![NHS South West Yorkshire Partnership NHS Foundation Trust]

Trust Board (performance and monitoring)
Tuesday 1 December 2020 at 9.00
Microsoft Teams Meeting

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	9.00	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	9.01	**Declarations of interest**	Chair	**Verbal item**	2	To receive
3.	9.03	**Minutes from previous Trust Board meeting held 27 October 2020**	Chair	**Paper**	2	To approve
4.	9.05	**Matters arising from previous Trust Board meeting held 27 October 2020 and board action log**	Chair	**Paper**	5	To approve
5.	9.10	**Service User / Staff Member / Carer Story**	Director of Operations	**Verbal item**	10	To receive
6.	9.20	**Chair's remarks**	Chair	**Verbal item**	3	To receive
7.	9.23	**Chief Executive's report**	Chief Executive	**Paper**	7	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
8.	**9.30**	**Performance reports**				
	9.30	8.1 Integrated performance report Month 7 2020/21 - Include an update from IPR sub-group	Director of Finance & Resources and Director of Nursing & Quality	**Paper**	60	To receive
	10.30	8.2 Serious Incident report Quarter 2 2020/21	Director of Nursing & Quality	**Paper**	5	To receive
9.	**10.35**	**Business developments**				
	10.35	9.1 South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of HR, OD & Estates and Director of Strategy	**Paper**	10	To receive
	10.45	9.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) - Calderdale Collaborative	Director of Strategy and Director of Provider Development	**Paper**	10	To receive
	10.55	9.3 Receipt of Partnership Board minutes	Chair	**Paper**	5	To receive
	11.00	*Break*			*10*	
10.	**11.10**	**Strategies and policies**				
	11.10	10.1 Equality, Involvement, Communication and Membership Strategy	Director of Strategy	**Paper**	5	To approve

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.15	10.2 Exclusions or Addendums to Trust policies as a result of Covid-19	Director of Finance & Resources	**Paper**	5	To receive
11.	**11.20**	**Governance matters**				
	11.20	11.1 Emergency Preparedness, Resilience & Response (EPRR) Compliance	Director of HR, OD & Estates	**Paper**	5	To receive
	11.25	11.2 Safer staffing report	Director of Nursing	**Paper**	5	To receive
	11.30	11.3 Sustainability 19/20 annual report and strategy update	Director of HR, OD & Estates	**Paper**	5	To receive
12.	11.35	**Assurance and receipt of minutes from Trust Board Committees and Members' Council** - Clinical Governance & Clinical Safety Committee 10 November 2020 - Finance, Investment & Performance Committee 24 November 2020 - Mental Health Act Committee 3 November 2020 - Workforce & Remuneration Committee 12 November 2020 - Members' Council meeting 30 October 2020	Chairs of committees/Members' Council	**Paper**	10	To receive
13.	**11.45**	**Use of Trust Seal**	Chair	**Paper**	5	To receive
14.	**11.50**	**Trust Board work programme**	Chair	**Paper**	3	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
15.	**11.53**	**Date of next meeting** The next Trust Board meeting held in public will be held on 26 January 2021	Chair	**Paper**	2	To receive
16.	**11.55**	**Questions from the public**	Chair	**Verbal**	10	To note
17.	*12.05*	*Close*	Chair	**Verbal**		To receive

With **all of us** in mind.

Minutes of Trust Board meeting held on 27 October 2020
Microsoft Teams meeting

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Mike Ford (MF)	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
	Dr.Subha Thiyagesh (ST)	Medical Director

Apologies:	Members

In attendance:	Carol Harris (CH)	Director of Operations
	Sean Rayner (SR)	Director of Provider Development
	Salma Yasmeen (SY)	Director of Strategy
	Andy Lister	Company Secretary (author)

Observers:	Elaine Powell	Trust Board Carer Story
	Dylan Degman	Publicly Elected Governor - Wakefield

TB/20/75   Welcome, introduction and apologies (agenda item 1)
The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies were noted as above and the meeting was deemed to be quorate and could proceed.

AM outlined the Microsoft Teams meeting protocols and etiquette and identified this was a business and risk Board meeting. AM reported this meeting was being live streamed for the purpose of inclusivity, to allow members of the public access to the meeting.

AM informed attendees that the meeting was being recorded for administration purposes, to support minute taking, and once the minutes had been completed the recording would not be retained. Attendees of the meeting were advised they should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place.

AM reminded the members of the public that there would be an opportunity at the end of the meeting for questions and comments, received in writing.

TB/20/76   Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return in March 2020.

It was RESOLVED to NOTE that no further declarations had been submitted.

With **all of us** in mind.

TB/20/77   Minutes from previous Trust Board meeting held 29 September 2020 (agenda item 3)

SYo pointed out some inconsistencies regarding SYa, SY and SYo within the minutes. In future SY to be used for Salma Yasmeen and SYo for Sam Young.

Action: Andy Lister

It was RESOLVED to NOTE and APPROVE the minutes of the public session of Trust Board held 29 September 2020 as a true and accurate record.

TB/20/78   Matters arising from previous Trust Board meeting held 30 June 2020 (agenda item 4)

The following items from the action log were reviewed:

- TB/20/66a - Tim Breedon (TB) reported this was about having the right links with the academic research centre in Bradford. Those links exist, and TB and Dr.Subha Thiyagesh (ST) will make further contact through work with Dr Adrian Berry. To close.
- TB/20/66a – TB noted the update. AM queried the rise in care plans not being offered. TB reported he would circulate this information to the Board. Then to close.

Action: Tim Breedon

- TB20/68 - all points are being considered as part of finalising the Equality, Involvement, Communication and Membership draft strategy that is due in November. AM noted the Equality and Inclusion committee isn't meeting prior to that Board and so members need to see the amendments before coming back to Board. SY reported it would be circulated next week.

Action: Salma Yasmeen

- TB20/96b - the lay member on the revalidation oversight group. AM queried the term of office. ST reported this would form part of the group review after 18 months. AM suggested a term of office should be put in place on review. To close.
- TB/20/74 in relation to whether we can post a recording of this meeting on our website. AL updated he had liaised with Karen Coleman from the West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System) and there was a need for further discussions about publishing our meetings on the website. To remain open.

EM mentioned a discussion from last month in relation to the increase in acuity, what learning was to be taken and whether this was part of the action log, or part of the academic research action. Should this be reflected in services and skills mix? Reference page 11 of the minutes.

TB reported that TB/19/11c refers to the introduction of the safe care approach, which links acuity to staffing and this would be included in the safer staffing report coming to November board for review.

It was RESOLVED to NOTE the changes to the action log.

TB/20/79   Service User/Staff Member/Carer story (agenda item 5)

Carol Harris introduced Elaine Powell who was to provide this months' Board story for Black History Month. Elaine had come forward as a volunteer with Creative Minds to give her story:

Elaine stated she is from a BME background being of Caribbean mixed-race heritage. She is a lecturer with a teaching specialism in Special Educational Needs and Disabilities (SEND). and is particularly interested in Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorders (ASD).

She has spent almost 45 years as a volunteer and almost 33 of those working in the area of ADHD/ASD disorders. She has worked for many voluntary organisations in the local community, some national and has done international work also.

Much of this work has centred around her interest and knowledge of health, including mental health and also looking into health of BAME communities. She is also a volunteer working with groups in the Jamaican diaspora in the UK.

Elaine described how she was a parent looking for support as she had a child who was displaying various characteristics of a condition that was not recognised in the UK at the time. This is now known as ADHD and no support services seemed to exist at that time from either a medical, educational or social care perspective.

She began a mission to change this, as initially she knew of no other parents in this situation and GPs and other professionals had a lack of knowledge in this area. There was no one diagnosing this condition or offering any support.

Over time, she was involved in establishing support groups, putting on conferences, attending conferences and seminars as a speaker to educate professionals. She managed to persuade a local consultant paediatrician from her local hospital to attend a conference she was involved in putting on. He then became the first person to really get involved and start diagnosing children.

Children's services for ADHD were established in her local hospital, her child being the first diagnosed. She completed a research study on ADHD while at university in the early 90s. Her research papers were distributed to many parents, groups and professionals to inform others and raise awareness.

A multi-disciplinary team was established who used some of her work to develop a booklet for professionals that was distributed by the Local Education Authority (LEA) to all Kirklees schools. She attended years of meetings with Kirklees council, LEA and the NHS mental health trust, working with them to develop support and understanding.

Eventually, a service was established by the Trust and Dr Marios Adamou was appointed to head up the ADHD/ASD service. The service is still running and has grown to cover a wider area of Yorkshire.

Although she has never received real acknowledgement for this work, Elaine is so proud that she has helped to educate others in this field and helped to develop the service we now have. She continues to teach graduates who are our future health professionals about ADHD and ASD disorders.

AM thanked EP for all she had done and achieved and apologised that she hadn't been acknowledged for her work.

Other Board members thanked EP for her story and CH provided an update on the current service.

RW reflected that EP was proof that people were never "just a parent/carer?"

RW reminded the Board that we need to ask ourselves whether we are genuinely supporting carers and genuinely engaging people in the development of services.

It was RESOLVED to NOTE the Service User Story and thank Elaine Powell for her services to the provision of ADHD/ASD services over 33 years.

TB/20/80   Chair's remarks (agenda item 6)
Chair's remarks
AM highlighted the items on the agenda for today's private Board meeting:

- Corporate risks that are commercially confidential
- A review of the investment appraisal framework

- Receive a report on the Chief Executive's dual role
- Commercially confidential business developments in South Yorkshire, the draft governance review for the Integrated Care System, and integrated care developments in Barnsley.
- Commercially confidential business developments in West Yorkshire, including the forensics lead provider collaborative work.
- A financial planning update for both the South Yorkshire and Bassetlaw and West Yorkshire and Harrogate Integrated Care Systems.
- A draft Community Partnership agreement for Calderdale.
- A verbal update on serious incident investigations.
- Trust financial planning arrangements for the remainder of the year.

It was resolved to NOTE the Chair's remarks.

TB/20/81   Chief Executive's report (agenda item 7)
Chief Executive's report

Rob Webster (RW) reported people had received "the Brief". There was also a short report updating on subsequent events. RW wanted to give a further update due to the speed at which things were progressing.

- Between this month and last month there was now a new tiered approach based on subregions e.g. West Yorkshire and South Yorkshire. This is meant to simplify the COVID restrictions and make them more sensitive to local circumstances. They will be backed by packages of support agreed between local leaders and central government.
- We remain in a regionally led response to the pandemic, which is known as a level 3 response under the NHS Emergency Preparedness, Resilience and Response arrangements. A level 4 response would be nationally led.
- South Yorkshire is now in Covid tier 3 as of last weekend.
- West Yorkshire and Harrogate remains in Covid tier 2, but this remains under review and conversations are ongoing. There is potential for West Yorkshire to move into tier 3.
- The prevalence of Covid-19 is increasing. Hospital admissions, people on mechanical ventilators and deaths are all increasing.
- Our local resilience forums in both areas continue to meet. These include all partners such as local government, the fire service, police service, business and local authorities.
- As part of the Integrated Care Systems (ICS) we take a full role in these meetings in our places to help coordinate and manage the response.
- Financial plans for the Trust alongside the financial plans for the ICSs have been submitted for the rest of this year.
- We continue to work collaboratively in all of our places.
- Last week the work on tackling inequalities and public health, particularly in West Yorkshire, took place.
- There was a two-day summit on the climate crisis with announcements around small schemes, grants for primary care and respiratory services. Grants for active travel, as well as bigger schemes taking place with local government around flood management and infrastructure were also featured.
- The report of the review to address inequalities for Black, Asian, and Minority Ethnic (BAME) groups was published last Thursday. The launch was attended by 200 people online. The report has been circulated by the NHS national chief people officer as an example of good practice. RW has sent the report to Government equalities minister Kemi Badenoch who is completing a national piece of work on inequalities.
- Dame Doreen Lawrence has published her report today on difficulties faced by people from different communities. This reinforces that people from BAME origin face inequalities and a bigger impact from the coronavirus nationally.
- The recommendations of the WY&H review build on work that was already ongoing, and our BAME network inputted into the work very strongly.

