completed assessment care package and commenced service delivery within 18 weeks?.<br>• More broader review of LD service, compared with national benchmarks<br>• Approved set of contract parameters with local commissioners | CJ | |
| 13. | Annual work programme | The Committee confirmed they were all happy with first draft of the annual work programme presented by MB. It was agreed a regular review of specific issues within the IPR would take place. Trust Board to select which issue to do a deep dive on at FIP meeting in February. | MB | Action MB |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
|---|---|---|---|---|
| 14. | Date of Next Meeting | The next meeting of the Committee will be held on Thursday 27 February 2020 at 1:30-14:30 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield. | | |

South West Yorkshire Partnership NHS Foundation Trust

**Finance, Investment & Performance Committee (FIPC)**
**Thursday 27 February 2020**

| **Present** | **In attendance** | **Apologies** |
|---|---|---|
| **Members**<br>Tim Breedon (TB)<br>Mark Brooks (MB)<br>Chris Jones (CJ) (Chair)<br>Kate Quail (KQ)<br>Sam Young (SYo) *(via dial in)*<br>*Attendees*<br>*Carol Harris (CH)* | Jane Wilson (JW) (Note taker) | Rob Webster (RW) |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
|---|---|---|---|---|
| 1 | Introductions and apologies | Chris Jones (CJ) welcomed everyone to the meeting. | CJ | |
| 2. | Declarations of interest | There were no declarations of interest | CJ | |
| 3. | Minutes from previous meeting | The minutes from the FIP meeting held on 23 January were approved. | CJ | |
| 4. | Review of progress against agreed actions | **Action 013 – IPR -** It was agreed a regular review of specific issues within the IPR would take place. Trust Board to be asked if there are any specific issues it would like the FIP to do a deep dive on at the FIP meeting in April.<br>**Actions 016 & 017 – Mental Health benchmarking report**<br>MB suggested this be reviewed in conjunction with updated information in the model hospital which is expected in April. | MB<br><br>MB | |
| 5. | Review of committee related risks and any exception report as required (need to agree with Audit Committee) | Key highlights:-<br>MB stated nothing had changed fundamentally over the course of the last month when this report was last reviewed and asked the committee if they had any specific concerns since last report was produced. CJ raised a couple of questions the first in relation to Barnsley CAMHS, the latter around Barnsley in general. MB confirmed the CAMHS tender was imminent. MB confirmed the Barnsley income risk was currently identified in the private session of board, stating it was not currently allocated to this committee. He did suggest an update on the latest developments would be beneficial to the FIP committee and that he would bring this to the March meeting.<br>In relation to risk levels below 12, SYo stated the colour coding was incorrect. | MB | Action MB |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
|---|---|---|---|---|
| | | The committee agreed they were satisfied with the overall level of risk included in the report. | | Action MB |
| 6. | Current year financial performance, full year forecast including CIP performance | <u>Month 10 finance report key highlights</u><br><br>• Pre Provider Sustainability Funding (PSF) surplus in month 9 of £348k. This represents the sixth consecutive month a surplus has been reported and is largely due to continued pay underspends, additional income, reductions in out of area placement costs and expenditure control.<br>• The year to date clinical revenue position recognises remaining risk around CQUIN delivery and other known risks. Continued work with commissioners is ongoing to finalise potential additional investment in 2019/20 (effectively priming recurrent investment in 2020/21).<br>• Pay budgets have continued to underspend; £0.7m in January. 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.<br>• Non pay is higher than plan in January (£456k) largely due to IT investment but cumulatively is £1.1m less than the same period last year<br>• Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend of £6.3m is already £1m above the full year cap of £5.3m, 41% above the year-to-date cap and 19% higher than the same period last year. Approximately £0.6m of the costs incurred relate to waiting list and other non-recurrent initiatives.<br>• Capital expenditure of £2.7m is £1.9m lower than plan, partly as a result of delays whilst the final capital plan was agreed. A review of all projects took place in January and there is confidence the full year plan of £6.0m will be achieved.<br>• The Trust is confident the year-end control total of £240k will be achieved and given year-to-date performance coupled with non-recurrent income is projecting an over-achievement by £0.3m.<br><br><u>Financial forecast 19/20, key highlights</u><br><br>• Trust assured to achieve control total, working collaboratively with partner trusts<br>• Trust has benefited from a number of non-recurrent upsides in 19/20<br>• Real challenge to meet the ICS consolidated control total this year. Following agreement at the January Trust Board the Director of Finance has offered to improve the year-end outturn position by £0.3m in order to support the wider ICS achievement of its control total.<br>• Estates management have been successful in achieving a nil rates valuation on Mount Vernon. 145k upside.<br>• Some of the ambitious recruitment plans have not yet resulted in staff starting with the Trust and as such some of the BDU year-end forecasts have improved.<br>• Over £1m upside expected in February from St Luke's transaction this financial year. No cash receipt for 12 months<br>• Ossett Health Centre disposal has been completed. No loss on disposal and £0.9m cash receipt | MB | |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | • CJ asked if it was still possible to spend on capital schemes in line with the Trust plan this year. MB agreed that it looks ambitious, but also noted that assurance has been sought from the Head of Estates and Head of IT regarding their own plans. Both have confidence final spend for the year will be in line with plan. MB was also mindful of the fact that as many of the schemes this year are smaller in size the capital accruals figure may be under-stated. He noted that a lot of work is in progress<br>• CJ asked if in relation to OOA beds and PICU, the system seems to be working better for acute. CH responded that there were peaks and troughs throughout the year and that this was not unusual. CH stated that a piece of work had been carried out with Niche across the West Yorkshire & Harrogate ICS in relation to gender specific PICU and that Niche believe there is a way total demand can be reduced.<br>• CH stated that single point of access was a sticking point for the Trust and confirmed that a team with specific expertise in PICU had been set up at local level to review this, stating that one of the things the group would be looking at is the size of wards. CH confirmed she was currently working with MB and his team on daily data thereby trying to minimise impact of peaks and troughs. CH did feel there was a national pressure; TB agreed | | |
| 7. | Review of output from quality impact assessments | TB stated there had been no quality impact assessments (QIA) conducted since the previous meeting. He confirmed that any clinical issues from a QIA are reviewed at the Clinical Governance & Clinical Safety Committee (CGCS). The next meeting is scheduled for 7 April 2020.<br><br>KQ raised the question of whether the Trust uses the risk matrix system. TB replied no but confirmed that they do use key criteria, i.e. 30 questions against domains that are then assessed by teams, followed by a panel.<br><br>CH commented that key conversations at board yesterday were linked to the risk register. KQ asked whether it would be beneficial to do a deep dive into some QIAs. TB stated he did not feel this was particularly necessary as feedback from the Trust external auditors (Deloittes) was good and there have been no issues arising from previous QIAs CH stated that Charlotte Dyson, Non-Executive Director has also been involved in the process and that has worked well. CJ confirmed that it was not the FIP Committees role to look at the effectiveness but for TB to assure committee members the process is effective. | TB | |
| 8. | Review of progress against financial sustainability plan | MB reported the plan is not significantly different to the report presented to the Committee in January 2020 but that progress has been made in the areas detailed below:- | MB | |

| Ref | Milestone/Action | Progress |
|---|---|---|
| 2.1 | Each BDU identify and propose Cost Improvement Plans for 2020/21 | 2020/21 CIPs discussed at Operational Management Group. Some identified with an additional 1% challenge applied to all budgets. Quality Impact Assessments to be completed on 26.02.20 |
| 3. | Reduce Agency Spend – Reduce the number of locum Medics. | There has been a further reduction in number of agency medics from 23 in June 2019 to 15 and it is expected that this will reduce further to 14 at the end of February 2020.<br>Agency focused working group to be re-established reporting progress to the Recruitment and Retention group and OMG. |
| 5 | Tender Opportunity Plans | Bids and tender update submitted to EMT February 2020. Main current focus is Barnsley CAMHS with timeframe likely to be the tender issued at |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | |
|---|---|---|
| | | the end of February. |
| 6.1 - 6.10 | Top 10 Loss Making Services | Actions and work to mitigate losses is progressing |
| 7. | Creative Minds & Museum Services | Workshop held between Creative Minds and Recovery College staff in January with the aim of exploring the relationship between Creative Minds and the Recovery Colleges and how they can work closer together to deliver a collective, broader offer to communities on behalf of the Trust. |
| 14 | Model Hospital and Internal Team Benchmarking | BDU workshops to identify areas with scope for improved productivity and next steps are progressing. |
| 16.2 | Non Pay Review - MFD provision and rationalisation. | Tender complete and preferred supplier identified. Contract period 2020 - 2025. Potential savings identified of £50k per annum.<br>- A paper on MFD paper to go to EMT on 5th March |
| 16.6 | Non Pay Review – optimisation of postage | Further work to identify potential savings of digital postage through new MFD machines progressing.<br>- The trust now only sends out 2nd class mail<br>- 73 of 86 faxes removed from sites |
| 20.2 | Care Closer to Home – focus on PICU | Programme of work underway with deliverables, objectives and activities identified. Specific project meetings to be scheduled to focus on this work. |
| 22.6 | Drugs and Medicine Management - identify and undertake actions to rationalise Clozapine choice. | Project Manager recruited and will start w/c 17th February. Project plan to be developed.<br>- Area historically struggled capacity wise.<br>- Complex but some opportunities<br>- Barnsley costs higher than rest - why? |