- The recommendations focused on four areas:
  - People have access to good work
  - Reflective leadership
  - Commissioning and planning are altered to focus on inequality
  - Mental Health is tackled appropriately within different communities
- There were 12 recommendations overall which would be agreed at the December partnership board, which RW and AM attend with all other Chairs and Chief Executives. Also present would be all political leaders of councils, all health and wellbeing board chairs, every chief officer of Clinical Commissioning Groups (CCG) and NHS bodies, third sector partners and lay members. This is the highest level of governance in the partnership.
- On Friday a report was published regarding housing and health in West Yorkshire including areas of good practice including work in which the Trust is involved. This focus on inequalities and our contribution to it, is something the Board has discussed several times including our contribution to inequalities through our priority programmes.
- From the action log there are eight actions we are expected to take nationally in relation to inequalities which are coming back to Trust Board in December.
- During the pandemic there are things we must keep an eye on. One is protecting the vulnerable. Reports from the Care Quality Commission have focused on the failings of care for people who are vulnerable including those with a learning disability or mental illness.
- They include findings around do not resuscitate (DNR) orders and restricted practice including seclusion and segregation. We will pick up the outcome of these reports through Executive Management Team (EMT) and Clinical Governance and Clinical Safety (CGCS) committee.
- In the context of uncertainty and constant change these reports are a reminder that we mustn't lose sight of what it important and that we keep a focus on safety first, always.
- As we end black history month, RW wanted to pay tribute to all staff that have spoken out this month and the outgoing leadership of the staff network. To change behaviour, you have to change minds.
- Staff continue to do brilliant jobs. Mark Brooks (MB) sent a message to the governance, finance and IT teams this morning reflecting on everything they had done in October. This was a true testimony to everybody within this organisation from finance to the frontline and the work they continue to do.
- Barnsley, as a place, is thanking everybody with its "Pride of Barnsley" awards and it's good to see our staff receiving accolades.
- At this time, our job is to be calm, clear and focused and we have the leadership to do this.

AM reiterated her thanks to all our staff who are working so hard at this time.

Charlotte Dyson (CD) stated she supports the sentiment and compassionate leadership is important in current times. It was good to see the letter sent out from Carol Harris (CH), Tim Breedon (TB) and Subha Thiyagesh (ST) reiterating the importance of social distancing and PPE. It is also important we recognise good practice and good behaviour and CD had seen this in Trust communications, and it is important that the Board shows this too.

Chris Jones (CJ) complimented RW on his final paragraph and this summarised what leadership is about. In relation to the inequalities and BAME agenda, is it the ICS, us, or NHS England (NHSE) who are going to activate change?

RW responded to say that the changes involve the trust, the system and the regulators working together, that is the essence of ICS' and the BAME review was a good reflection of this,

The 12 actions we must take, from reasonable housing and good jobs, to breaking down the stigma and working with third sector organisations around mental health, the sector group will be a critical party in the implementation of those actions.

Ultimately, we need to judge the impact on citizens. Sheila as a resident of Chapeltown in Leeds said, "I don't believe it's going to happen". As a system we should consider this "Sheila test" in everything we do. How does it feel if you are Sheila, have lived in Chapeltown all your life and have been trying to deal with inequalities for a generation? How do we make sure Sheila feels we are doing something and this time it is going to be different?

We have clear actions, signed off at a high level, they are in the top ten priorities for the partnership, there is an action plan that is real and will be scrutinised by real people who are directly affected.

It was RESOLVED to NOTE the Chief Executive's report and TB's update and comments.

TB/20/82   Risk and Assurance (agenda item 8)
TB/20/82a   Board Assurance Framework (BAF) strategic risks (agenda item 8.1)

For the purpose of the board meeting MB reiterated the process that had taken place over the last few months:

- Normally the Board reviews and updates the strategic risks in readiness for the beginning of each financial year.
- This year, due to the focus on the response to Covid-19, we retained the same Board Assurance Framework (BAF)
- We have discussed the BAF as a Board, in line with our strategic priorities and objectives
- On September 8th 2020 at the strategic board potential updates to the BAF were discussed and two weeks ago we had a separate session to deal with this subject.
- The culmination of these meetings is the 13 proposed strategic risks in the paper
- 4 risks are new, some of the others have been merged or re-articulated, and one risk has been removed after identifying we have completed enough actions to reduce the level of strategic risk.
- The purpose of today's paper is to gain agreement of the proposed strategic risks
- The actions following this will be to build up the details of the BAF over the next couple of months
- It is a key document for the Board but is also a document used extensively by bodies such as the CQC and internal audit to support their understanding of our assurance framework.

AM stated this reflected clearly the amount of work and detailed discussion that had taken place. Four new strategic risks and one risk removed was unusual and reflects the times we are in.

The following was discussed in section TB/10/82b but relates specifically to the Board Assurance Framework so is included here for ease of understanding.

RW suggested that one change to the BAF, might be a risk that states "failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19". We know that Covid-19 will be with us for a while, it has become a strategic risk rather as well as an operational risk. Keep the 13 risks already agreed and add a 14th, the risk of failure to maintain staff wellbeing during Covid-19.

AM summarised that the risk had now become strategic as opposed to only operational and therefore needed to move from the organisational risk register (ORR) to the BAF.

It was agreed to add a further strategic risk to the objective of making SWYPFT a great place to work - ''Failure to maintain the wellbeing of our staff during the Covid-19 pandemic and its subsequent impact'

A full BAF will be presented at the next business and risk Board in January 2021.

It was RESOLVED to APPROVE the strategic risks as amended for inclusion in the Board Assurance Framework

<u>TB/10/82b</u>   <u>Corporate / Organisational Risk Register (ORR) (agenda item 8.2)</u>

MB reported the Organisational Risk Register had evolved since March.
- The risk management process had always been strong, and specific Covid-19 risks had now been added over the last few months
- The Board strategy session identified a number of other possible risks. These have now been captured and we have identified in the front sheet where these have not been incorporated into the BAF and can be considered by committees and lead directors for inclusion in the risk register.
- The risk around a no deal Brexit needed to be reinstated.
- There was limited change in risk scoring. Reviews of risks had taken place at committees and EMT
- The 15+ risks are the same risks that have been at this level for some time.

CD reported as CGCSC chair it was good to see we are going to look at the community health service strategy and this was a risk that needed addressing.

CD asked if we reflect the huge operational pressure, we are under from issues such as Covid-19, the economy, national operational and system change in all of our risks? It is clear they are in individual sections, but should they be reflected more across the board?

AM referenced risk 1530 – the risk that Covid-19 leads to a significant increase in demand. Is the risk that we are unable to meet an increase in demand? AM didn't feel increasing demand presented a risk unless we were unable to meet it. This linked to CD's comments about the increase in operational pressure and this being reflected in current risks.

Mike Ford (MF) the Audit committee chair, stated there are few risks which are allocated to the Audit committee. MF feels this is unusual from his perspective but accepted the other existing committees meant risks are better distributed. MF supports CD's comment, but there is another risk in the area of organisational strain. This relates to taking part in many different initiatives and business cases and doing so at a time when things are challenging, and it's something the Board should be aware of.

MF continued that risks 1154 and 1533, didn't have entries in the middle column, summary of actions to get them down to target, and asked why was this?

MB responded by stating if these were individual risks, progress should be queried with the director/committee lead. If no actions were present, this must have been agreed by the committee.

MB agreed that collectively a lot of individual risks build up to represent the pressure in the organisation at any one time. The question was whether we needed another risk to reflect this or look at the attached document that reflects the overall risk score for the organisation.

AM noted that the heat map shows a significant increase in risk since the outbreak of Covid-19 occurred. The average risk score has gone down but the overall level of risk across the organisation has increased significantly and remains high.

CH stated there was an increase in operational pressure but reported each one of these issues is captured as a specific risk with a mitigating action plan to control the risks. If she were to describe all of this as one risk of operational pressure, she would still have to break it down to be able to understand and manage it.

CJ stated that, from a Finance, investment and performance (FIP) committee perspective, no risks were changed at yesterday's meeting. In relation to CH's comments every operational risk has a financial consequence. Some of those topics were discussed yesterday.

The short-term financial risk is "can we deliver the plan?" This is about controlling costs. The longer-term risk is around uncertainty of the financial arrangements.

Risk 1531, CJ asked if we are doing enough for service users with protected characteristics, who are more vulnerable to Covid-19. He stated that we have done a huge amount for the workforce, but CJ could not see evidence in this document that it was taking place in communities.

1545 relates to litigation, is there any sign of this emerging, locally, regionally, or nationally?

MB reported not as yet but it is being monitored. The risk of litigation review work was completed at the start of the pandemic looking at what the risks are and the controls we have in place. There is likely to be a time lag before we see if any of these risks becomes a reality.

AM noted that risks 1154 and 1533 are aligned to the Workforce and Remuneration committee and would be reviewed again in November.

TB responded to CJ's query as to whether we have got the Covid-19 impact on service users with protected characteristics covered in committee. TB reported that clearer objectives and timescales were needed. The data needed to be right so that when we do something, we know what impact it has made. There is progress, but there is work still to be done.

CJ stated to quote RW's "Sheila test", we need to understand the data and the actions that follow.

TB acknowledged and supported CJ's comments.

SYo updated, in relation to the workforce risks, these had been reviewed in October's meeting, including the challenging of scores, mitigations and the wording of risks. The next committee is in November and there is expected to be a restructure around the workforce risks. This will include an update on what actions should be in place.

AGD reported there was the issue of the collective risks on our workforce of a number of smaller risks. The issue of fatigue, and the length of time the pandemic has been in place needs to be factored in.

RW suggested we must recognise the significant number of actions going on around workforce and wellbeing. Actions are being taken against the risks held by the Workforce and Remuneration Committee.

RW continued, in terms of overall risks, the heat map is a good example of how we can gauge risk across the organisation, and we need to use this more. He then described how the BAF captures our strategic risks. One of the strategic risks is about capacity and the capacity to meet demand. If we use the BAF against those 13 areas of strategic risk, we might have greater sense of where we think things are escalating. This then makes these collective risks in the register redundant.

AM raised a risk not allocated to a committee regarding legal risks.

MB reported it was difficult to allocate as it had the potential to affect all areas. One committee could perhaps take an overview.

AM proposed it goes to Audit committee for their review, which was agreed
Action: Audit Committee

It was RESOLVED to NOTE the key risks for the organisation, including the changes and additions agreed arising from discussion at the Board meeting.

TB/20/83   Business developments and collaborative partnership working (agenda item 9)

TB/20/83a   South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 9.1)

AGD reported the paper is self-explanatory and updated in the following items:
- There has been a real focus around the coronavirus response
- Partnership working continues to manage the impact particularly across the acute trusts
- A single Covid-19 ward was considered but it was decided not to proceed and instead it is being managed with mutual aid across the system
- Positive progress is being made as a result of learning from the work conducted in West Yorkshire around the equality and diversity agenda with a view to mirroring the same process in South Yorkshire.

SY updated:
- In relation to the mental health, learning disability and autism group, it is now confirmed that the work on developing a mental health provider alliance will go ahead in November.
- Transformation funding to support the long-term ambitions around enhancing crisis and community services was now available through South Yorkshire and Bassetlaw ICS and the West Yorkshire & Harrogate ICS and proposals to access this funding were being established against a tight timeline.

AM stated previously the issue had been whether mental health, learning disability and autism had sufficient visibility in the SYBICS. One of the aims of the alliance was to strengthen this visibility. AM asked AGD if these services had the right amount of visibility and inclusion at the health executive group (HEG)?

AGD agreed that there is an acceptance of the importance of the mental health, learning disability and autism agenda, at the HEG, though the meeting can be dominated by the acute services agenda.

Jan Ditheridge (Chief Executive of Sheffield Health and Social Care NHS Foundation Trust) and Kathryn Singh's (Chief Executive of Rotherham, Doncaster and South Humber NHS Foundation Trust) engagement with the HEG has increased and this had helped. Previously AGD was the only representative for mental health services.

AM queried the emerging provider collaboratives in South Yorkshire, and whether the Trust should be a partner in these?

SY updated that, and although we are a partner in the system, officially it's because our patients are accounted for through West Yorkshire.

AGD stated we have a strong relationship with the other mental health trusts which work outside of the HEG. We are included in the Barnsley system agenda at a place level and at a provider collaborative level we are seen as a very strong partner.

RW stated we should look at whether we need to be a formal partner in risk shares and associated provider collaborative arrangements in South Yorkshire. We continue to have some Barnsley services that are covered by West Yorkshire arrangements, transforming care for people with learning disabilities for example.

Changes to CAMHS in West Yorkshire mean Leeds community healthcare continues to be part of the provider collaborative on Tier 4 CAMHS despite a move to only provide community CAMHS. We need to review risk and reward, financial arrangements and service models. The arrangements have worked well, and we have no immediate risks from them, but it is worth another assessment.

MB stated the way the national arrangements were being managed is also of note.

RW suggested we should discuss the emerging arrangements and options for the Trust.

Action: Salma Yasmeen

CJ asked if there is any insight into the delay of the forensic collaborative going live in SYBICS?

SY reported this was primarily due to Covid-19 and they have reviewed the time frames of all the collaboratives. It is to allow time for the work to be completed.

RW stated there is a link between South and West Yorkshire arrangements because of the flow of people and this needed to be taken into account in the conversation in the private meeting of the Board.

EM observed this was now a well-developed plan. There is mention of a bereavement support scheme due to end on 31st December 2020, should this be reviewed?

SY reported this was being looked at and they are considering extending this time frame.

It was RESOLVED to NOTE the update from the SYBICS and Barnsley integrated care developments.

TB/20/83b   West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 9.2)

SY asked for the paper to be taken as read, but highlighted the following points:

- Calderdale has developed an exemplary model by engaging their BAME communities, thinking about people with mental health and learning disabilities, and has a comprehensive action plan.
- There have been targeted communications through community development workers.
- They have worked with their primary care partners who provide services to neighbourhoods, focusing on access to vulnerable service users.
- The learning that has been identified from this process will help us improve our partnership work going forward.

MF asked what are the implications of the digital maturity review that has taken place? Are there areas of strength? Where do we sit? Are we mature or are we requiring development?

MB updated there was not a firm view of where we sit, we play into both ICSs in terms of digital maturity and digital groups. We have made very strong progress in terms of digital infrastructure and some of these actions had been brought forward by Covid-19. MB reported he couldn't accurately make a direct comparison to other organisations.

AM noted that when the Board had looked at our progress against our digital strategy objectives, there was very strong performance and delivery.

RW reassured the Board that there were two organisations that were given funding based on this assessment because of their capacity and infrastructure needs. We were not one of them.

He concluded that we have made huge progress on digital infrastructure in line with our digital strategy. He suggested EMT need to think how we connect better into this ICS level work.

Action: EMT

EM asked about the working of the ICS regarding BAME communities and housing. Housing was a large factor in tackling some of the issues faced by our communities. How did that fit into the ICS picture now and who is taking responsibility for this aspect?

SR reported there is a housing and health work stream within the WY&H ICS, led by Sarah Roxby who was seconded into that role from Wakefield District Housing. There is a section on housing in the lead provider collaborative adult secure report this afternoon. There have been several workshops and conferences on how we support people with learning disabilities and mental health challenges in a secure environment and that work is gathering pace.

KQ asked if the crisis transformation funding was different to the mental health investment standard funding?

MB confirmed this was separate to the mental health investment standard.

SYo requested sight of the report on digital maturity.

Action: Salma Yasmeen

AM noted the all-age liaison work is now up and running and we are meeting all the core 24 standards which is excellent progress.

It was RESOLVED 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.

TB/20/83c   Receipt of Partnership Board Minutes (agenda item 9.4)

AM noted that the Barnsley Health and Wellbeing Board is back up and running in public.

It was RESOLVED to RECEIVE the minutes from partnership boards.

TB/20/84   Performance reports (agenda item 10)
TB/20/84a   Update on arrangements in place for the management of Covid-19 (agenda item 10.1)

- AGD highlighted Silver command meetings had gone back to three times a week.
- There was concern around the growing number of staff absences and Covid-19 related absence
- This has been a focus of the stress testing that had taken place. An extraordinary silver event had looked at staff absence and the implications.
- We are now into the second wave of the pandemic and this is creating pressure for staff and services.
- It is a more complex situation now than we faced in the first wave. Staff absence is one issue, trying to maintain and restore services is another.

AM stated it was important to note the difference between the EPRR response levels, referred to earlier in RW's report, and the Operational Pressures Escalation Levels (OPEL) scores referred to here. We are currently operating at OPEL 2 in the Trust as a whole and each of

our services does a regular assessment of its OPEL levels, so individual Trust services can be at different levels.

System partners also may be operating at different OPEL levels, which can have an effect on partnership arrangements.

CD asked whether committees needed to review governance arrangements as had happened previously. CD asked what the general view was amongst the Board.

AM reported it was something RW and AM had discussed briefly, and we might want to consider pausing any non-essential governance in order to reduce the administrative burden on our staff teams.

MF reported he would have to consider this. MF asked if there were any lessons to be learned from last week's stress test?

AGD reported that business continuity plans needed to be reviewed along with the feedback. AGD has received highlighted actions we need to take.

AM suggested further discussion about overall governance throughout the organisation could take place outside of the Board meeting.

AGD reported we are also facing pressure from national requirements, for example we now need to report daily in relation to flu vaccination numbers. We need to factor national requirements in our own governance review.

AM suggested it would be useful to review committee work plans, as we had reviewed strategy timescales and pushed some things back. Our focus should be on supporting our workforce and maintaining business continuity and reducing the governance burden where we can.

TB stated it was important to consider this pandemic is going to be around for some time. We might need some longer term thinking around this and a longer-term plan given what we know now.

AM agreed with TB. The fatigue of staff and maintenance of wellbeing was paramount.

RW stated we have just done further work on strategy priorities and the BAF and our risks. The next thing to do is to see what indicators are linked to this. The question is often what governance we can reduce. We have the opportunity with the refocus around priorities to have a fresh look of what we really need to do and make things more focused. RW asked for the Board's views.

AM stated she would support RW's analysis. Normal process would be for a governance review at the end of the year but suggested we might need to do something now. Should the Audit committee take sight of this? Do we have capacity to do this now or do it at some point before the end of the year?

CJ asked if given Tim's analysis whether the whole EPPR process is the right way to manage this? CJ questioned if you can run an organisation on command and control structures in the long term and continue to be a compassionate and well-led organisation. Given AGD's comment about the first wave have we considered what we could stop doing?

AGD stated that is what the business continuity plans are for, a phased approach and what core services we need to maintain. We are not at this point yet, but we need to know how we respond if things develop.

AM stated we were still at OPEL level 2, if we go up to 3 or 4 that would trigger different decision-making under business continuity planning.

EM stated she was conscious of the conversations earlier around the legal implications of the pandemic and that this was something we might need to review sooner rather than later.

MF stated he was happy for the Audit committee to have oversight regarding the overall governance situation and asked if this was this part of the work that Andy Lister (AL) and his team looked at around work plans? Did we need to look at the long list of items for each meeting and review whether we could be fully effective around our risks and ambitions at the same time?

AM noted we needed to consider what we need to do, and what we can do.

KQ stated she supported RW's comments. KQ had noted that welfare facilities for staff were being improved and referred to how important this was and should be prioritised.

ST reported there was the immediate crisis and the long-term aspects of the pandemic to consider. Intelligence suggests we are in this for the long term, and even with a vaccine the virus may re-occur like winter flu. There was also the likely increase in demand for mental health services. From a staff perspective, wellbeing was an issue, all staff are affected, and not all of them are asking for help. It is affecting all portfolios in terms of governance.

ST reported that research and development were going to play a big role in this, and we needed to look at how we will support this.

AGD referenced our estate from KQ's comments. He noted the challenge of hydration/breaks when in PPE and socially distanced. The estate was not set up in that way. Reviews are taking place, particularly in inpatient areas as to how to facilitate changes in the environment to promote staff safety and wellbeing.

In terms of the broader wellbeing offer, as a Trust, we believe we are ahead of others, but we also need to develop our offer. We need to appoint another occupational therapist for support regarding long Covid-19, another mental health nurse to maintain resilience, and the one thing that can get overlooked is physical health.

Maintenance of physical health is also a priority along with maintaining good diet and healthy lifestyles, which in turn benefit mental health.

AM updated that an estates strategy update was coming to November Board, and this will propose a refresh of the existing strategy for the next 18 months.

SYo commented we seem to be looking to "restore back" to what we used to have, and we need to be looking to new ways of doing things, including governance. It was about not going back to where we were but designing things to be where we want them in the future.

AM concluded there had been a full discussion and there needed to be a review of governance arrangements and asked that the Audit committee take oversight of this.

Action: Audit Committee

AM thanked all staff for their continued response to Covid-19 which had been "nothing short of phenomenal".

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

TB/20/84b   Integrated performance report (IPR) month 6 2020/2 (agenda item 10.2)

Quality

TB highlighted the following points:
- Safer staffing on inpatient wards had been maintained but there remained significant pressure in the system.
- The limitations of current safer staffing reporting arrangements against establishments has been acknowledged. These reflect the national framework Work on the safe care tool is being undertaken and will form part of the safer staffing report coming to CGCS committee in early November.
- There has been a downward trend in the number of incidents reported. This has been investigated and no immediate issues have been identified.
- It was positive to see the number of restraints reducing
- The number of under 18s admitted to adult beds has increased and this is being closely monitored.
- Further work reporting against the eight priority actions to address inequalities is continuing.
- Covid-19 outbreak management and testing are continuing as the need arises.
- Complaints response times had recently been very good, but this month had been a challenge due to operational pressure and being unable to allocate investigators. A triaging system was being established to maintain realistic timescales dependent on the nature of the issue.

EM queried Information Governance breaches and noted the numbers were still quite high.

MB reported that updated comms had been in place for four to five weeks and there is likely to be some time lag as most of the IG incidents recorded took place before the new comms messages. The increase in incidents started when Covid-19 broke out. People have become more aware of the issues. The main cause continues to be human error. It will need another couple of months to allow the message to take hold. No recent incidents had required an Information Commissioners Office (ICO) submission.

CD raised a question on overtime. Has there been a big increase and how is it being measured/monitored? Also, with respect to community staffing levels, what is the situation with caseloads and how are people managing?

TB confirmed overtime was being monitored and went through the bank and e-rostering so that thresholds were maintained. CGCSC has resurrected the safer staffing work and a pilot is under way with community services looking at caseloads. Caseloads are reviewed by managers on a monthly basis as a minimum. We want a more scientific approach to look at caseloads by team which is being looked at as part of the "safe care" work.

MF stated the IPR was discussed at Finance, Investment and Performance (FIP) committee yesterday. The fill rate slide was discussed (page 26 of the pack), and asked if TB had picked the actions up from that?

TB confirmed he did. The safe care work we are doing will cover this. Currently we report on a national requirement on fill rates against establishments. This doesn't necessarily identify the pressure in the system. This is how we get figures at 130% because we may have increased acuity meaning increased observations resulting in one to one or even two to one support on top of the establishment requirement. This is the work going on with safe care.

EM raised a point regarding flu vaccinations and asked, given current staff absences through Covid-19, considerable pressure in the system and winter around the corner, do we need to do something different?

AGD stated there had been 1,157 vaccinations to date, which is ahead of last year and, given the complexities of the current environment, is positive. There are local BDU delivery plans with peer to peer vaccinations. People can go to GPs and pharmacies to be vaccinated and

staff will be financially reimbursed. The next set of vaccines are due for delivery on 4th November. It was going well under difficult circumstances.

There is a Bronze flu meeting each Tuesday and a Silver flu meeting on Friday which enabled AGD to take stock of progress. AGD reiterated the importance of getting the flu jab early so it avoids conflict with any future Covid-19 vaccine.

AM asked about levels of clinical supervision, which are a concern.

CH reported significant hotspots had been identified and the under-performance wasn't across all services. A lot of work had been done in Calderdale and Kirklees and they were now at 91.6% for clinical supervision. Focussed action was now being taken to and learn from this work and improve in other areas.

<u>NHSI national Indicators</u>

The Board took these as read as matters to highlight had already been raised.

<u>Locality</u>

CH reported the difficulty is in balancing the work to restore services against the rising pandemic numbers. Staff absence due to Covid-19 is currently at 230, 4.4% of the workforce. The largest number are symptomatic, others were made up of household symptoms or isolation. 80 staff are working from home but 150 are not. Wakefield has the highest rate of absence at 8.1%, the next highest is Barnsley.

Barnsley General Community services:
- Pressure in the system is resulting in pressure on community services due to Covid-19.
- There were hotspots of staff absence in neighbourhood nursing services.

Barnsley Mental Health and CAMHS:
- There are CAMHS challenges in tier 4 bed admissions which are part of a WY&H service or through other providers, and adult beds are being used. The stays in the adult beds are longer due to difficulties in accessing tier 4 beds.
- Mental health community services are seeing increases in contact through the single point of access, similarly in CAMHS, but numbers are not back to pre-Covid levels.
- There are some challenges on IAPT access targets
- All-age liaison teams are now established in all our places. If children/young people present in A&E they see the liaison team which frees up capacity for CAMHS to provide a better crisis response. There are also significant improvements in waiting times.

Inpatients:
- Patient flow remains a constant challenge, not just to mental health beds but how we support the acute trusts with their pressures.
- Acuity remains high.

Mental Health Community services:
- Supervision remains a challenge in some areas.
- There are some areas for improvement regarding Care Programme Approach (CPA) reviews.
- An action plan is in place in all community settings to make sure we are optimising the use of our estate to safely provide a variety of services.

Forensics, Learning Disability (LD), Attention Deficit and Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD):
- Staff absence remains high in forensics. The completion of work required in relation to the lead provider collaborative in WY&H ICS is challenging as a result.

- Learning Disability services were focused on concerns around engagement as Covid-19 risks increased. Staff were finding creative ways to manage this, which is essential.
- The ADHD and ASD services continue to deliver their service throughout the pandemic. They are now looking at how to support 17-year olds with ASD in Calderdale and Kirklees to relieve some of the pressure on children's teams.