- Whilst agencies spend is high, agency medics have reduced by 8.
- Tender opportunities, MB stated there are also business case opportunities as opposed to tender opportunities.
- Barnsley CAMHS tender ongoing.
- Contract negotiations ongoing and well developed in West Yorkshire. Less developed to date with the specialist commissioner.
- MB explained the need for constant flexibility in the plan given the changing environment and changes in risk profile. He added that some areas of potential improvement such as out of area beds and agency are very well defined, whilst others are developing. Communication and engagement will remain key.
- CJ asked that discussions around the model hospital and benchmarking to be brought back to the meeting in the next couple of months
- SYo asked about the progress on internal productivity. MB stated that Rebecca Thorn and the P&I team have worked very hard on developing this and suggested inviting her back to a future FIP meeting to provide an update
- CJ felt this was a good discussion. He added that the Committee needs assurance on progress and we need to

Action MB

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | ensure the good work leads on to something.<br>• CJ asked about corporate overheads and when the committee would be able to receive a more detailed report on benchmarking and actions. MB explained he would like to take this to EMT first and bring to the April FIP meeting.<br>• KQ asked about the SSG report that stated the Trust was unsure what the impact of the various changes made on the ooa bed process has been. CH explained we do have a lot of information and it is not straight forward to determine what the impact of each individual intervention has been. She added we need to determine how we best use the data we do have. | | Action MB<br>Action MB |
| 9. | Agency – self certification | CH stated that a recent action from the Trust Board was to review the agency self-certification document and update it for current practice, processes and issues. CH confirmed this has been reviewed by the agency group and a copy of this document provided to the FIP committee for their review and comment.<br>CH stated that no further declaration to NHSI was required, confirming the review has been carried out as part of internal assurance and agency forms part of the agenda in EMT meetings with NHSI.<br>Key highlights:-<br>• Agency group is taking a critical look at what we are doing<br>• Agency usage this year is broadly in line with the plan. Whilst the number of locums has reduced it has increased with other staff groups so this will form greater focus within the programme team. CH working with Vickie Whyte on how to re-approach this.<br>• CH suggested more assurance is required on the checking process for booking staff for inpatient wards<br>• There is a good process for the use of medics that are off framework.<br>• CJ concluded by stating the Committee felt assured to feed back to Trust Board on 24 March<br>• CJ asked for an update on the actions to be brought back to the committee in six months. | CH | Action CH |
| 10. | Review of Decision Tree | • MB reminded the committee that a review of the decision tree was requested by the Trust Board.<br>• KQ felt it was very clear<br>• CJ concluded by stating the Committee was assured. That the decision tree as described is comprehensive and appropriate. | | |
| 11. | IPR | Key highlights:-<br><br>• CJ felt the front sheet summary was helpful in identifying key issues<br>• TB noted that Quality issues are captured in CGCSC.<br>• SYo noted that patient safety incidents have increased. TB explained this issue has been taken into CGCSC and been subject to focused review. He also reminded members of the committee that a number of incidents are re-graded following review. Looking at trends the number of incidents is not outside normal variation.<br>• SYo - Community risk assessment – 95% of target figure down to 69%. TB - trajectory goes beyond March, subject to separate discussion at CG&CSC on 7 April 2020.<br>• CJ – asked about the number of service users discharged and not followed up within seven days. CH noted the number of discharges have fallen. On occasions it can be a struggle to get hold of people within 7 days if they leave the area or do not return messages. 1 patient has tipped Barnsley from being 100% to 94%. TB suggested percentages are not always helpful. CJ suggested it would be helpful to see the absolute numbers in addition to the | CH | Action TB |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | percentages.<br>• CH stressed the biggest risk is considered to be the first 72 hours following discharge, so internally the focus was on making contact within this timeframe.<br>• SYo suggested doing deep dive on one of the priority programmes. MB suggested it was not necessarily within remit of FIP but advised he would take a look at the priority programmes reported on in the IPR and confirm where they are currently reviewed. He stated if there are any gaps as a consequence the committee could then agree if they need to be reviewed in further detail either at FIP or another committee. MB to bring back to meeting in March.<br>• CJo asked about extending safer staffing into community. TB explained this has been piloted. When the pilot finishes around May an assessment will be made. | | Action MB |
| 12 | Operating Plan – first draft | MB confirmed the draft plan is due to be submitted to NHSE&I on 5 March 2020. The final plan is due to be submitted on 29 April 2020 with contracts signed by 27 March 2020. The Trust intends to have a final plan available and prepared by the end of March 2020 so it is worked on from the beginning of April 2020.<br>Key highlights:-<br>• SYo comfortable with discussion of assumptions at Trust Board.<br>• CJ explained he still has some nervousness about using run rate as a base as this will mean entering the year with more financial risk. MB agreed with this and felt that £1m of additional savings target needed to be firmed up with a further £1m identified to mitigate against identified risks. MB also added that the level of growth in mental health services will reduce in 21/22 and as such the staff pay saving in that year will also reduce. As such more sustainable plans need to be implemented.<br>• TB felt the approach to the plan makes sense for 20/21 and messaging is key.<br>• KQ asked about the savings in nursing and if we are managing now can we not continue to manage?<br>MB explained that a sizable proportion been through new investments which wouldn't be repeated next year. He also pointed to the fact a good proportion of nursing pay savings are offset by spend on temporary staffing.<br>• MB added he has asked for some information from each BDU that will enable him to look through run rate assumption in more detail, team by team. This will help inform the reasonableness of the assumptions in the plan. In addition a further £1m savings will be targeted to mitigate against expected risk. | MB | |
| 13. | Deep dive on income element of the financial sustainability plan - Estates | Key highlights:-<br><br>• MB opened the discussion by noting that the Estates & FM costs in the Trust have reduced in absolute terms in recent year. When unavoidable cost increases such as pay awards are adjusted for the underlying saving is higher than quoted.<br>• MB also noted the report explains views on what is considered to be 'influencable' cost in the short term. Such costs as lease charges on PFI buildings are largely fixed, and in fact subject to increase.<br>• It was also noted there is a balance between cost and quality of buildings/other factors. For example the benchmarking information clearly shows us having high property maintenance cost, but the Trust does have low backlog maintenance costs as a consequence.<br>• MB also provided an example from last year when we compared detailed stroke unit costs with Barnsley hospital. SWYPFT costs are much higher than the hospital's, but the SWYPFT stroke unit is 100% en-suite.<br>• One area for further assessment is the work that has been carried out on internal benchmarking of energy costs. | | |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | Recent investment in hubs have typically provided higher costs given the use of comfort cooling in some building for example. Much of the improvement will need to be via culture and behaviour.<br>• KQ felt it would be helpful to understand level of detail related to cleaning. Is there any scope to reduce costs? For example could this be something which is outsourced? MB noted that our PLACE report is amongst the best in the country for cleaning standards.<br>• SYo noted the low total waste cost is good. MB felt this may be connected to the change in waste provider from 2018 onwards and that benchmarking costs may change in future years.<br>• CJ noted the good work to date in terms of cost reduction and asked where the future opportunities for further efficiency improvements are. He suggested it would be helpful to carry out a deep dive into some areas i.e. new buildings vs old buildings, energy costs per square footage etc. MB – suggested any deep dive is carried out after the updated estates strategy has been finalised. | | |
| 14. | Items to be brought to the attention of Trust Board/Committees | • Target to exceed control total managed at year end to benefit trust and wider system.<br>• Received and agreed agency self- certification, look at again in 6 months for a reviewed of progress against actions and the impact of these.<br>• Committee is assured about the decision tree used for business development opportunities.<br>• IPR - identified themes picked up elsewhere.<br>• Operating Plan assumptions will be strengthened by provision of timelines proposed for recruitment, additional CIP challenge against risk | CJ | |
| 15. | Annual work programme | The Committee confirmed they were all happy with first draft of the annual work programme presented by MB. It was agreed a regular review of specific issues within the IPR would take place. Trust Board to select which issue to do a deep dive on at FIP meeting in April. | MB | Action MB |
| 16. | Date of Next Meeting | The next meeting of the Committee will be held on Tuesday 24 March 2020 at 9:30-11:30 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield. | | |

South West Yorkshire Partnership NHS Foundation Trust

**Finance, Investment & Performance Committee (FIPC) – Thursday 23 April 2020**
**Virtual meeting, via Skype for Business**

| | | |
|---|---|---|
| **Present**<br>**Members**<br>Tim Breedon (TB)<br>Mark Brooks (MB)<br>Chris Jones (CJ) (Chair)<br>Kate Quail (KQ)<br>Sam Young (SYo)<br>*Attendees*<br>*Carol Harris (CH)* | Jane Wilson (JW) (Note taker) | **Apologies**<br>Rob Webster (RW) |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| 1 | Introductions and apologies | Chris Jones (CJ) welcomed everyone to the meeting. Apologies were received from Rob Webster (RW). | CJ | |
| 2. | Declarations of interest | There were no declarations of interest | CJ | |
| 3. | Minutes from previous meeting | The minutes from the FIP meeting held on 24th March were approved. | CJ | |
| 4. | Review of progress against agreed actions | MB confirmed that most actions were understandably deferred given the impact of the response to the Covid-19 pandemic; stating it would be very unlikely that any of those deferred would be pursued over the next 4 months whilst temporary contracts for financial arrangements were in place. From a financial perspective the Trust will operate with temporary financial arrangements for at least the next four months. MB advised the committee that he had engaged in a number of national finance director phone calls. CJ stated it was good that the committee could be updated regularly.<br><br>CJ asked if there was anything in the work Rebecca Thorn (RT) from Performance & Information (P&I) was doing that the Committee should be changing focus on to use now.<br>MB stated that RT was currently100% engaged in internal reporting for Cocid-19 which included:-<br>• Daily reporting on numbers of staff who are not at work by team and service<br>• New MH SitRep report which will be incorporated into the national dashboard report.<br>• Reporting on staff testing and the results | MB | Action - MB |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | MB explained that RT and her team are still providing limited reporting on activity happening within teams and that hopefully in the next month with a bit more head room she may be able to change the focus of what her team is doing to support what the service provision will be beyond the initial Covid-19 peak.<br><br>CJ stated it was really good work that RT was doing and did not want to lose sight of this or the progress that had been made with providing internal productivity and benchmarking information.<br><br>CJ suggested that the committee return to this at a more appropriate time on the agenda. | | |
| 5. | Review of committee related risks and any exception reports as required | Key highlights:-<br><br>• MB explained that the risk register had been updated for previously agreed changes. Furthermore any impact from Coivid-19 was shown in italics. There has been a change in focus of some risks given the new financial, planning and contracting circumstances.<br>• MB highlighted that the wording on risk 275 had changed from being related to the impact of funding in local authorities on service provision to the availability of resources within local authorities and the associated impact on service provision. CJ agreed with the risk and asked if it still should be overseen by the committee. MB agreed to review with EMT.<br>• MB highlighted that risk 1511, which is new, relates to the role of lead provider for forensics across West Yorkshire. MB confirmed that given the impact of Covid-19, the majority of the work on the project has been effectively put on hold until July. KQ asked for clarification about what the main risk was for the Trust regarding the lead provider collaboratives<br>• MB explained that the largest financial risk is that resulting from the transfer of commissioning monies and the associated responsibility for the provider collaborative and what would happen if there was an overspend against these monies. It is expected there would be a risk share in place between the providers. Soft intelligence is that this is a budget that overspends and given the fact the total budget is in excess of £50m even a small % overspend could cause a financial issue. This is why there is due diligence taking place. He confirmed April 2021 was still the assumed go live date for the lead provider collaborative and that work would hopefully re-start on due diligence in the summer.<br>CJ stated it is important that this is on the risk register and that it is a live risk. | MB | Action - MB |
| 6. | Current year financial performance | <u>Month 12 key highlights</u><br><br>• Additional national funding of £942k as part of an allocation to NHS providers of mental health services.<br>• Financial risk rating moved from 2 to 1 given the improvement in margin resulting from this additional income.<br>• CIP plan target of £10.6m was achieved. The difference compared to previous forecast was made up by non-recurrent means, as a result of some including the confirmation of additional non-recurrent income of £1.3m in March 2020.<br>• MB also noted that out of area (OOA) bed spend was the highest it had been all year in March, largely driven by PICU and additional nursing costs.<br>• Cash balance £36m largely consequence of improved financial performance, timing of capital spend and strong working capital management.<br>• Planning to submit draft accounts on 27th April. If required this submission can take place on 11th May but we plan to submit on original date given the fact we have retained key staff at work and completed the draft. | MB | |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | • MB stated that the finance team led by Rob Adamson, Deputy Director of Finance & Susan Baines, Head of Financial Accounting had done a great job in producing the draft accounts whilst working remotely.<br>• KQ commented that the draft accounts were very straight forward to understand.<br>• CJ stated the executive dashboard looked very strong, albeit with a bit of good fortune following receipt of £942k towards year end. He stated as a result of a lot of good work that has gone on throughout the Trust we are now in a far better place than anticipated at the start of the financial year, some of which has been achieved with some non-recurrent activities, which is a legitimate management tool.<br>• CJ felt there was still an ongoing challenge around agency which was not going away in the current situation. MB noted that prior to the suspension of the planning process the agency cap for 2020/21 had been increased to £7.3m.<br>• MB stated that irrespective of the level of agency staffing, we will always aim to have as many substantive staff as possible. He confirmed the Trust is using more temporary staffing during the Covid-19 pandemic.<br>• CH confirmed recruitment activity had stepped up, although Covid has interrupted this.<br>• KQ raised the question of whether the Trust could be recompensed for agency use if it is Covid specified. MB confirmed this is the case. He added that the same level of control and processes need to be in place whilst using agency staffing during the period of the pandemic.<br>• CJ expressed his concern in relation to the total spend on agency which was £0.9m higher than previous year. MB noted that approximately £0.8m of agency spend in 19/20 was incurred as a result of investment in service investment and waiting list initiatives. CJ questioned if this was still an area we have not got under control, and asked what we were doing to improve recruitment.<br>• MB stated that he saw this as more of a recruitment and retention challenge, rather than not having good control. He explained there had been good audits, along with a review process involving NHSE&I national experts. He reported that there has been some positive improvement in the second half of the year with the number of medical locums reducing. He acknowledged that it was a very challenging market in general and for some specific roles.<br>• TB stated he agreed and that bank and agency staff were being used to maintain staffing levels. He said we are in an extremely competitive market, and are we sure we are doing the right things around the recruitment and retention agenda.<br>• CH confirmed the work that we have been doing in relation to recruitment and retention is starting to have real impact and boost to recruitment.<br>• Out of area bed placements have been more challenging, although demand for adult acute placements reduced in the second half of March. The most notable demand in recent months has been for PICU placements, including gender specific. There are currently 5 people out of area for PICU that are requiring a gender specific environment, where we are unable to provide a bed internally. | | |
| 7. | Temporary financial arrangements | Key highlights:- | | |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | • In line with current national guidance the Trust will receive block income, with values set nationally, for April to July 2020. This was based on month 9 actual contracted income. This does leave the Trust with a shortfall on income given which should be covered by separate top-up and true-up processes.<br>• There is an issue with Barnsley CAMHs income as it has historically been provided by the local authority and has not been covered by these new arrangements.<br>• On national calls and with associated guidance it is clear the intention is that the Trust will get all reasonable costs covered for 4 months.<br>• During this four month period it has also been stressed that proportional financial governance needs to continue.<br>• MB advised that a purchase policy note had been released recently asking for all suppliers to be paid within 7 days of goods or services received.<br>• KQ raised the question of whether this would be a huge leap for the trust and were finance well placed to do this MB explained that to make payments we have to make sure all requisitions are appropriately approved, and that there are several hundred budget holders that we are dependent upon to approve invoices when they come in. Rob Webster to put some comms out in his daily update. MB stated it is essential we do not pay suppliers without having proper approval and governance. MB stated in terms of the capital regime that has recently been published there is a separate funding stream for Covid-19 related capital.<br>• KQ commented that this report was really clear and that the increasing role of the ICS is unfolding for everyone.<br>• CJ stated that most of capital funding is coming from Trust cash fund reserves.<br>• MB reported that West Yorkshire ICS will receive a capital allocation based on what has been included in original operating plans.<br>• CJ asked if there are savings we could log in some way. MB replied that efficiency savings are not required for the first four months of the year, but there remains a requirement to exercise fiduciary duty and ensure value for money is being attained.<br><br>CJ thanked MB for providing a very useful summary | This was based | |
| 8. | Review of IPR framework | Key highlights:-<br>• MB stated the IPR was not currently available to share. He stated the updated version will be available for Trust Board to review on Tuesday 28th April.<br><br>MB provided a brief report on the framework of the IPR for the next four months<br><br>• The aim of the interim framework is to enable focus on the response to Covid-19 whilst at the same time enabling oversight on other metrics that the Trust needs to ensure it keeps in view and on top of.<br>• A separate Covid 19 response section has been added in and will evolve as the response progresses. It is based on six key areas of action as per the letter sent by Simon Stevens and Amanda Pritchard to chief executives in March.<br>• TB stated the key thing is to stick to original response letter from Simon Stevens as this might help to benchmark in future.<br>• MB stated that there is a high degree of focus on workforce in the IPR.<br>• CJ stated that after looking at some of the example metrics it would be really useful to see analysis by different characteristics, i.e. possible impact of virus on BAME colleagues. MB replied that currently the report was not catching | | |