AM thanked operational staff for keeping going in the current time and continuing to make improvements in services.

<u>Priority Programmes</u>

SY asked to take the report as read and highlighted:

- the communications team continued to engage with each of our places across the ICS to assist the system and the Trust with communication around Covid-19.
- Key areas of focus included Information Governance.
- There is a community survey out at the moment seeking feedback from the public, service users and carers about our community services.
- In terms of engagement and involvement, work is based on the strategy refresh including governors, volunteers and members of the community.
- Work is ongoing to refresh the Trust-wide Covid-19 Equality Impact Assessment (EIA) due to the ever-changing nature of the pandemic.
- We now have feedback from the services through the toolkit that was developed to capture patient experience during Covid-19. Information collated will go to the data intelligence group to formulate what we can learn from the results.

We have maintained contact with our volunteers but given the nature of Covid-19, a number are still reluctant to come back. We will continue to work on this and maintain contact.

SYo queried whether this was leaving a gap for us, and if so how are we filling the gap?

SY stated recovery colleges and Creative Minds are managing this through digital means and new ways of working that have been introduced. A lot of volunteers were embedded in our services and it was the richness they bring that would impact on services but safety had to come first. The volunteer service is looking at ways of keeping volunteers engaged and utilising their services wherever possible.

KQ raised learning disability services and the number of restraints. It was documented under "challenges" in the report and lists the referrals from Leeds. There are only two Assessment and Treatment Units (ATUs) currently open and we have the only seclusion unit.
The potential for levels of acuity to rise is high, demand remains high and supervision levels remain low. There is likely to be regulatory focus in this area. What can we do to increase supervision and make sure staffing and training are at the highest possible standards?

CH stated she, ST and TB had all met with the deputy with responsibility for learning disability to look at how to support the learning disability leadership team and the learning disability services to manage pressures and issues in the service. SR, ST and CH meet regularly to review learning disabilities and input into the work across the ICS. We are keen to get clinical leaders more engaged with that future work because it needs to be clinically driven. The clinical leads and the consultants need to help develop the right service model so that we can deliver safe assessment and treatment units for us, Leeds and Bradford.

We have a mixture of "regularly commissioned" beds in our Assessment and Treatment Unit, Horizon, and two "spot purchase" beds. If required, we don't use the spot purchase beds in order to keep services manageable and safe.

CH confirmed that long term segregation did take place and that there needed to be greater understanding of what this meant in practice as the label was very different to the perceived meaning. For example, CH and RW had previously met all the service users being monitored in long term segregation. For the service users this meant they had a full area of Horizon to themselves because they found it difficult to be with the rest of the patient population and they have their own dedicated staff.

They were all accessing leave, to go and see family members, to go and get fresh air, or go for a walk. It means their care is delivered outside of the rest of the ward population and the service users themselves reported that that was much better for them in their personal circumstances.

RW commented that each of those individuals were on Horizon as part of a transition. One of them had gone from being fully restrained in an educational establishment daily, to being in segregation on Horizon in their own part of the unit, being free to do all sorts of things and were actively engaging with staff.

Another was replicating arrangements they had at home, where they lived with family in an area which allowed them to be free to spend time on their own or with people they trusted. They were in transition to new accommodation, on an improvement trajectory and moving on.

Finance

MB gave the following highlights:

- In the first half of the year we have been able to claim Covid-19 monies to breakeven with Covid-19 claims or retrospective top up.
- Pay costs continue to increase and there was a one-off cost in September through the medical pay award that had been agreed nationally.
- Capital expenditure; we have reduced our forecast by about £1 million based on the impact of Covid-19.
- Out of area bed costs came down slightly in September compared to August and July.
- The use of locked rehab beds in Barnsley continues to operate at a much higher level than it previously has done.

CJ commented that he had nothing further to add from the FIP committee. In relation to safer staffing and staffing in general they had noted a change in the oversight of agency staffing.

EM commented that non-pay expenditure showed quite an increase on the projected spend for the second half of the year.

MB reported this was due to things that haven't taken place in the first half of the year due to Covid-19. Examples being paying for some of the new digital solutions and training. He added there is always more expenditure on estates in the winter for such items as heating, gritting and maintenance.

Workforce

AGD gave two brief highlights:
- We are rolling out the e-appraisal system and looking at how this might support supervision in the future.
- Food safety; training - work is underway to get up to the target level. Anyone in housekeeping or catering were now fully up to date and operating in line with policies.

EM stated that her experience of the e-appraisal had been positive, and it had felt focussed.

AM thanked everyone involved for all the work that had gone into the IPR.

It was RESOLVED to NOTE the Integrated Performance Report and COMMENTS made during discussion accordingly.

TB/20/84c   Priority Programmes (agenda item 10.3)

SY highlighted the following points:

- Additional work has taken place since the last Board, including conversations held at the recent strategic Board meeting.
- Some changes have been made to the improving health domain.
- A working group facilitated by MB has already met around developing metrics against each of the priority programmes.
- Work continues around developing action plans that will underpin the Equality, Involvement, Communication and Membership strategy, which will add to the priority programmes work.

AM thanked SY and her team for all the work that had taken place to get us to this point.

RW commented it was difficult to consolidate something so complex into brief simple summaries and that significant progress had been made. Once we have the indicators set out, and most of them are clear from the work done on the quality account and what the safety measures, we should be able to see the golden thread between what we are trying to achieve and what we are measuring.

EM approved of the document.

CJ stated it was a good piece of work. She commented that we need to be clear why we have picked particular measures, and whether we have the right ones.

If IAPT, as a resource constrained activity, is increasing access for one group, this may limit access for another group, and we need to be open to that challenge. Is there something we can define around productivity which perhaps isn't the same as reducing waste?

In reference to making it a great place to work CJ questioned whether WDES and WRES were going to be enough? There had been a big discussion today about workforce and there may be other measures that needed to be considered.

SY stated, in relation to the workforce components and each of those priorities, there are a significant number of metrics being collected but the conversation of the subgroup has been really helpful to give focus on the eight inequality actions. We are now scoping out the programmes in more detail. The work around productivity and waste needed to be defined. We need to think about the wording around productivity which has unhelpful connotations at a time when staff are fatigued from dealing with the pandemic.

MF suggested if the correct metrics for the priority programmes are selected this could result in a reduction in other metrics currently recorded in the IPR.

AM summarised there was strong support for this across the board, which has been echoed at EMT. AM thanked SY for her perseverance in producing a comprehensive document which would help to give us a real focus.

It was RESOLVED to AGREE the proposed priorities and areas of focus, NOTE the continued work on developing the specific metrics and measures and work to develop the specific and cross cutting actions to address inequalities equality and involvement.

TB/20/85   Governance matters (agenda item 11)
TB/20/85a   Quality Account (agenda item 11.1)

AM asked to take the report as read and asked if there was anything TB wanted to highlight.

TB reported it had been seen in the private board during its development and was being presented to the public session.

MF noted that on page 225 onwards there is a series of actions. A number are marked for March 2021. MF queried if the work could be completed in this timescale given the operational strain or was it a deadline that had to be met?

TB reported they were achievable at the time of the production of the report. These are current plans, but we reserve the right to review the dates due to the impact of Covid-19.

RW stated this was a good challenge from MF. If you look at the standards you would anticipate most of them should be delivered. We should keep an open mind on improvement during Covid, because CAMHS waiting times have continued to improve during this last six months. If we look at the indicators, we should ask the question is this still achievable and what is the expected trajectory.

Action: Tim Breedon

It was RESOLVED to RECEIVE and APPROVE the 2019/20 annual Quality Account report.

TB/20/85b   Health and Safety Annual Report (Agenda item 11.2)

AGD stated the report had been delayed due to Covid-19 and was being brought directly to Board before going to CGCS committee in November. The 2020/21 objectives were not being presented for approval as they were paused during Covid-19.

AGD asked to take the paper as read and highlighted the following points:

- The Health and Safety Executive (HSE) came into the Trust in January and February 2020 for a formal inspection. The result was a credit to the whole organisation given the level of positive feedback.
- We were one of only a few trusts who didn't have any actions.
- This was a partnership agenda, it wasn't just about the health and safety team, operations, nursing and staff side were all involved.

AM stated this report shows that we have strong performance around health and safety which was recognised by the HSE earlier this year.

SYo queried if the deferred actions are being picked up in CGCSC, so we can understand the risks, as they are all important actions.

AGD reported when the objectives were paused, it was felt we would be through the pandemic by now. A more fundamental review of the health and safety objectives is required to go into committee in November and how that may affect 2021/22 objectives.

AM noted that a lot of the health and safety team are engaged in making sure our estate is operational during Covid-19.

RW stated there will be some actions which will take on a slightly different complexion as a result of Covid-19 as the level of risk may increase or decrease. As we are reviewing the actions, as a result of the pause, we need to have that mindset.

Place inspections as an example, have been reduced. As a result, intelligence on health and safety is reduced. We should be positive about the exceptional report from HSE and receiving no actions and no written comments. We should take the Board's direction and look again at the actions with a "Covid-19 lens" as some of the previous safeguards might have changed.

Action: Alan Davis

AM commented that visits to our services, particularly by non-executive directors and by governors, which currently couldn't take place, are an important part of maintaining a safety culture. There is a need to establish whether virtual service visits could be accommodated during Covid-19 and the Board sought concrete proposals on this issue.

Action: Alan Davis

It was RESOLVED to APPROVE the Annual Safety Services Report 2019/2020.

TB/20/85c   The Responsible Officer (agenda item 11.3)

RW reported the expectation in many trusts is that the Medical Director is normally the Responsible Officer. We had approved a different arrangement which meant Dr Berry has been the Responsible Officer. Given Dr Berry's move on secondment to a different role, we need to confirm ST as Responsible Officer noting it is a statutory obligation. RW fully supported and endorsed ST for being suitable for that role.

It was RESOLVED to APPROVE Dr Subha Thiyagesh as Responsible Officer.

TB/20/86   Assurance and receipt of minutes from Trust Board Committees (agenda item 12)
AM asked the chair of each Committee to provide an update:

Audit Committee – MF reported this had been his first committee as a chair. It was a very professional and well organised, effective meeting. MF had noted a lot of the papers on this committee were from MB and his team.

There are lots of individual papers, as there are for Board, and discussions are taking place about reviewing the work plan to enable deep dives on individual subjects and having time to think about things in more detail, rather than dealing with multiple agenda items at every committee.

Finance, Investment and Performance Committee – CJ reported he had covered most the items he wanted to raise. CJ asked to note the implementation of the SBS finance and procurement system. The implementation had been successful, overcoming challenges along the way. The next challenge was to do the first financial month end and produce the first set of management accounts out of the system. CJ reiterated his thanks to MB and his team.

Workforce and Remuneration Committee – SYo reported a lot of time was taken up discussing risk. The agenda was changed to make it more of a development session where there was opportunity to have more free discussion around the organisational development strategy and the workforce strategy. The WRC is going to take place every other month from now on, this will mean meetings are more frequent but shorter in duration.

AM reflected that both the Equality and Inclusion committee and the West Yorkshire Mental Health, Learning Disability and Autism Collaborative committees in common both had strategy sessions set aside in the work plan. This may be something that other committees wanted to think about implementing.

West Yorkshire Mental Health, Learning Disability & Autism Collaborative Committees in Common

The committee met last week and agreed to review the memorandum of understanding, which had now been in place for three years. AM reported this was important, to remind everyone of the principles of the collaborative, and ensure they are embedded and recognised by all. This was also good governance as things have changed in the last three years. Any changes made would be brought back to Board.

AM noted the Assessment and Treatment Unit (ATU) update was to be discussed in the private session later on.

Provider collaboratives have been discussed as a regular agenda item, the CAMHS Tier 4 update was present in the paper, and the forensic provider collaborative was to be discussed in the private Board.

The committee also looked at potential future waves of provider collaboratives which are under development and they would continue to keep that in view as the whole process develops.

AM added that a programme update was taken around all of the programmes in the collaborative and there was a detailed discussion around maintaining mental health and well-being of all our staff and looking at all the available offers through the collaborative and beyond.

Work was ongoing around the transformation of psychiatric intensive care units (PICU) and the committee had reviewed what was happening with capital funding, noting Bradford have been unsuccessful in their bid for national funding for Linfield Mount. This was a set-back, and there was strong support across the collaborative to try and help Bradford District Care Trust in their search for capital funding for their development.

There was also discussion about the sustainability of the core team. There is an excellent core team supporting this collaborative at West Yorkshire level. Issues around the expanding workload and the sustainability of the team need to be addressed.

There is a Non-executive director and governor engagement event on 27 November 2020.