| Item no. | Item/area | Progress and actions/decisions | Lead | Action |
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| | | that level of information, but this can evolve.<br>• CH stated this would mean individual team leaders going in to ESR and that may be this is something we need to discuss at Board. This is already being discussed at Operational Management Group (OMG) and Silver command meetings.<br>• CJ asked if we can we continue to explore this without making excessive burdens on individuals.<br>• KQ commented this is a really good self-explanatory paper. | | |
| 9. | Investment business cases | All tendering with NHS business has currently been paused, we do not expect any notable tenders within the next 6 months. | | |
| 10. | New risks identified | MB stated this is more for a discussion for Board on Tuesday when everybody has had the opportunity to run through risks on the updated risk register. | | |
| 11. | Items to be brought to the attention of Trust Board/Committees | • Report on financial performance outturn. Exceeded control total.<br>• Need to understand recurrent revenue costs of decisions made during the initial phase of the pandemic and how these may impact on future financial plans and sustainability<br>• Feedback on temporary financial arrangements and how they are evolving<br>• Challenges around paying supplier within 7 days<br>• Capital regime | | |
| 12. | Any other business | CJ stated he would like MB to pass on the Committee's thanks to Rob Adamson, Susan Baines and the finance team for their financial efforts in these unprecedented times. | | Action - MB |
| | Date and time of next meeting | The next meeting of the Committee will be held on Tuesday 26 May 2020, 9:30-11:30. This will be a virtual meeting, via Skype for Business. | | |

South West Yorkshire Partnership NHS Foundation Trust

# Minutes of the Mental Health Act Committee Meeting held on 12 November 2019

| | | |
|---|---|---|
| **Present:** | Dr Subha Thiyagesh | Medical Director (lead Director) |
| | Kate Quail | Non-Executive Director (Chair) |
| | Tim Breedon | Director of Nursing and Quality |
| | Erfana Mahmood | Non-Executive Director |
| **Apologies:** | Members | |
| | Laurence Campbell | Non-Executive Director |
| | Salma Yasmeen | Director of Strategy |
| | Attendees | |
| | Carol Harris | Director of Operations |
| | Terry Hevicon-Nixon | Operations Manager - Working Age Mental Health (Calderdale) – local authority representative |
| | Anne Howgate | AMHP Team Leader (Kirklees) – local authority representative |
| | Deborah Longmore | Adult Safeguarding Named Nurse, Barnsley Hospital NHS FT |
| | Stephen Thomas | MCA/MHA Team Manager (Wakefield) – local authority representative |
| **In attendance:** | Shirley Atkinson | Professional Development Support Manager (Barnsley) – local authority representative |
| | Clive Barrett | Head of Safeguarding, Mid Yorkshire Hospitals NHS Trust |
| | Julie Carr | Clinical Legislation Manager |
| | Yvonne French | Assistant Director, Legal Services |
| | Gary Haigh | Independent Associate Hospital Manager, Vice Chair of the Hospital Manager Forum |
| | Chris Lennox | Deputy Director of Operations |
| | David Longstaff | Independent Associate Hospital Manager, Chair of the Hospital Manager Forum |
| | Angela Monaghan | Chair |
| | Kathryn Sykes | Social Worker, Adult Mental Health Team (Wakefield) – local authority representative |
| | Victoria Thersby | Head of Safeguarding (Calderdale & Huddersfield NHS FT) |
| | Cherill Watterston | Chair of BAME Network (item 2) |
| | Angela Whitworth | MHA/MCA Administration Manager, Kirklees |
| | Sarah Millar | PA to Medical Director (author) |

## MHAC/19/42 Welcome, Introductions and Apologies (agenda item 1)

The Chair, Kate Quail (KQ) welcomed everyone to the meeting. The apologies, as above, were noted.

It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

There were no declarations of interest to record.

## MHAC/19/43 The Act in Practice (agenda item 2)

MHAC/19/43a BAME Network (agenda item 2.1)

Presentation from Cherill Watterston (CW) on the work of the Black Asian and Minority Ethnic (BAME) Staff Network and a proposal for service user engagement and data collection to improve ethnicity recording and culturally sensitive care.

Mental Health Act Committee (MHAC) acknowledged the positive work undertaken over the last 3-4 years although agreed that more work was needed to improve ethnicity reporting and the experience of service users.

Angela Monaghan (AM) raised concerns over the assertion in the presentation that the NHS and system as a whole is institutionally racist. It was noted that there were also social factors involved such as an increase in race crime and national austerity measures. AM raised the need for local data as well as robust discussions about the SWYPFT workforce and how it reflects the community it serves. It was noted that the Trust does not currently have all the necessary data, hence the proposal.

David Longstaff (DL) was keen to see the detail behind the figure of BAME service users being 8 times more likely to be placed on a Community Treatment Order (CTO) as this did not reflect his experiences. Gary Haigh (GH) agreed that this differed from his own experience as an independent Hospital Manager.

CW will share the Independent Review of the MHA 2019.

**Action: Cherill Watterston**

CW asked Committee to consider the proposal for someone to spend one day per week for perhaps 6 months speaking to service users and getting a better idea of their circumstances and needs. This individual would also look at prevention in the community and ethnicity data collection. It was agreed that this was a good idea in principle and would be taken to EMT for approval.

**Action: Subha Thiyagesh**

Committee thanked CW for the presentation and agreed that it would be useful to receive updates on progress at each MHAC, via YF and to revisit this subject in full in a year's time to evaluate progress.

## MHAC/19/44 Legal updates (agenda item 3)

MHAC/19/44a Deprivation of Liberty and 16-17 year olds (agenda item 3.1)

Julie Carr (JC) reported that The Supreme Court had decided that 16/17 year olds could not be held on parental consent and an application would need to be made to the Court of Protection or High Court to ensure that these individuals were not unlawfully deprived of their liberty. This meant that the Liberty Protection Safeguards due to come into force in 2020 would extend to 16/17 year olds. Committee were assured that the Trust was as prepared as possible at this point in time.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

MHAC/19/44b Applications to the Court of Protection for Serious Medical Treatment decisions (agenda item 3.2)

JC reported on cases where NHS Trusts had brought applications to the Court at a very late stage and had insufficient access to appropriate legal advice or support. MHAC were assured that SWYPFT have sufficient legal advice available via the Trust's Legal Services department and can support services for such cases to run smoothly. JC added that there had been feedback from the courts to that effect.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

MHAC/19/44c CQC report – The state of health care and adult social care in England 2018/19 agenda item 3.3)

JC advised that the annual report had been published and had focused on mental health and learning disability services where the CQC had seen a decline in the quality of services, with a third of mental health and learning disability services requiring improvement or rated as inadequate. MHAC noted that whilst a reduction in the number of inpatient beds was in line with the Five Year Forward View, it appeared that beds were being closed before the money was available to improve community services and this was of concern.

The findings of the report identified a number of areas for focus in the next year:

- Staffing
- The quality of leadership
- Access to the full range of effective treatment and care interventions, other than medication
- Sexual safety on mental health wards
- Minimising restrictive interventions
- The physical fabric of wards

MHAC were assured that a programme of regular meetings with the CQC were arranged where issues raised within this report could be addressed.

There was discussion and it was noted that the concerns around LD services was a national issue. Tim Breedon (TB) indicated that SWYPFT was leading on the LD Operational Delivery Network and had a positive CQC rating for local community and inpatient services. TB added that recruitment and retention of registered LD nurses was of concern as the workforce was diminishing. It was also noted that there was an issue around how autism beds were commissioned.

KQ referred to the last CQC report where the Trust, via the MHAC, had benchmarked itself against the report and then the executive trio had used the findings in their visits to services. This had been raised in Clinical Governance and Clinical Safety Committee and TB would confirm that that committee had sight of the relevant issues.

**Action: Tim Breedon**

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

## MHAC/19/45 Local Authority and Acute Trusts (agenda item 4)

The following updates were noted:

**Victoria Thersby (VT) – Calderdale & Huddersfield NHS Trust**

- Two young people had been sectioned on a paediatric ward for under 16s.
- It had been identified that the system of processing Mental Health Act work was incorrect and this had now been rectified.
- There was a focus on work around CAMHS and training for general staff in relation to extended stays on wards.
- Identifying outcomes to improve care and best interest meetings were really useful.