RW asked to reinforce the point about support. He explained ICSs are not formal structures, and have no allocations or funding, and the capacity within them is made up of people from different places. The funding for programmes is often delivered from transformation monies, and we have a situation where the government is thinking about how ICSs are developed going forward and whether they should be statutory organisations with staff. That has not been resolved and there is no recurrent funding anda lack of clarity over transformation funding next year.

As an Integrated Care System West Yorkshire and Harrogate have agreed to underwrite the costs of all the programmes including those for mental health and learning disabilities until October 2021.

In the meantime, the core team are doing a review of how they make capacity sustainable and in doing so, conduct a review of all the programmes to make sure they are still required. This should have a positive outcome on the programme to ensure it has what is really needed and will make sure it has the capacity to do what is required.

To note, AM is no longer chair of the committees in common, it is now the Chair of Bradford District Care Trust, Cathy Elliot.

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

TB/20/87   Trust Board work programme (agenda item 13)

AM noted that the strategic overview of business and associated risks should have been received today but the decision had been taken to defer the item. AM asked to consider how to progress this item? Everything else remained as indicated. The constitution review has been deferred and this was agreed at EMT, supported by AM. MB stated that as long as time permits, he would like to review the scheme of delegation by January 2021 given the change in finance ledger system, some changes made temporarily due to the pandemic and work with Barnsley community services.

RW referenced the strategic overview of business and associated risks. This is a process where we update the PESTLE and SWOT in great detail and cross-reference it with the risk register.
This is a large undertaking and probably requires a lot of changes in the context of Brexit and Covid-19.
RW questioned whether we wanted to use this kind of process to assess our strategic risks because we've just been through a process to assess what our strategic risks and priorities should be. RW therefore questioned what value this process would bring. At some point in the future it would be worth asking ourselves why we conduct this process.

MB suggested it was a helpful piece of work that maybe only needs conducting annually as part of the planning process.

Action: Mark Brooks/Salma Yasmeen

MF noted looking at November we appear to be receiving five different strategies. MF questioned whether these had been through committees previously and was it realistic to expect the board to have a thorough and proper debate on five strategies all at one meeting?

AM explained that the estates strategy will not be a full update, but an 18-month plan extending the existing strategy. The equality, involvement, communication and membership strategy has been through a number of iterations and is coming back to Board next month.

The sustainability strategy will have to be deferred as there is no current capacity. This is anticipated to be brought to Board in February 2021.

Organisational Development and Workforce strategies were in conversation and on track for first draft to go to WRC in November, from there we can determine how far it is from the final draft.

The Constitution review date was now to be April 2021.

RW noted when we get to the Constitution review, we could look at which strategies are reserved for the Board and which could go to committees.

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

TB/20/88   Date of next meeting (agenda item 14)

The next Trust Board meeting held in public will be held on December 1 2020.

TB/20/89   Questions from the public (agenda item 15)

Nil

Signed: Date:

TRUST BOARD 27 OCTOBER 2020 – ACTION POINTS ARISING FROM THE MEETING

[   ] = completed actions

Actions from 27 October 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/78	TB agreed to circulate an update outside of the Board meeting regarding the number of CPA care plans being offered to patients.	Tim Breedon	November 2020	Complete – update circulated 23/11/2020.
TB/20/78	The equality, involvement, communication and membership draft strategy to be circulated to E and I committee members prior to November Board.	Salma Yasmeen	November 2020	Complete – strategy on the agenda for approval at Board 1 December 2020.
TB/20/82b	14th strategic risk to be added to the BAF "failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19". To go back into EMT for refinement.	Mark Brooks	January 2021	Risk added to first draft of BAF and going to EMT on 10 December 2020.
TB/20/82b	Audit Committee to have oversight of the legal risks in relation to Covid-19.	Audit Committee	January 2021	
TB/20/83a	What are we going to sign up to in terms of a committee in common or governance arrangement in South Yorkshire, and what do we need to consider as part of our financial arrangements and our risk share, as part of new care models within the next couple of months.	Salma Yasmeen / Mark Brooks	January 2021	
TB/20/83b	There has been huge progress on infrastructure against our digital strategy. We do need to think how we connect better into this work across the ICS. EMT should look at how we're doing this.	Mark Brooks	January 2021	
TB/20/83b	Report regarding digital maturity across the ICS to be circulated to Board members outside of the Board meeting.	Salma Yasmeen	November 2020	Complete – report circulated to Board 25 November 2020.

With **all of us** in mind.

Min reference	Action	Lead	Timescale	Progress
TB/20/84a	Further review of governance arrangements given the enduring nature of Covid-19 to be monitored by the Audit Committee.	Audit Committee	January 2021	
TB/20/85a	Quality account actions to be reviewed, in light of the second wave of Covid-19 and assess if March 2021 timescale is achievable for actions and if not, set a new target date.	Tim Breedon	January 2021	
TB/20/85b	Review the actions in relation to Health and Safety objectives through a "Covid-lens" as some of the previous safeguards may have changed.	Alan Davis	January 2021	
TB/20/85b	Review service visits and look how these can be completed during Covid-19 by digital means.	Clinical Governance & Clinical Safety Committee	January 2021	
TB/20/87	Look at frequency of strategic review of business and risk and see if this can be linked to the BAF, ORR and triangulation report cycle.	Salma Yasmeen/ Mark Brooks	January 2021	

Actions from 29 September 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/62	A new action should be created to make sure the Trust delivered against the eight actions required by NHSE/I to address inequalities.	Tim Breedon	November 2020	Complete – the IPR is being updated to include appropriate data.
TB/20/66a	Charlotte Dyson (CD) commented that in the CGCS committee agenda setting meeting, the slides about the predicted level of demand had been really useful. The board might want to think about emerging community risks such as homelessness, students going to university, long term covid-19 and the psychological implications of these things. The Trust needed to be aware demand from other areas that we might not usually see. An agenda needs to be raised at CGCS committee would be looking into these aspects.	CGCS Committee	November 2020	Complete – report provided at CG&CS Committee 10 November 2020.

TB/20/66a	MB reported that if we looked at what our requirements were for demand and capacity, planning prior to Covid-19 it would be very different to what it is now. Previously if there was a tender coming up or a specific piece of work required, we would do some basic demand and capacity modelling work. The Trust was going to have to think quite carefully about how it structured some of its functions. AM summarised by saying that FIP would look at these issues in detail and we would make sure these were kept in view of the board as required.	FIP Committee	February 2021	
TB/20/66a	RW stated the board needed more assurance on supervision. We should make sure that staff had the opportunity to have supervision, even if it was through digital means, to ensure that supervision was taking place as required. TB suggested to enhance the planned report on supervision and take it to the next CGCS committee and then report into the next board.	Tim Breedon	November 2020	Complete – report provided to CG&CS Committee 10 November 2020 and update included in IPR.
TB/20/66b	KQ reported that the key themes around learning disabilities were stark. Evidence of people with learning disabilities dying a considerable number of years early and evidence of bias in the care resulting in unequal treatment. These are the kind of things that need to be included in the equality strategy. TB agreed that these factors needed to be taken into the Equality and Inclusion Committee. We needed to look at we did internally in our response but also how we supported the system.	Tim Breedon	December 2020	Scheduled on the E&I Committee agenda for 8 December 2020.

| TB/20/66d | CD commented that the RC report was positive with 90% of staff feeling that their line manager was interested in their wellbeing. "I feel that the Trust listens when concerns are raised" seemed a bit low. Was there any comment on that?

AGD reported this was one of the areas where we will want to drill down further. It is Freedom to Speak Up (FTSU) month in October, and there was going to be a real drive in this area. FTSU guardians were being spoken to with a view to them moving away from casework and into engagement.

CD reported she would like to see how this impacted on the plan that was being brought to CGCS committee next time | Alan Davis | February 2021 | To be included in the FTSUG report submitted to the Clinical Governance and Clinical Safety Committee in February 2021. |
| TB/20/68 | AM confirmed that this strategy would come back to board in October. The next Equality and Inclusion committee was in November and so there needed to be some consultation with committee members in between so final comments could be included. | Salma Yasmeen | November 2020 | Complete – superseded by action TB/20/78 above. |

| TB/20/68 | KQ commented that the Equality, Inclusion, Communication and Membership strategy was very bold and clear and this was positive.

On the diversity section there were some additions to be made (pg 247 on diligent). There was an assortment of figures on BAME communities but these didn't include the LGBT groups.

The engagement was also great, but on pg 249 it reported people wanted a "human – human" relationship built on dignity and respect. On page 250 it said "make sure that the use of internet, social media and computers form part of the source of information but not the main part". Later on we say our website is going to be the main source of information?
On pg 253 it mentions the joint needs assessment. Was this the joint strategic needs assessment (JSNA) that CCG's and Local Authorities do or was it a new piece of work, in which case who was going to do it? We possibly don't have the capacity but the ICS may have?

TB reported that the JSNA's were the existing piece of work but KQ's comment about joining up with the ICA was relevant.

SYa welcomed KQ's comments and stated they would revisit some of the data within the strategy to make sure it picked up the key issues. | Salma Yasmeen | November 2020 | Complete – superseded by action TB/20/78 above. |

TB/20/68	RW reported there would be diminishing returns on the E,I,C,M strategy and the focus should now be on the actions and sessions such as the LGBT session with private board yesterday will be really helpful. Let's sign this off soon and sharpen up the actions. CJ agree with RW. There is no lack of data. Our own bottom up understanding needs to be reviewed in terms of how we may create inequalities through our own processes and activities and so we need that theme to come through. We then need to identify the key priorities for our communities. SY agreed to get some draft plans and metrics in place for the next E and I committee meeting in December 2020.	Salma Yasmeen	December 2020	Work has commenced on developing the action plans that will go to the next E&I Committee.
TB/20/69d	AM cited a national piece of work around disability at board level and noted that might be something we wanted to formally sign up to.	Angela Monaghan	January 2020	
TB/20/69d	RW reported we hadn't really grasped the opportunities around learning disabled staff or learning disabled people working with the board. We don't have easy read versions of papers or presentations from this meeting. RW continued to say we do a good job on strategies and policies on this but less so in relation to board meetings. Something of this nature in the WDES action plan going forward would be beneficial. The action plan on the WRES is in the right territory. The report from West Yorkshire ICS will add to this and we should take on board those actions when they come through.	Alan Davis	November 2020	

TB/20/69d	AGD agreed with CJ that the question was what we were, as an organisation, going to do about bullying and harassment. We heard pre-covid-19 that one of the issues was office banter and where the boundaries were. The big issues for the BAME staff quality network is the issue around service users and carers and that needed to be dealt with in the right way. This model came from staff in Kirklees, they have equity guardians and a framework to support staff who have actually gone through that process. This needed to be driven forward.	Alan Davis	November 2020	
TB/20/69d	EM asked if we were able to extend reciprocal mentoring to cover disability? AGD reported that this was something that could look to be rolled out across a number of different areas. Project Search was something that was being looked at with the Mid-Yorkshire Trust and how we could mirror that. (Project search is a training programme looking at how to support young people with learning disabilities into paid employment)	Alan Davis	November 2020	
TB/20/69g	RW supported the proposal for the Board Development Programme but asked if we had review and evaluate if we had implemented things that we agreed we would do as part of the leading for improvement development. RW reflected on the conversations from today's board and stated it was good to see the SPC charts in the IPR report, beyond that it was hard to see what we changed. AGD agreed to carry out an evaluation and reflection of the leading for improvement development. This would form part of the diagnostic work.	Alan Davis	November 2020	A review of the Leading Improvement Board Development programme will go to November's Board meeting.

Min reference	Action	Lead	Timescale	Progress
TB/20/74	RW reported the West Yorkshire and Harrogate ICS recorded the public meeting and posted it on their website for a number of days. AL could speak to Karen about their experience of doing that. RW also queried how well we were promoting this meeting on social media before and during the meeting. If AL and AM were to review it would be useful to involve SYa and Dawn Pearson.	Andy Lister	January 2021	15.10.20 meeting held with Karen Coleman from the WY&H ICS. AL to discuss outcome with AM. 27.10.20 AL updated a production company are used by the ICS and there is an editing process that takes place before meetings are published online. 20.11.20 Further discussion has taken place with Julie Williams and due to concerns around governance further discussion needs to take place.

Actions from 28 July 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/50b	Update actions for risk 1528 to include the review Health Watch reports and the ICS work that has taken place to evaluate services with the public.	Salma Yasmeen	October 2020	Risk updated and will be included in risk register update at October Trust Board.
TB/20/50b	AGD reported that the Robertson Cooper staff survey was important so that the Trust knew how people had been feeling during this time. The Workforce and Remuneration Committee had agreed that there was the need to drill down and review the data that was emerging.	Alan Davis	October 2020	Paper on Trust Board meeting in September 2020 and on the agenda of the Workforce and Remuneration Committee 13 October 2020.
TB/20/50b	SYo stated that at the Committee meeting there had been discussion about risk 1533 "Risk that as a number of key workforce activities have been suspended they could cause future problems around burnout and resilience, professional and personal development, staff and service safety". This risk had been defined quite early on in Covid-19 when the Trust didn't know what the impact on the workforce would be. SYo stated she would take an action away for the Workforce and Remuneration Committee to review risk 1533 and give more clarity as to the true nature of the risk.	Workforce and Remuneration Committee	October 2020	Workforce and Remuneration Committee 13 October 2020.

| TB/20/51c | MB suggested that it would be helpful to inform the Members' Council of progress being made with regard to the forensics lead provider collaborative programme of work | Sean Rayner / Angela Monaghan | October 2020 | Members' Council meeting on 30 October 2020. |
| TB/20/53a | AM reported that SYa had mentioned earlier the CIO network. At present our Trust doesn't have a Chief Clinical Information Officer (CCIO). MB explained that this appointment had been delayed as a result of Covid-19. Discussion had been held with both TB and Subha Thiyagesh (STh) and an appointment process will take place. | Tim Breedon / Subha Thiyagesh | January 2021 | Update November 2020 – the job description is being finalised with a plan to advertise by the first week in December, open for two weeks. The interviews will take place in January 2021. |

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 project with community teams, but it is too early to make recommendations. Timescales for introduction will be reported into the next CG&CS committee.	Tim Breedon	November 2020	Complete. 10.11.20 Timescales reported into CG&CS Committee and included in safer staffing report.

Title:	Chief Executive's Report
Paper prepared by:	Chief Executive
Purpose:	To provide the strategic context for the Trust Board conversation.
Mission / values / objectives:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers / previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.
Executive summary:	We continue to monitor effective communications during this period of transition. The latest monthly briefing for all staff is attached at **[Annex 1]**. The publication of The View and the weekly Coronavirus update continues, as does the virtual weekly Chief Executive Huddle open to all staff.

Since the last edition of The Brief there have been a number of significant developments:

- **The rising rate of prevalence of Covid across the country has led to national restrictions being imposed for a period of four weeks.** These restrictions replace the tiered system of restrictions which had seen South Yorkshire & Bassetlaw (SY&B) in the highest tier (3) and West Yorkshire & Harrogate (WY&H) about to enter that tier in early November 2020. National restrictions are due to be lifted on 2 December 2020 and we are likely to see a new set of restrictions, again in tiers, with enhanced measures within them. At the time of writing we expect both West and South Yorkshire to be returned to the highest risk rating with the greatest degree of restrictions

- **Significant progress has been made on developing vaccines for Covid**. Vaccines by Pfizer and Biontech, Moderna and AstraZenica (the Oxford vaccine) have demonstrated efficacy of at least 90% in trials. Once licenced for use, the vaccines will be used in line with priorities set by Government. These are likely to include our staff and people over 80yrs in the first phase. Arrangements are being made for delivery of the vaccines using a combination of hospitals, general practices and council's capacity. This is being coordinated by our Integrated Care Systems (ICS').

- **Following developments in Liverpool around mass testing of the population it is likely that West Yorkshire & Sheffield will be involved in similar testing programmes.** This is due to the fact that West Yorkshire and South Yorkshire have been at the highest levels of prevalence in recent times. Discussions continue about the exact focus of this type of testing. In the meantime, asymptomatic staff testing it due to started within the Trust with twice weekly testing for staff using home testing kits. This is likely to

With **all of us** in mind.

pick up asymptomatic staff who will then be excluded from work until they get a negative test from pillar 1 or pillar 2 testing. Alongside this we have begun recruiting to the Siren Study looking at antibody testing for a cohort of staff.

- **The Government has updated its advice on who should be classed as Clinically Extremely Vulnerable (CEV).** People with stage 5 chronic kidney disease and adults with Downs Syndrome have been added to the list. Some children have been removed from the list. During the national restrictions people who are CEV have been advised to take extra care and work from home where possible. This has led to an additional level of absence in the Trust and capacity issues. This has exacerbated absence from the focus on working from home wherever possible.

- **In this context the Trust has decided to move to Operational Performance Escalation Level (OPEL) 3.** This has led to a further prioritisation of our programmes, 7day corporate support for clinical services, and a prioritisation of further work agreed through Gold Command. Partner organisations, particularly Barnsley Hospital NHS Foundation Trust and Mid Yorkshire Hospital NHS Trust have faced severe pressures which have required our support and mutual aid. For example, staff from Barnsley Community Services have worked at Barnsley Hospital and across both systems we have been helping with patient flow. During this period the excellent relationships that we have forged and improvements in integrated care have come to the fore.

- **We have also begun to increase our focus on inequalities.** This reflects work done nationally on measuring the impact on people from different backgrounds, and work done locally through the WY&H BAME Review. Further evidence emerged this month of significant inequality and significant risk for adults with a learning disability. A Public Health England (PHE) report found that adults with a learning disability are 6.3 times more likely to die from Covid and this affects people from across the age range. We have done a rapid review in the Trust of work that we need to do and are supporting work done within the WY&H system on addressing these issues.

- **The new financial arrangements for 2020/21 are in place.** This is covered in the finance report which has been provided using the new finance system implemented by the team during the second wave. It is to their credit that this has been a success to date. In terms of wider finance arrangements, it's likely that we will receive a share of £50 million made available nationally to support discharge in the mental health sector. This will help to maintain our improved performance on the use of out of area beds.

- **Integrated care has proven to be a real benefit over the period of the pandemic.** The NHS Confederation published a report on the future of ICS' this week, the report is attached at **[Annex 2]**. This is ahead of expected developments in the New Year linked to a forthcoming NHS Bill. This is likely to put ICS' on a statutory footing.
- **Staff wellbeing continues to be a priority** as we seek to make SWYPFT a great place to work. Actions on wellbeing are continuing in all services, with corporate support in place. At this point in time we have the equivalent of 200 more whole time staff in place than we had this time a year ago, and we want to retain staff in a compassionate and inclusive culture.

	We are operating in a system that is being asked to deliver safe and effective care every day; that is being asked to implement the biggest flu programme in history; that is being asked to implement the fastest roll out of a new vaccine in our lifetimes; that is being asked to work in new ways with technology; that is facing serious operational stresses; that is part of one of the biggest testing programmes in history; that is also being asked to work with partners in new, dynamic and agile ways. The response from the Trust and its staff has been consistent and positive throughout. The early part of this pandemic had clarity on national lockdown arrangements and shared support for significant action. We are now in an environment where the balance or judgements we have to make around non-Covid treatments and Covid treatments, and the impact of lockdown on people's health versus the impact of Covid on people's health, means things are more variable, uncertain, complex and ambiguous. As a Board we must recognise that this is the case and use our values to guide us in making decisions and prioritising our efforts at this time.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

The Brief

29 October 2020

Monthly briefing for staff, including feedback from Trust Board and executive management team (EMT) meetings

NHS
South West Yorkshire Partnership
NHS Foundation Trust

With **all of us** in mind.

Today's brief

Welcome to the Brief being delivered through Microsoft Teams.

Please put your device on mute so that background noise is limited and turn your camera off unless you are speaking. You can ask questions throughout the presentation using the chat function. Questions will be collated and shared so if we don't get time to answer all of them online we will make sure a response is sent out to you.

Thank you for joining us for our Brief broadcast.

With **all of us** in mind.

Our mission and values

During challenging times is it important we focus on our values.

We exist to help people reach their potential and live well in their community.

To achieve our mission we have a strong set of values:

- We put people first and in the centre and know that families and carers matter

- We're respectful, honest, open and transparent

- We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow

Dave Watson, from Creative Minds, was one of many people and teams who were awarded a Barnsley Council Spirit Award for outstanding contribution to the Barnsley coronavirus response.

With **all of us** in mind.

Coronavirus
Keeping informed, acting responsibly

NHS South West Yorkshire Partnership — NHS Foundation Trust

We need to stay focused and keep up to date by reading the guidance and information on the intranet, and on the Public Health and NHS England websites.

As the national picture changes and infection rates increase we need to work at all levels to ensure our response is based on local need and our business continuity plans.

Our **Gold** command meeting now meets on a Monday and **Silver** command has increased to meet three times a week. This helps us to react quickly. **Bronze** meetings continue to take place in operational and corporate services.

We continue to work in each of our local areas as part of **outbreak management measures and** are a part of weekly Gold, Silver and Bronze meetings. This means we are a part of local decisions made as part of the pandemic response.

We need to continue to follow the official guidance; and ensure good hygiene, social distancing, wearing face masks, and limiting unnecessary contact with other people.

We must keep on protecting each other.

HANDS   FACE   SPACE

LOCAL COVID ALERT LEVEL VERY HIGH

Hands   Face   Space

With **all of us** in mind.

Coronavirus
Keeping up to date

**NHS South West Yorkshire Partnership**
NHS Foundation Trust

It is important to keep informed of what is happening nationally and in our local areas.

Local infection rates (as of 25 October)

Area	Infections per 100,000 (Week 16 – 22 October)	Numbers infected in region at 25 October
Barnsley	525 (+78)	5650 (+718)
Calderdale	407 (+100)	3932 (+480)
Kirklees	371 (+74)	8930 (+898)
Wakefield	387 (+80)	6274 (+749)

Research has shown that some people are experiencing **long COVID**, meaning symptoms such as fatigue, shortness of breath and anxiety can have a long lasting effect. A referral process is in place so that long COVID sufferers can access rapid support and care.

National infection rate
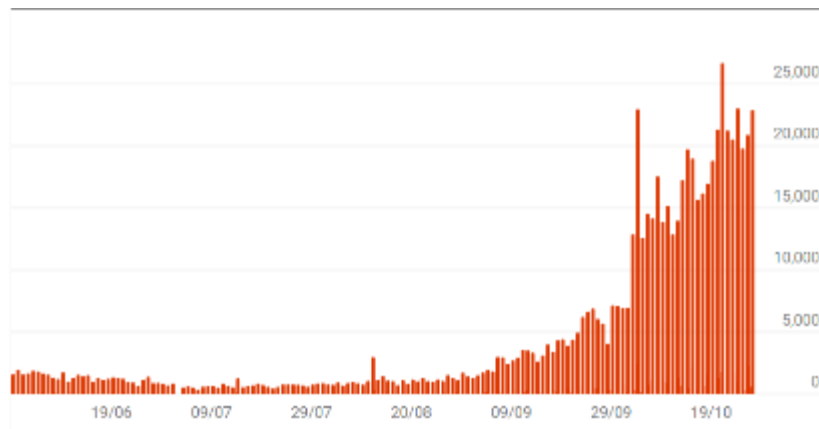
Daily reported deaths due to coronavirus

Seven-day average: 200
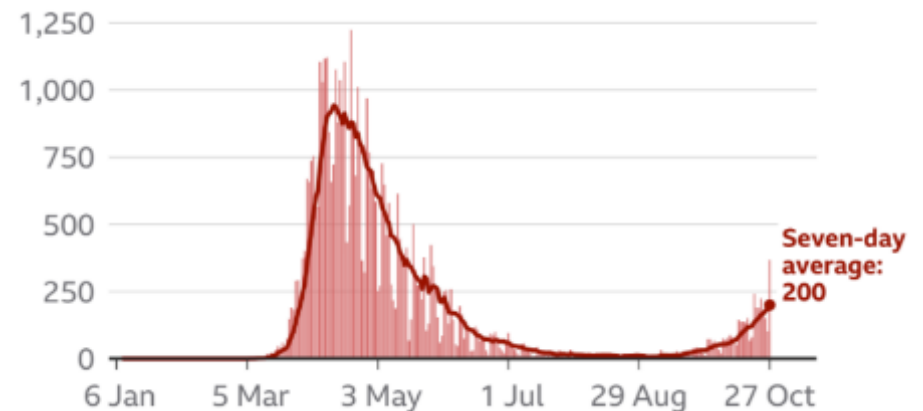
ICS update: West Yorkshire and Harrogate

NHS

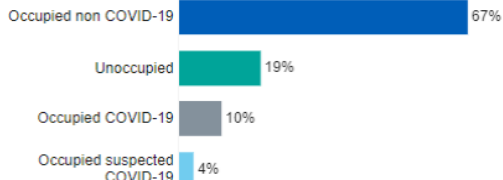|	Number of beds occupied by confirmed COVID-19 cases as of 8am	HDU/ITU beds occupied by confirmed COVID-19 cases as of 8am	Inpatients diagnosed with COVID-19 in past 24 hours	New admissions with COVID-19 in past 24 hours	Patients currently awaiting swab results as of 8am		Of these discharges to usual place of residence	Staff - All Absences	Of these COVID-19 related absences
Number of open beds reported 6,108	618	59	94	22	380	All discharges 57	48 (84%)	4,257	1,423 (33%)