**Clive Barrett (CB) – Mid Yorkshire Hospitals NHS Trust**

- Similar ongoing issues in relation to children coming in following self-harm and some consultants were unhappy with the 'cooling off period' mentioned in the NICE guidance. Also the difficulty in locating Tier 4 beds.
- Developed Mental Health Strategy in response to the CQC plan expecting acute Trusts to do more in relation to mental health. Will launch the strategy together with an action plan for implementation.
- CB linked with Carly Thimm to replicate the good work done in VT's Trust around receipt and scrutiny of Mental Health Act papers and guidance for middle grade doctors. CB reported a really good level of support from SWYPFT and its legal teams. VT reiterated that.

**Shirley Atkinson (SA) – Barnsley Local Authority**

- Started a local network implementation group, chaired by Barnsley CCG to prepare for introduction of the Liberty Protection Safeguards.
- Looking at operational guidance in relation to consent – SA met with Sarah Leason-Hurley, one of the Quality and Governance Leads at SWYPFT.

**Kathryn Sykes (KS) – Wakefield Local Authority**

- Local implementation network meetings have taken place in Wakefield in May and June so far and the local authority are taking the lead for implementation. Yvonne French (YF) added that there were plans for further meetings, along with CCG colleagues, every 4 weeks in Wakefield to keep updated and consider training needs.

YF updated Committee on the work across the SWYPFT footprint on Liberty Protection Safeguard implementation plans. It was noted that Wakefield had already made good progress and YF would be meeting with SWYPFT Deputy Directors in January to discuss operational needs. A local group had also been established in Calderdale although there were difficulties because of the wait for legislation, delayed due to Purdah. YF advised that there had been less involvement in Kirklees. KQ asked if this was a problem and YF advised that this would be escalated if it becomes an issue.

CB added that Mid Yorkshire had started to look at pathways (elective and emergency) in relation to Liberty Protection Safeguards needed for day surgery which may represent a possible deprivation of liberty.

## MHAC/19/46 Minutes of previous meeting held on the 29 August 2019 (agenda item 5)

CB raised that reference to Section 2 should be amended to Section 5.2 under MHAC/19/32.

**Action: Sarah Millar**

**It was RESOLVED to APPROVE the notes of the meeting held on 29 August 2019 (with the above amendment) as a true and accurate record of the meeting.**

## MHAC/19/47 Matters arising (agenda item 6)

MHAC/19/47a Action points (agenda item 6.1)

The action points were noted and the following items raised:

- MHAC/19/34 – YF reported that Estates had submitted a minor capital bid to soundproof the Tribunal room in the Unity Centre and this was supported by the Deputy Director. DL reiterated the negative impact that noise was having on hearings and GH expressed frustration at the length of time this issue had been ongoing. KQ acknowledged that Estates had made previous attempts to solve the noise problem and, as these had not been successful, extensive work would now be involved to resolve the matter. Chris Lennox (CL) would feedback on the minor capital bid to the next meeting.

  **Action: Chris Lennox**

- MHAC/19/35 – YF advised that upon checking data from electronic and manual sources, differences had been identified. However, it appeared that the questions being asked of SystmOne to extract the electronic data may need to be modified. YF will bring an update to the next meeting.

  **Action Yvonne French**

- MHAC/19/35a – This action was due in March 2020 and YF indicated that there had already been a lot of changes to the overall report. An updated version will come to the next meeting.

MHAC/19/47b Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.2)

Subha Thiyagesh (ST) raised two items relevant to MHA Committee that had been discussed in EMT. YF will circulate the Risk Register to Committee members.

**Action: Yvonne French**

- Risk of lack of information share or documentation could lead to serious harm occurring from known patient safety risk. Clear procedures are in place in relation to the Mental Capacity Act.
- Risk of inconsistent recording or practice relating to patients' rights, Section 17 leave and/or assessments of capacity to consent to admission and treatment and restrictive practice could lead to risk of serious harm. MHAC were assured that control measures are in place. Risk level 6 does not reach organisational Risk Register level and will be monitored by Committee.

YF reported on the next steps:

- Patients' Rights is a KPI for Trust Board and November data would be reported in the December IPR (no Board meeting in December). New guidance was being rolled out to all wards recording on SystmOne, with new parameters making it more manageable.

Reminders will be issued to clinical staff and followed up. Electronic white boards are also in use in some areas as a reminder system.

- Section 17 - page 2 of the form is now being managed by the Mental Health Act office. September figures were reported to October Board and a significant improvement was noted. However, the system appears to rely on a couple of individuals so carries some risk. Work is ongoing with Matrons and Practice Governance Coaches to strengthen the system. YF advised that there had been an increase in the number of applications for Tribunals and Managers' Hearings, possibly because of an increase in the reiteration of rights. All hearings were covered up to January but MHAC were asked to note the additional pressure for clerking.
- Consent to Treatment – being looked at to see if anything specific needs to be done.

## MHAC/19/48 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)

MHAC/19/48a Performance report – Monitoring information Trust wide July-September 2019 (agenda item 7.1)

The report was considered and the following noted:

- Ethnicity recording – following migration to SystmOne some missing ethnicity data had been extracted from the shared record and the report now captures that information. As a result there had been a significant reduction in the number of patients where ethnicity was recorded as 'unknown'.
- There had been a reduction in the number of admissions under the MH Act. It was reported that Ward 18 was closed to new admissions for 3 weeks, however Committee were advised that the ward was still open to settled admissions and it was not clear that the reduction could be attributed to that. YF and CL to clarify.

**Action: Yvonne French/Chris Lennox**

- Internal transfer activity from the Dales remains the highest source of transfer activity amounting to a total of 11 transfers. The main reason for internal transfer was being returned to home area which was in line with Care Closer to Home.
- The use of civil sections across the Trust had shown a slow but steady increase in the number of uses of the Act with a total increase of 44 uses over the rolling year.
- There was one admission of an under 18 to the Trust in Quarter 2.
- CTO activity continues to run against the national trend of increasing activity, showing a steady state of 66 open CTOs at the close of Quarter 2.
- Hospital Managers – one concern relating to a patient not receiving their reports prior to the hearing. DL advised that this was immediately rectified and there was now a process in place to mitigate this risk. There was also a concern relating to the availability of advocacy services in Kirklees. It was noted that the capacity was stretched and DL indicated that from a Hospital Manager's perspective, there was some uneasiness when dealing with complex cases. JC added that in such cases the legal team can liaise with Kirklees and ask for the hearing to be prioritised. MHAC also noted a concern in relation to difficulty in obtaining funding for a specialist placement and it was acknowledged that this was a challenging and complicated process with scope for improvement.
- There were 4 reports of delays to SOADs attending wards to complete treatment authorisations in Quarter 2. JC indicated that a new process was being tested and appeared to be successful and ST confirmed that there had been no concerns raised in recent months.
- There had been 3 CQC notifiable deaths in Quarter 2 and MHAC were assured that the Serious Investigation process was being followed.

- MHAC considered whether the relatively low rate of admission from arrest was a positive or not. It was agreed that more information on the service users and their experiences would be needed to consider this further.

**Action: Chris Lennox**

- The highest rate of admission under the MHA was in Barnsley at 65%. Kirklees had the lowest rate of admissions under the Act at 30%.
- Section 49 activity continues to be an issue although successful repudiations have increased.

Erfana Mahmood (EM) raised that the average Length of Stay appeared to be increasing and CL advised that there were Length of Stay action plans for Barnsley and Wakefield as part of the Care Closer to Home workstrand. MHAC noted that there was no correlation of adverse impact around length of stay and sometimes individuals needed to be in hospital. CL added that quarter to quarter there are changes and long stay discharges would also affect the figures.

KQ queried the high level of variation in admissions between Barnsley and Kirklees. CL indicated that it reflected the relatively low admission culture in Barnsley and also that Calderdale and Kirklees have a high number of people coming in for shorter periods of time. This was also being picked up as part of the Care Closer to Home work looking at Trustwide admissions. It was acknowledged that there were differences in localities in relation to informal and formal admissions and ST reiterated the different services, population and CCGs involved. MHAC noted that the figures were not necessarily adverse to service users in Barnsley.

AM referred to the use of CTOs and queried if the use was broken down by ethnicity (given that BAME service users were 8 times more likely to be subject to a CTO). DL and GH reiterated that they were keen to see the detail behind this as it was not reflective of their personal experiences and suggested that the figure could relate to national statistics rather than SWYPFT. It was agreed that YF and CW would look into this.

**Action: Yvonne French/Cherill Watterston**

KQ queried whether internal transfers, despite being part of the Care Closer to Home agenda, were always in the best interest of services users who would have to meet a new clinical team and build new relationships, etc. KQ also noted that 2 Appeals needed to be cancelled at short notice due to patients being transferred on the same day. This emotionally impacts on service users and carers and requires time to set up appeals in the new service, with the need for new IMHA/IMCA, new clinical team etc. CL advised that transfers were clinically driven and only carried out if beneficial to service users. Also, the number of transfers was reducing and the next report should reflect that.