Number of beds occupied by COVID-19, suspected COVID-19, occupied by non COVID-19 and unoccupied

- Occupied non COVID-19 — 67%
- Unoccupied — 19%
- Occupied COVID-19 — 10%
- Occupied suspected COVID-19 — 4%

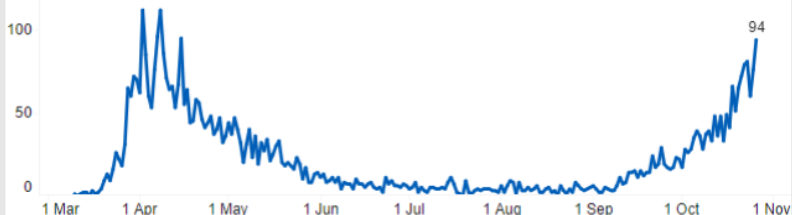### Number of confirmed COVID-19 patients occupying beds as of 8am

618

Number of confirmed COVID-19 patients occupying HDU/ITU beds as of 8am

59

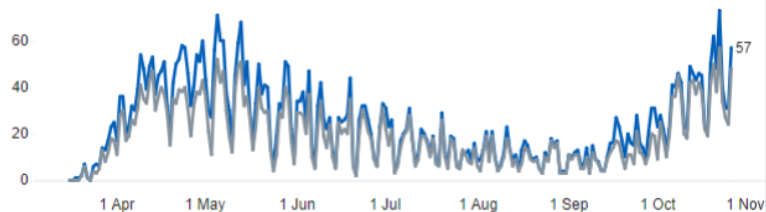### Inpatients diagnosed with COVID-19 in past 24 hours in hospital setting

94

New admissions with COVID-19 in past 24 hours in hospital setting

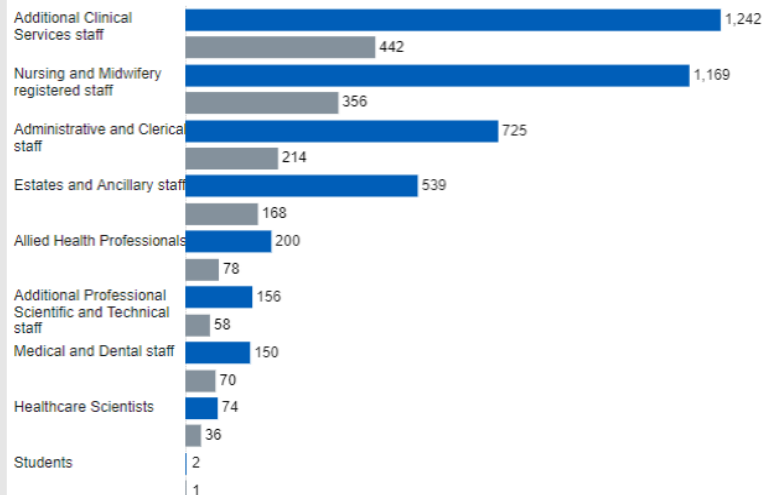22

Number of confirmed COVID-19 patients occupying beds and on oxygen supply (MV, NIV and O2) as of 8am on the 27 October 2020

- Mechanical ventilation — 25 (7%)
- Non-invasive ventilation — 46 (13%)
- Oxygen — 296 (81%)

All staff absences and of these, COVID-19 related absences reported on 27 October 2020

Staff group	All absences	COVID-19 related
Additional Clinical Services staff	1,242	442
Nursing and Midwifery registered staff	1,169	356
Administrative and Clerical staff	725	214
Estates and Ancillary staff	539	168
Allied Health Professionals	200	78
Additional Professional Scientific and Technical staff	156	58
Medical and Dental staff	150	70
Healthcare Scientists	74	36
Students	2	1

All discharges and of these, to usual place of residence in past 24 hours

57

ICS update: South Yorkshire and Bassetlaw

NHS

	Number of beds occupied by confirmed COVID-19 cases as of 8am	HDU/ITU beds occupied by confirmed COVID-19 cases as of 8am	Inpatients diagnosed with COVID-19 in past 24 hours	New admissions with COVID-19 in past 24 hours	Patients currently awaiting swab results as of 8am	All discharges	Of these discharges to usual place of residence	Staff - All Absences	Of these COVID-19 related absences
Number of open beds reported **3,966**	**625**	**48**	**51**	**13**	**264**	**15**	**15 (100%)**	**3,913**	**1,943 (50%)**

Number of beds occupied by COVID-19, **suspected COVID-19,** occupied by non COVID-19 and **unoccupied**

- Occupied non COVID-19 — 72%
- Occupied COVID-19 — 16%
- Unoccupied — 10%
- Occupied suspected COVID-19 — 2%

Number of confirmed COVID-19 patients occupying beds as of 8am

625

Number of confirmed COVID-19 patients occupying HDU/ITU beds as of 8am

100

23 October 2020

Number of confirmed COVID-19 patients occupying bed

Please note
Due to a collection change, this graph and relating graphs shows a su
up until the 26th April (Patients with COVID in HDU, ITU, IDU, MH, LD
thereafter uses beds metrics (Beds with MV, NIV, O2 or any other bed
These definitions should bring an identical set of information.
The MHLDA collection does not currently include the beds information
show a drop in the data.

Inpatients diagnosed with COVID-19 in past 24 hours in hospital setting

51

New admissions with COVI

13

Number of confirmed COVID-19 patients occupying beds and on oxygen supply (MV, NIV and O2) as of 8am on the 26 October 2020

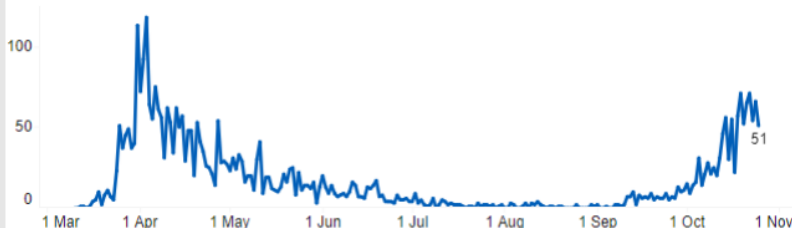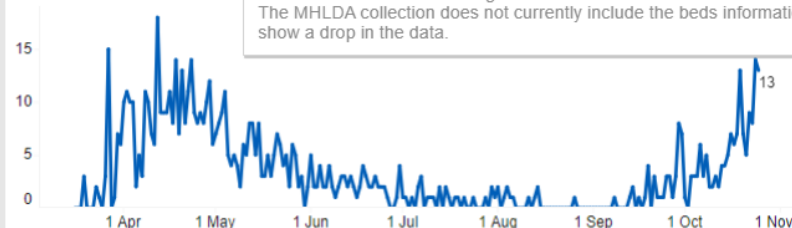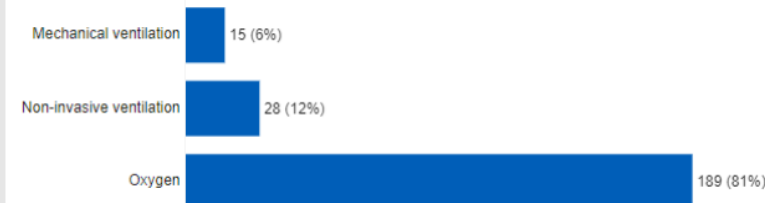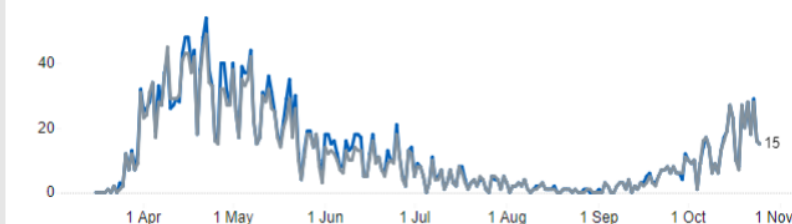- Mechanical ventilation — 15 (6%)
- Non-invasive ventilation — 28 (12%)
- Oxygen — 189 (81%)

All staff absences and of these, COVID-19 related absences **reported on 26 October 2020**

- Nursing and Midwifery registered staff — 1,156 / 626
- Additional Clinical Services staff — 1,008 / 489
- Administrative and Clerical staff — 644 / 313
- Estates and Ancillary staff — 484 / 187
- Allied Health Professionals — 206 / 114
- Medical and Dental staff — 179 / 99
- Additional Professional Scientific and Technical staff — 138 / 52
- Healthcare Scientists — 75 / 44
- Students — 23 / 19

All discharges and of these, to usual place of residence **in past 24 hours**

15

Our proposed priority areas 2021/2022

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Improve health

- Play a full role in our Integrated Care Systems and associated places to contribute to outcomes in their 5 year plans
- Improve outcomes through our wellbeing services, physical health and services for people with mental health and learning disabilities
- Enhance creative, cultural and digital offers through Creative Minds and our recovery colleges

We deliver the targets agreed in our ICS strategies

Improve care

- Continually improve patient safety
- Safely deliver and restore inclusive services locking in innovation
- Provide care as close to home as possible
- Deliver improvements, particularly in CAMHS and forensic services

We restore services, deliver our quality targets and improve our CQC ratings

Improve resources

- Integrate digital approaches to the way we work
- Spend money wisely and reduce waste

We deliver our financial duties and improve efficiency

Make this a great place to work

- Support the provision of a healthy, resilient and safe workforce
- Refresh and deliver our sustainability strategy and action plan

We improve our staff survey results and deliver our WRES/WDES indicators

Understanding equality, and addressing inequality through Inclusive Involvement

#allofusimprove and be outstanding

Underpinned by #allofusimprove, using quality improvement to ensure we learn from organisational change.

With **all of us** in mind.

Improving Health:
Joining up the response in every place

West Yorkshire and Harrogate Health and Care Partnership

South Yorkshire and Bassetlaw Integrated Care System

NHS South West Yorkshire Partnership NHS Foundation Trust

Integrated care systems continue to refocus their work to ensure system support.
- Increased critical care
- Better discharge from hospital
- Protection for vulnerable people in communities
- The safety and wellbeing of staff
- Business continuity and mutual aid
- Moving to recovery and a new way of working

Both ICS' are planning for reset and recovery and ensuring people access healthcare services where they need it This is as well as regional support on test and trace, testing, and the availability of PPE.

South Yorkshire and Bassetlaw is working on coordinated messages to help our acute partners to manage capacity of the acute hospitals in the area, including an approach to the use of the Nightingale Hospitals if needed.

West Yorkshire and Harrogate has produced a report looking into how we tackle health inequalities for BAME communities and colleagues. It was launched at a public event last week and can be found on the ICS website.

West Yorkshire and Harrogate
Health and Care Partnership
Review Report Easy Read

Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues

EasyRead

We are working with the West Yorkshire and Harrogate ICS on a suicide awareness campaign for Winter aimed at all staff.

With **all of us** in mind.

Improving Health:
Joining up the response in every place

NHS South West Yorkshire Partnership NHS Foundation Trust

We continue to attend coronavirus response meetings in every place, as well as helping to develop services:

Barnsley
The move to more joined up and integrated care in Barnsley continues, despite the pressures in the system brought about by the coronavirus response.

Kirklees
We are working with Huddersfield University on a project to use artificial intelligence to help diagnose Attention Deficit Hyperactivity Disorder (ADHD) in adults. The first of its kind AI work has been awarded £140k and aims to shorten the time it takes for people to be diagnosed.

Wakefield
Wakefield Connecting Care continues to bring partners together to develop integrated care. We are a central part of moves in the district to develop a family approach, which includes our CAMHS and wellbeing teams. Coordinated partnership pandemic activity continues too.

Calderdale
Iffath Hussain has joined our strategy team on a project to build and integrate physical health into our services in Calderdale. The aim is to promote physical wellbeing alongside mental health support for staff and service users.

Yorkshire Smokefree
The work on the **Quit programme** continues at pace to make hospital sites in South Yorkshire smokefree. Our Yorkshire Smokefree service is leading on this for the Trust with the aim of making Kendray one of the first sites to go smokefree.

Wetherby
Following an outbreak in which many prison officers needed to isolate the team supported the unit to keep services going. Thankfully Trust staff didn't need to isolate.

Improving Care:
Safety and quality

In September we had:
- 970 incidents – 796 rated green (no/low harm)
- 166 rated yellow or amber
- 8 rated as red
- There were 2 reported serious incidents this month
  1 of deliberate damage and 1 self harm with suicidal intent. All staff should complete the online Zero Suicide training, found on ESR.

We continue to monitor all incidents where **coronavirus** is noted in the Datix entry. This is so we can identify any themes and trends that require action. This helps us to keep our services safe and bring out improvements wherever we can.