**It was RESOLVED to RECEIVE and NOTE the contents of the monitoring report.**

MHAC/19/48b Local Authority Information (agenda item 7.2)
Monitoring information had been received from Kirklees and acknowledged by Committee.

KQ reported that in discussion with LA leads and acknowledging their time and effort required to complete the monitoring for Committee, it had been agreed that future reporting would be verbal and by exception, so monitoring reports would no longer be received.

**It was RESOLVED to NOTE the update.**

## MHAC/19/49 CQC compliance actions (agenda item 8)

MHAC/19/49a MHA Code of Practice oversight group feedback (agenda item 8.1)

YF reported that the Code of Practice group had been established to have oversight of any working or implementation groups.

The following workstreams have been identified:

- Leave implementation group
- Section 132 patient rights group
- Seclusion and segregation group
- Reducing Restrictive Practice (blanket restrictions) group

YF advised that there was really good engagement with the oversight group and people valued the opportunity to discuss how the work can progress.

YF updated that the draft 136 policy should be signed off at the next multi-agency meeting and progress was being made in relation to a joint Section 140 policy, along with the CCG, for the locating of inpatient beds.

**The Committee RESOLVED to:**

- **RECEIVE the update in relation to implementation of the MHA/MCA Code of Practice group.**
- **NOTE the progress with the MHA 136 policy as agreed at the MHA Committee.**
- **NOTE the seclusion and segregation implementation group.**

MHAC/19/49b MHA/MCA/DoLS mandatory training update (agenda item 8.2)

YF reported the current position as:

- Mental Capacity Act/DoLS training – 93.19% compliant
- Mental Health Act training – 88.85% compliant

against an 80% target. Committee noted this positive progress and achievement although noted that there were some hot spots relating to individual teams/services that needed to be addressed.

YF added that there had been positive feedback from the CQC on staff knowledge.

JC advised that an increased number of training sessions had been scheduled for next year.

**It was RESOLVED to RECEIVE the report and to NOTE the level of compliance with the mandatory training target and plans for future training.**

## MHAC/19/50 Audit and Compliance Reports (agenda item 9)

MHAC/19/50a Community Treatment audit (agenda item 9.1)

JC reported that the 2019 audit and activity report was taken from SystmOne for the first time and this change in data collection had resulted in a 100% return rate.

The main conclusions from the audit were:

- Investigation into the poor recording rates had identified that the Section 132 patients' rights recording facility had not been opened to the community teams and the recording of CTO rights was limited. However this matter had not been raised by clinical staff with the MHA Administrators – this was quickly rectified and work is ongoing with Learning and Development to develop a recorded information clip for the intranet.

- The use of recall and revocation provisions of CTOs appear to be effective by the evidence of the reduced length of admissions for the revoked CTO patients in comparison with those patients who had been admitted under Section 3. It suggested that CTO recalls were occurring at an earlier stage of relapse, resulting in shorter admissions – this was not in line with the national picture and the audit also showed lower numbers of revocation in recall.

The next steps were noted as:

- Following from the implementation of SystmOne we will explore its recording capabilities through the optimisation group.
- Involvement of the Matrons and Practice Governance Coaches has supported timely responses to the audit.
- The audit will be circulated to the BDU's for review and development of action plans.

JC indicated that ethnicity would be included in next year's audit.

DL emphasised the positive use of CTOs when considering patient rights and quality of life.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

## MHAC/19/51 Care Quality Commission visits (agenda item 10)

MHAC/19/51a Visits and summary reports received in Quarter 2 (agenda item 10.1)

JC reported that there were 7 CQC Mental Health Act visits in Quarter 2 which represented an increase following completion of the well-led inspection.

Within the quarter, five MHA monitoring summary reports were received relating to ward visits made to; Appleton ward, Chippendale ward, Thornhill ward, Enfield Down and Beechdale.

2 responses were submitted to the CQC; Chippendale ward and Thornhill ward.

The Committee received detailed information about the outstanding issues and KQ noted that there were fewer incidents of recurring themes which indicated that ongoing work was effective. Positively, the CQC had commented on the rapport of staff with service users. EM indicated that she had seen a real improvement since starting to attend MHAC. TB reported that there had been a couple of reports recently with only one area for attention identified which represented a significant improvement. Committee acknowledged the positive progress made.

YF advised that there had been a recent meeting with the CQC to ask how they identify a blanket restriction and the need to care plan for each patient in relation to the restriction. SWYPFT took the view that the care plan would not change the restriction and the CQC were going to consider their policy.

**It was RESOLVED to RECEIVE the report and to NOTE the positive progress.**

MHAC/19/51b Update on CQC MHA action plans (agenda item 10.2)

YF reported that the one outstanding action from 15/16 had now been completed and Committee acknowledged that there had been a significant amount of work undertaken in replacing bedroom door panels at Newton Lodge.

There were 21 open actions at the end of the quarter and it was noted that some of these were past their due date and some were not yet due. Of the ones past their due date, some had a process in place, however ward staff were keeping the action under review so it was not yet completed. Committee asked for more detail on the outstanding actions and YF would bring a breakdown by BDU to the next meeting with an update on each point. YF also confirmed that the actions were spread across wards and BDUs and did not relate to one area.

**Action: Yvonne French**

**It was RESOLVED to RECEIVE the report and to NOTE the progress of the actions following CQC visits.**

## MHAC/19/52 Independent Hospital Managers (agenda item 11)

MHAC/19/52a Hospital Managers' Forum Notes 24 September 2019 (agenda item 11.1)

The Committee received the notes of the last Forum. DL reported that a carer had attended to talk about their experience of being a carer and how that had resulted in them developing their own mental health difficulties. The carer highlighted the importance of service users not being discharged until appropriate support mechanisms were in place.

**It was RESOLVED to NOTE the update.**

MHAC/19/52b Hospital Managers' annual review feedback (agenda item 11.2)

The Committee noted that DL would step down as Chair at the next Forum and GH would take up this role. The election process for the new Vice Chair was underway and would be confirmed at the meeting on 20 December 2019. KQ thanked DL for his very valued, insightful and relevant input to MHAC and thanked GH for taking over the role.

Committee were assured that all Hospital Managers met the standards required of them to sit as a panel member. 23 Hospital Managers were re-appointed for a further year and JC and EM were considering options for recruitment including ways to diversify. A training programme was being developed which should be ready shortly and the findings of the review would be presented in a 'you said we did' format to the next Forum.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

MHAC/19/52c Hospital Managers' payment (agenda item 11.3)

YF reported that, following communication from HMRC, Hospital Managers who used to be paid directly via BACS now needed to be added to the Trust payroll.

DL and GH had facilitated engagement events and had reached a compromise that Hospital Managers would be classed as 'office holders' with no contract or receipt of regular payments, to remain independent.

KQ thanked DL and GH for their partnership approach in getting this issue resolved and within a short timeframe.

**MHAC/19/53 Key Messages to Trust Board (and Clinical Governance and Clinical Safety Committee as necessary) (agenda item 12)**

The key issues to report to Trust Board were agreed as:

- BAME presentation and proposal to improve ethnicity recording, service user experience and prevention/ community support.
- Mandatory training for MHA and MCA – strong overall but some hotspots
- Highlight again in relation to two big pieces of work expected due to changes in legislation resulting in mandatory training and partnership working within localities
- Strong partnership working
- CTOs and how they work well for SWYPFT – feedback from Hospital Managers that they are used effectively
- CQC and positive progress with actions
- Resolved risk around Hospital Managers' payments
- Risk Register – 2 items

**MHAC/19/54 Date of next meeting (agenda item 13)**

The next Committee meeting will be held on 10 March 2020 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield from 2.00-4.30 pm.

South West Yorkshire Partnership NHS Foundation Trust

# Minutes of the Mental Health Act Committee Meeting held on 10 March 2020

| | | |
|---|---|---|
| **Present:** | Dr Subha Thiyagesh | Medical Director (lead Director) |
| | Kate Quail | Non-Executive Director (Chair) |
| | Tim Breedon | Director of Nursing and Quality |
| | Erfana Mahmood | Non-Executive Director |
| | Laurence Campbell | Non-Executive Director |
| | Salma Yasmeen | Director of Strategy |
| **Apologies:** | Attendees | |
| | Shirley Atkinson | Professional Development Support Manager (Barnsley) – local authority representative |
| | Terry Hevicon-Nixon | Operations Manager - Working Age Mental Health (Calderdale) – local authority representative |
| | Anne Howgate | AMHP Team Leader (Kirklees) – local authority representative |
| | Deborah Longmore | Adult Safeguarding Named Nurse, Barnsley Hospital NHS FT |
| | Stephen Thomas | MCA/MHA Team Manager (Wakefield) – local authority representative |
| | Kathryn Sykes | Social Worker, Adult Mental Health Team (Wakefield) – local authority representative |
| | Victoria Thersby | Head of Safeguarding (Calderdale & Huddersfield NHS FT) |
| **In attendance:** | Carol Harris | Director of Operations |
| | Clive Barrett | Head of Safeguarding, Mid Yorkshire Hospitals NHS Trust |
| | Julie Carr | Clinical Legislation Manager |
| | Yvonne French | Assistant Director, Legal Services |
| | Gary Haigh | Independent Associate Hospital Manager, Chair of the Hospital Manager Forum |
| | Chris Lennox | Deputy Director of Operations |
| | Gordon Walker | Independent Associate Hospital Manager, Vice Chair of the Hospital Manager Forum |
| | Laura Oates | Operational Manager, Horizon Centre |
| | Enzo Harris | Advanced Nurse Practitioner, Horizon Centre |
| | Sarah Millar | PA to Medical Director (author) |

## MHAC/20/01 Welcome, Introductions and Apologies (agenda item 1)

The Chair, Kate Quail (KQ) welcomed everyone to the meeting. The apologies, as above, were noted.

It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

There were no declarations of interest to record.

## MHAC/20/02 The Act in Practice (agenda item 2)

MHAC/20/02a The use of Segregation in learning disability services (agenda item 2.1)

Presentation from Laura Oates (LO) and Enzo Harris (EH) on the use of Segregation in learning disability services, in particular at the Horizon Centre.

Mental Health Act Committee (MHAC) acknowledged that the legal term Long Term Segregation actually refers to a personalised care environment for service users.

It was noted that there was scope for improvement in the system as service users often lose their home environment due to admission to hospital and this is being picked up by Tom Jackson, Clinical Lead for Learning Disability Services via the Yorkshire and Humber Operational Delivery Network which is a clinical network improving care for people with learning disability and autism.

MHAC thanked LO and EH for their presentation.

## MHAC/20/03 Legal updates (agenda item 3)

MHAC/20/03a End of life care for adults: service delivery, NICE guideline [NG142] (agenda item 3.1)

Julie Carr (JC) reported on the NICE guideline which covers organising and delivering end of life care services to ensure that people have access to the care that they want and need and is intended to be used alongside the NICE guideline on care of dying adults in the last days of life [NG31].

JC referred to a quality improvement workshop and a pilot for Calderdale and Kirklees Older People's Services which is supported by the Quality Improvement Team and is considering the impact of the new guideline and preparing for its implementation.

An update will be brought back to MHAC prior to roll out.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

MHAC/20/03b JK v A Local Health Board, [2019] EWHC 67 (Fam), High Court – Family Division (Lieven J), 13th November 2019 (force feeding under Section 63 MHA) (agenda item 3.2)

JC reported on cases where an individual had refused food and was considered at court to have the capacity to make decisions about refusing food and had made a recent valid advance decision refusing medical intervention, even if his life was at risk. The court held that the individual's refusal to eat was a consequence of his autism and the case fell within Section 63. The court did not, however, make a declaration that the individual could be force fed as it was not clear that force feeding would be in his best interests.

JC advised that a briefing will be presented to medical colleagues in August at a planned session and the Trust has a process in place to support clinical staff with legal advice should a similar situation arise within the Trust.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

MHAC/20/03c Briefing – Annual CQC State of Care Report – Monitoring the MHA 2018/19 (agenda item 3.3)

JC reported that the Trust had been benchmarked against the national picture and the outcome was positive. Committee noted that care planning continues to be an area where improvement is required and work is ongoing to improve this.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

## MHAC/20/04 Local Authority and Acute Trusts (agenda item 4)

The following updates were noted:

**Clive Barrett (CB) – Mid Yorkshire Hospitals NHS Trust**

- Reported good working relationship with SWYPFT in relation to the Mental Health Act. Mid Yorkshire have a relatively low number of people sectioned per year and processes are in place.
- Work is ongoing in relation to the Mental Health Strategy and an operational manager has now been appointed.
- The first rapid process development workshop is being arranged for the start of April which will focus on functional neurological disorder. There are 6 elements involving staff working on training, supported by the Psychiatric Liaison Team.
- A CQC visit is expected before July and it is anticipated that they will be looking at what Mid Yorkshire are doing in relation to Mental Health, Dementia, Learning Disability and Autism.

## MHAC/20/05 Minutes of previous meeting held on the 12 November 2019 (agenda item 5)

CB referred to the acute trust update (MHAC/19/45) and indicated that 'Lasting Power of Attorney' should read 'Liberty Protection Safeguards'.

Erfana Mahmood (EM) referred to the Hospital Managers' annual review feedback and indicated that 'JC and EM were working to recruit one more' should read 'JC and EM were considering options for recruitment including ways to diversify'.

**Action: Sarah Millar**

**It was RESOLVED to APPROVE the notes of the meeting held on 12 November 2019 (with the above amendments) as a true and accurate record of the meeting.**

## MHAC/20/06 Matters arising (agenda item 6)

MHAC/20/06a Action points (agenda item 6.1)

The action points were noted and the following item raised:

- MHAC/19/48a – In relation to the low rate of admission of service users following arrest, it was acknowledged that this should not be viewed as negative or positive without appropriate detail. It was suggested to consider this over a 6 month period, taking into account age range, ethnicity, etc and for more detailed information to come to the November meeting. Carol Harris (CH) also suggested a presentation for November from an appropriate practitioner.

**Action: Chris Lennox**

MHAC/20/06b Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.2)

It was noted that there were no specific items for MHA Committee.

MHAC/20/06c Mental Health Act Committee annual report to Trust Board (agenda item 6.3)

Committee received the draft report and KQ advised that it would be taken to Audit Committee on 14 April 2020.

- MHA Committee annual report – the following was noted:
  - There was discussion on adding the word 'independent' to the Hospital Managers, however it was noted that as this was a paper for Trust Board, the legal term of 'Associate Hospital Managers' would be retained, but with an acknowledgement of the independent status of Hospital Managers added.
  - An addition would be made to acknowledge the MHA Code of Practice Group as an effective clinical focus and grip resource.
  - An addition would be made to acknowledge that beneath the overall Trust-wide MHA/MCA training figures, any training 'hotspots' are identified and training then provided to the relevant BDU / service.

- MHA Committee self-assessment – Committee reviewed the results of its self-assessment survey. No actions were required from this. There had been a 50% return rate and it was noted that the majority of responses were positive. The following were noted:
  - *Q7: Are Committee members independent of the management team?*
    One respondent had answered 'no', however Committee acknowledged that apart from Audit Committee, all committees have executive team members.
  - *Q12: Has the Committee formally assessed whether there is a need for the support of a 'Company Secretary' role or its equivalent?*
    Again, one respondent had answered 'no', however Committee acknowledged that this has been previously assessed and that Company Secretary support is available if required and is received, for example with the Self-assessment and Annual Report process.

- MHA Committee Terms of Reference – draft agreed apart from one amendment to note that Committee receives Trust policies relating to the Mental Health Act and Mental Capacity Act which have been approved by the Executive Management Team rather than approves them.

- MHA Committee Work Programme – draft agreed with an update to highlight our quality improvement approach.

KQ will update the documents in advance of submission to the Audit Committee.

**Action: Kate Quail**

**It was RESOLVED to APPROVE the Annual Report, Terms of Reference and Work Programme for 2020/21 subject to the agreed additions/amendments.**

## MHAC/20/07 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)

MHAC/20/07a Performance report – Monitoring information Trust wide October-December 2019 (agenda item 7.1)

The report was considered and the following noted:

- There has been a significant reduction in the number of patients where ethnicity was recorded as 'unknown'.
- 1 Hospital Managers Hearing and 2 Tribunals were cancelled due to the patient being transferred on the day of hearing. KQ asked for this to be looked into in more detail as a total of 3 incidences seemed to be a high number.

**Action: Chris Lennox**

- 47% of all new admissions in Quarter 3 were under the Mental Health Act which represents a slight increase of 8% on Quarter 2 activity.
- There were 3 admissions of Under 18s to the Trust, only one being under the Mental Health Act.
- There were 31 appeals made to the Hospital Managers in Quarter 3 with only 6 appeals achieving a hearing.
- Deprivation of Liberty (DoLS) applications from the neuro-rehab and stroke-rehab wards were not being processed by the DoLS Teams for Kirklees and Barnsley patients within the 21 days for a standard authorisation and this remains an issue. JC explained how the system works and how DoLS are CQC notifiable only upon receipt of the outcome from the Local Authority.
- There have been 2 CQC notifiable deaths in Quarter 3.
- A total of 11 exception reports were generated in Quarter 3 across all activity. Each of them has been investigated and resolved.
- EM referred to 8 admissions of Black and Black British individuals which appeared to be a stark number. Chris Lennox (CL) advised that for a more accurate picture, a longer period of time would need to be considered. Tim Breedon (TB) added that this links with the work being undertaken by Equality and Inclusion Committee around access to services.
- In Quarter 3 the percentage of service users accessing services by ethnicity remained similar to the 2011 Census population profile with the exception of service users from 'Other Ethnic Groups' (e.g. Chinese or Arab). Gary Haigh (GH) indicated that there had been an increase in service users who had fled countries where they were in unsafe situations.

Committee acknowledged that a lot of work had gone into making improvements to the report. CL is also now involved at the draft stage which gives Committee a better opportunity to drill down into the detail of the data.

**It was RESOLVED to RECEIVE and NOTE the contents of the monitoring report.**

## MHAC/20/08 CQC compliance actions (agenda item 8)

MHAC/20/08a MHA Code of Practice oversight group feedback (agenda item 8.1)

Yvonne French (YF) summarised the function and remit of the Code of Practice group that had recently been established to have oversight of any working or implementation groups.

YF gave an update on the following workstreams:

- Section 132 patient rights group – A checking system is being run through SystmOne, however training would need to be given in advance of this being rolled out.
- Seclusion and segregation group – A Task and Finish group is being run for 6 months.
- Reducing Restrictive Practice (blanket restrictions) group – A clinical workshop is planned for May/June with a view to sharing best clinical practice. TB reported having a positive call with the CQC earlier today. CH asked for changes to the Search Policy to include additional measures and new equipment.

**The Committee RESOLVED to:**

- **RECEIVE the update in relation to implementation of the MHA/MCA Code of Practice group.**
- **NOTE the progress with the MHA 136 policy as agreed at the MHA Committee.**
- **NOTE the seclusion and segregation implementation group.**

MHAC/20/08b MHA/MCA/DoLS mandatory training update (agenda item 8.2)
YF reported the current position as:

- Mental Capacity Act/DoLS training – 92.34% compliant
- Mental Health Act training – 90.06% compliant

which was noted to be well in excess of the 80% target. YF advised that all hotspots previously identified are being dealt with by offering bespoke training.

EM queried whether it would be possible to roll out training prior to implementation of the new Liberty Protection Safeguards and JC advised that the draft Code of Practice and regulations are not expected until late spring/early summer so it was unlikely therefore that implementation would occur in October. The position will be kept under review.

KQ recognised that beneath the overall Trust-wide figures, any training 'hotspots' are identified and training then provided to the relevant BDU / service by JC.

**It was RESOLVED to RECEIVE the report and to NOTE the level of compliance with the mandatory training target and plans for future training.**

## MHAC/20/09 Audit and Compliance Reports (agenda item 9)

MHAC/20/09a Section 17 leave (agenda item 9.1)
JC reported that this was a review of KPI activity. Any forms that are not correct are being returned to wards so ultimately 100% of the forms are completed correctly. The target is for 100% to be correct first time and it was agreed to audit this over the next year and bring the findings back to Committee in March 2021.

**It was RESOLVED to RECEIVE the briefing and to APPROVE a further compliance report for March 2020/21 Committee.**

MHAC/20/09b Section 132 audit (agenda item 9.2)
YF updated that this audit report would come to the May Committee meeting. It was noted that the delay was due to difficulties in obtaining data from SystmOne.

**It was RESOLVED to NOTE the update.**

MHAC/20/09c Uncontested Hospital Managers' renewals and extension hearings (agenda item 9.3)
YF asked Mental Health Act Committee to consider a quality improvement pilot of undertaking paper reviews where the patient has capacity and is not contesting the renewal of the current detention or community treatment order. This would involve a temporary amendment to policy which would be taken through the Policy Group and EMT. Gordon Walker (GW) added that this could be beneficial although appropriate safeguards would need to be in place.

Committee noted that a change in policy was not required in order to undertake this pilot. Committee agreed to approve and support this quality improvement pilot.

**It was RESOLVED to SUPPORT the pilot of uncontested hearings.**

## MHAC/20/10 Care Quality Commission visits (agenda item 10)

MHAC/20/10a Visits and summary reports Quarter 3 (agenda item 10.1)

JC reported that there were 2 CQC Mental Health Act visits in Quarter 2 to The Poplars and Hepworth ward.

Within the quarter, 4 MHA monitoring summary reports were received relating to ward visits made to; Beamshaw, Ward 18, The Poplars and Hepworth ward.

5 responses were submitted to the CQC; The Poplars, Beamshaw, Beechdale, Enfield Down and Ward 18.

The Committee received detailed information about the outstanding issues. TB advised that the call with the CQC today had noted a positive improvement and that whilst some themes are reoccurring, there had been a significant reduction in frequency.

Committee noted that while the number of CQC visits may reduce, the Mental Health Act visits will be maintained.

KQ noted the positive actions that were repeatedly reported.

**It was RESOLVED to RECEIVE the report and to NOTE the positive progress.**

MHAC/20/10b Update on CQC MHA action plans (agenda item 10.2)

YF presented the summary paper taken from CQC action plans. Committee were asked to note that actions marked as outstanding and overdue were not a true reflection as progress was being made, however services had asked for the actions not to be marked as complete until changes were fully embedded in practice.

**It was RESOLVED to RECEIVE the report and to NOTE the progress of the actions following CQC visits.**

## MHAC/20/11 Independent Hospital Managers (agenda item 11)

MHAC/20/11a Hospital Managers' Forum Notes 20 December 2019 (agenda item 11.1)

The Committee received the notes of the last Forum. GH reported that the key issue discussed at the meeting had been that all invoices including expenses (e.g. car parking) were being taxed. This had since been resolved to the Hospital Managers' satisfaction.

**It was RESOLVED to NOTE the update.**

## MHAC/20/12 Key Messages to Trust Board (and Clinical Governance and Clinical Safety Committee as necessary) (agenda item 12)

The key issues to report to Trust Board were agreed as:

- 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

## MHAC/20/13 Date of next meeting (agenda item 13)

The next Committee meeting will be held on 12 May 2020 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield from 2.00-4.30 pm.

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 30 June 2020
# 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.<br>The Trust Seal has not been used since the report to Trust Board in March 2020.<br>There has been limited activity on contracting and leases due to the impact of Covid-19, however arrangements are in place to ensure that the Trust Seal can be used if required. This is monitored by the Corporate Governance Team and should a situation arise due to Covid-19 that would affect use of the Trust Seal, this will be escalated to the Board. |
| **Recommendation:** | **Trust Board is asked to NOTE that the Trust Seal has not been used since the last report in 31 March 2020.** |
| **Private session:** | Not applicable. |

NHS
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# 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 *(January 2020)* | # (if req'd) | | | ✘ | | | | | | | | | |
| | Digital Strategy *(April 2020)* | # | | | ✘ | | | | | | | | | |
| | Customer Services policy *(June 2020)* | | | # | | | | ✘ | | | | | | |
| | Estates strategy *(July 2022)* | | | # | | | ✘ (update) | | | | | | | |
| | Involving people strategy *(NEW – will replace Communication, Engagement and Involvement, Equality and Membership strategies)* | # (if req'd) | | | | | ✘ | | | | | | | |
| | Sustainability strategy *(June 2020)* | | | # | | | ✘ | | | | | | | |
| | Organisational Development Strategy*(June 2020)* | | | # | | | ✘ | | | | | | | |
| | Equality strategy | | | | ✘ | | | | | | | | | |
| | Workforce strategy | | | | | | | | | | | | | |
| | Quality strategy *(March 2021)* | | | | | | | | | | | | ✘ | |
| | Trust Board declaration and register of fit and proper persons, interests and independence policy *(March 2021)* | | | | | | | | | | | | ✘ | |

Policy / strategy review dates:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(delegated approval authority to Audit Committee, reviewed as required)*
- Treasury management strategy and policy *(delegated approval authority to Audit Committee, reviewed as required)*

- Constitution *(January 2020) – under review*
- Communication, Engagement and Involvement strategy *(to be merged with the Involving People Strategy)*
- Customer Services Policy *(next due for review in June 2020, extended to October 2020)*
- Digital Strategy *(next due for review in April 2020)*
- Equality Strategy *(next due for review in July 2020, to be merged with Involving People Strategy)*
- Estates Strategy *(next due for review in July 2022)*
- Learning from Healthcare Deaths Policy *(next due for review in January 2022)*
- Membership Strategy *(next due for review in April 2020, to be merged with Involving People Strategy)*
- Organisational Development Strategy *(next due for review in June 2020)*

- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(next due for review in February2023)*
- Procurement Strategy *(next due for review in June 2021)*
- Quality Strategy *(next due for review in March 2021)*
- Risk management strategy *(next due for review in April 2022)*
- Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in March 2022)*
- Sustainability Strategy *(to be reviewed with the Estates Strategy, by July 2022)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in March 2021)*
- Workforce Strategy *(next due for review in March 2023 (if approved at Board March 2020))*