There were **19 confidentiality breaches** in September, 2 more than last month. The Trust has a duty to assure the public that any information we hold is in safe hands. Everyone has a part to play. Make sure you are up to date with the advice provided on the intranet.

On 10 October we celebrated **World Mental Health Day** by sharing information on how to access support. We linked in with the West Yorkshire and Harrogate perinatal care campaign to promote our perinatal mental health support, and the online tools and resources available.

Mental health support for new and expectant mums in Barnsley, Calderdale, Kirklees and Wakefield

#WorldMentalHealthDay2020

Improving care:
Our performance in September

- **177** inappropriate out of area bed days
- **100%** of people recommend our community services
- **78%** of people recommend our mental health services
- **1.5%** delayed transfers of care
- **57.5%** referral to treatment in CAMHS timescales
- **3** people under 18 admitted onto adult inpatient wards
- **94%** of prone restraint lasted less than 3 minutes
- **125** restraint incidents
- **94.1%** of people dying in a place of their choosing
- **54.2%** of people completing IAPT treatment and moving into recovery

We had 43 falls in September, down from 45 in August. We continue to investigate all falls so that we can learn lessons and reduce risks.

We had **37** attributable pressure ulcers in September and continue to review all incidents to identify themes and learning.

We are inviting service users and carers to take part in a **community mental health survey** so that we can monitor the effect of the changes we made as a result of the coronavirus pandemic. This will help us to shape how we provide our services in the future. The survey is anonymous and available online.

With **all of us** in mind.

Improving care:
Our coronavirus related performance

As of 28 October:

- **There are currently 233 members of staff absent or working from home due to coronavirus. This has increased from 112 last month.**

- **151 members of staff are absent and 82 are working from home.** Of those absent, **none** are shielding, **45%** are symptomatic, **27%** have household symptoms, and **2%** have been advised to isolate by occupational health

- **We've processed 2,677 swab test results for staff and household members**, with **290** of these testing positive and **2,387** testing negative.

As of 20 October:

- **148 service users have been tested** on the wards. This is **23** more than last month. **38** of which were positive. Of these, **30** have since recovered**.**

- **Occupational health have taken 1,780 coronavirus calls.**

During the coronavirus pandemic the **Mental Health Museum** went online and offered access to its resources digitally. This included the sharing of 'lockdown stories' on social media. This involved people sharing their experiences and tips on how to stay well.

With **all of us** in mind.

Flu clinics
Now available for frontline staff

NHS South West Yorkshire Partnership NHS Foundation Trust

We're receiving a phased delivery of our flu vaccines. This means we are currently prioritising frontline staff in face to face contact with service users at our clinics.

If you'd prefer to have your jab at your local GP surgery, pharmacy or supermarket, we will reimburse you for the cost up to £20. **Let us know if you do, as your jab will still count towards our 'have a vaccine, give a vaccine' total.**

Clinic dates are on the intranet

It's back for 2020/21!
Have a vaccine, give a vaccine

For every member of staff who has a flu jab, we'll donate one life saving vaccine to a child in need through UNICEF.

Flu fact: It is impossible to get flu from the having the flu jab because the vaccine doesn't contain live viruses.

With **all of us** in mind.

Improving care
CQC update

CQC inspection activity
The CQC will be focusing on:
- A strengthened approach to monitoring
- Use of technology and keeping people connected
- Targeted inspections focused on concerns rather than routine planned inspections
- Continued mental health visits to inpatient units via remote working

CQC inspection of East Kent Hospital University Foundation Trust
The CQC conducted an inspection at William Harvey hospital in Kent in August. They found that staff were not wearing PPE properly, were not using hand gel, washing their hands properly and not adhering to social distancing guidelines. They also found large numbers of staff in small rooms. The hospital were asked to make 'significant improvements' and received an 'inadequate' rating.

CQC strategy
The CQC are doing some transition work in preparation for their new planned strategy and regulatory approach which will be implemented in April 2021. We have taken part in engagement events to contribute our views on the planned strategy.

Provider collaboration reviews
The CQC have completed their first 11 provider collaboration reviews. The next reviews around urgent and emergency care have now commenced and will then be followed by learning disability and autism, and mental health

A new resource tool on **'Patient First'** has been published, showcasing good practice.

Improving resources
Our finances in 2020/21

	Performance Indicator	Year to date	Forecast August 20
1	Surplus / Deficit		
	Covid-19 reimbursement	£3m	
	Top Up	£3.4m	
	Reported position	£0m	(£2.1m)
2	Agency Cap	£3.2m	£7m
3	Cash	£57.5m	£34.9m
5	Capital	£0.7m	£5.6m
6	Better Payment		
	30 days	97%	
	7 days	82%	

September is the final month when covid-19 cost reimbursement and a central top up will be provided retrospectively. For the year to date these claims equate to £6.4m in total, with £0.5m for covid-19 and £1.2m additional top up claimed in September.

Our pays costs are over £1.5m higher than they were last year with the equivalent of 200 more staff in place than one year ago

We have submitted a financial plan for the rest of this year showing a £2.1m deficit. National financial arrangements have been updated and we all have expenditure budgets we need to meet. Funding required to respond to Covid-19 is still available and being agreed by OMG.

Cash in the bank continues to be above plan largely due to the timing of block income payments (which are a month in advance).
A revised capital forecast for 2020/21 has been agreed taking account of current capital priorities and the impact of covid-19 on accessibility and costs. This has reduced the forecast by £1m.

82% of invoices have been paid within 7 days.

Improving care

FIRM risk assessment tool – more training dates available

NHS South West Yorkshire Partnership NHS Foundation Trust

The majority of services moved from the Sainsbury risk assessment tool on SystmOne to the formulation informed risk management (FIRM) on 28 September 2020.

Some specialist services such as forensics and ADHD move to the new tool on Monday 26 October.

To support the roll-out of the tool, we have FIRM champions in all BDUs alongside:

- A user guide
- Frequently asked questions (FAQs)

Virtual training is also available, with initial training running from 24 August until early October. New training dates have now been added for November. To find out more, visit the new FIRM intranet page.

Once the FIRM tool goes live in a service, previous Sainsbury's risk assessments will be available as read only. All new risk assessment must be completed using the new FIRM tool.

Any further requests for support should be made via the service desk.

With **all of us** in mind.

A great place to work
NHS staff survey 2020

NHS South West Yorkshire Partnership NHS Foundation Trust

Every year we listen to your views via an anonymous national staff survey. The survey asks for feedback about your job and working for the Trust. We use this information to help make the Trust a great place to work for everyone.

The 2020 national NHS staff survey launched on 5 October. It closes at 5pm on 27 November.

Most staff will have been invited to complete the 2020 survey by email. A small number of staff (who don't have regular access to email) will have received a paper version.

This is a national survey that we must take part in as a provider of NHS services. It's different to the Trust's wellbeing at work survey - which we choose to run - and asks a broader range of questions.

The survey is completely confidential and is overseen by the Care Quality Commission. Got a question? Visit the intranet.

With **all of us** in mind.

A great place to work
Priority updates

This month general staff sickness is **3.9%**. Turnover is **8.9%.** Remember there's support for **#allofus**

WorkPal e-appraisal
All staff are expected to have an e-appraisal by the end of December. So far 1,889 staff have registered on the system, 803 have completed a self assessment, and 144 have completed the full appraisal. For more info read our FAQs or watch one of the training films on the intranet.

Our **BAME staff network** held a virtual celebration event in October to mark Black History Month and celebrate the achievements of the network over the past year. They have also nominated new members of the **steering group**. More information is on the intranet.

October is **Black History Month** and staff have shared their personal stories and views on how improvements can be made to support black colleagues. So far Charlene Sibanda, Jacob Agoro, Evelyn Beckley, and Noma and Nomagugu Ndlovo have told their stories and shared their views. You can read all of the stories on our website.

Thank you to everyone who took part in the **Wellbeing at Work** survey and the subsequent listening events. This will help us further develop our Great Place to Work actions.

Improving care
What we can do to stay safe

#allofusimprove
and be outstanding

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

We all have a part to play in keeping ourselves, our colleagues and our service users safe and well.

The coronavirus pandemic has led to unprecedented demand on health and care services and has created substantial challenges for our staff. The response by our staff to the pressures and challenges posed has been fantastic and we should all be proud of what we have achieved.

Our Executive Trio and Staffside have written to remind us of our **professional responsibilities** and the impact of safety breaches. Not only can breaches have an impact on the health and wellbeing of our service users, it can impact on our professional accountability and could have repercussions. Take a look at the full letter on the intranet which includes information on what we can all do to help stay safe and promote good health.

We have also produced some updated guidance on **staff meetings and face to face contacts**. With the infection rate growing we should avoid staff meetings taking place face to face, and instead use digital tools wherever possible. This will help us to stop staff to staff infections. The full advice can be found on the intranet.

Information on the safety measures we have in place can be found on the intranet.

With **all of us** in mind.

Coronavirus update
What you can do to help

#allofusimprove and be outstanding

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Make sure you follow **social distancing** rules at work and in your day to day life; and don't exceed the occupancy numbers shown on the doors in Trust buildings.

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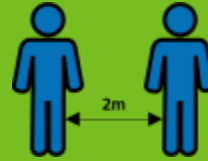
Download the NHS Covid19 Test and Trace App and make sure you turn it off when you arrive in work. It isn't designed for healthcare workers to use in healthcare settings.

We have changed the symptoms that we are now testing on. Have a look at the intranet to see the expanded list. If you, or someone you are close to develops **symptoms** book a test as soon as you can. You can find details of how to get a test on the intranet.

Keep yourself **up to date** by visiting the coronavirus pages on the intranet and download our Staff App to get updates on your phone.

Support your own health and wellbeing by taking **annual leave** and **socially distanced breaks** whenever you can.

Continue to **wash your hands** and use hand sanitizer when you need to.

And to help keep you and your loved ones safe, have your flu jab.

With **all of us** in mind.

Coronavirus
Recovery and stabilisation update

While the coronavirus pandemic continues we need to ensure that we can still deliver our core services as best we can. Our recovery work runs along with our business continuity plans to ensure we can balance the needs and expectations of local people.

Progress to date:

- The recovery planning framework and supporting toolkit has been developed in collaboration with the nursing, quality & professions directorate and shared widely for use across the Trust.

- Applying the toolkit, service level recovery plans are now established across the Trust to respond to identified need and sustain capacity to respond to ongoing management of covid19.

- We have developed an 'Equality, involvement, communication and membership strategy', embedding phase 3 and the People Plan asks in its content.

- All change is underpinned by a structured quality improvement approach involving people as close to the front line as possible, supported by planning and information management.
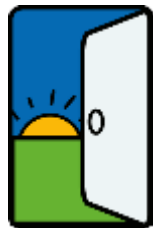
With **all of us** in mind.

Coronavirus
Recovery and stabilisation update

#allofusimprove
and be outstanding

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Next steps:

- We are using the insight gained from service users and our staff feedback to identify gaps to help shape the recovery of services.

- We are forming links to district health intelligence discussions to progress forecast modelling for mental health services.

- We continue to be involved in collective conversations with partners to shape a system response to coronavirus pressures.

- The safety and wellbeing of our staff and service users is paramount. We continue to progress recovery where it is safe to do so and reinstate business continuity plans as required by service need.

With **all of us** in mind.

A great place to work
Support when you need it

Remember that we have support available for all of us.

Our **occupational health** team have a dedicated phone line for general advice around coronavirus. You can contact the team on **01924 316036** (Monday-Friday, 8am - 4pm). Counselling is also available for self referral on **01924 316031**.

Our HR **telephone helpline and email account** for coronavirus enquiries is open Monday-Friday between 8.30am-5pm. The number is **07824 801649** and email is **COVID19-HR@swyt.nhs.uk**

Book your staff health check and start your journey to better health
Occupational health is resuming their staff health check programme with strict safety procedures in place. More details are on the intranet.

Our **pastoral and spiritual care service** have a confidential phone line for patients, carers and staff. It is available Monday to Friday between 9.30-10.30am and 2-3pm. The number is **01924 316341.**

You can also contact the national **#OurNHSPeople** phone line on 0300 131 7000 (7am – 11pm). There are online resources available https://people.nhs.uk/

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Put safety first always and keep the person at the centre of everything you do.

Help to stop the spread of the virus. Practise good hygiene, wear a face mask and practise social distancing.

Know what the rules are where you live and work, and how this impacts on what you do

Help us to make the Trust a great place to work by completing your NHS staff survey

Be careful when dealing with data and information. Check all information before you send it out.

If you haven't done so already, take the self assessment and book in your e-appraisal

Help us to keep everyone safe and well. Have your flu jab as soon as you can.

Visit the intranet regularly to keep up to date and informed.

What do you think about The Brief? comms@swyt.nhs.uk

Thank you to everyone for your response so far.

Keep doing the right thing.
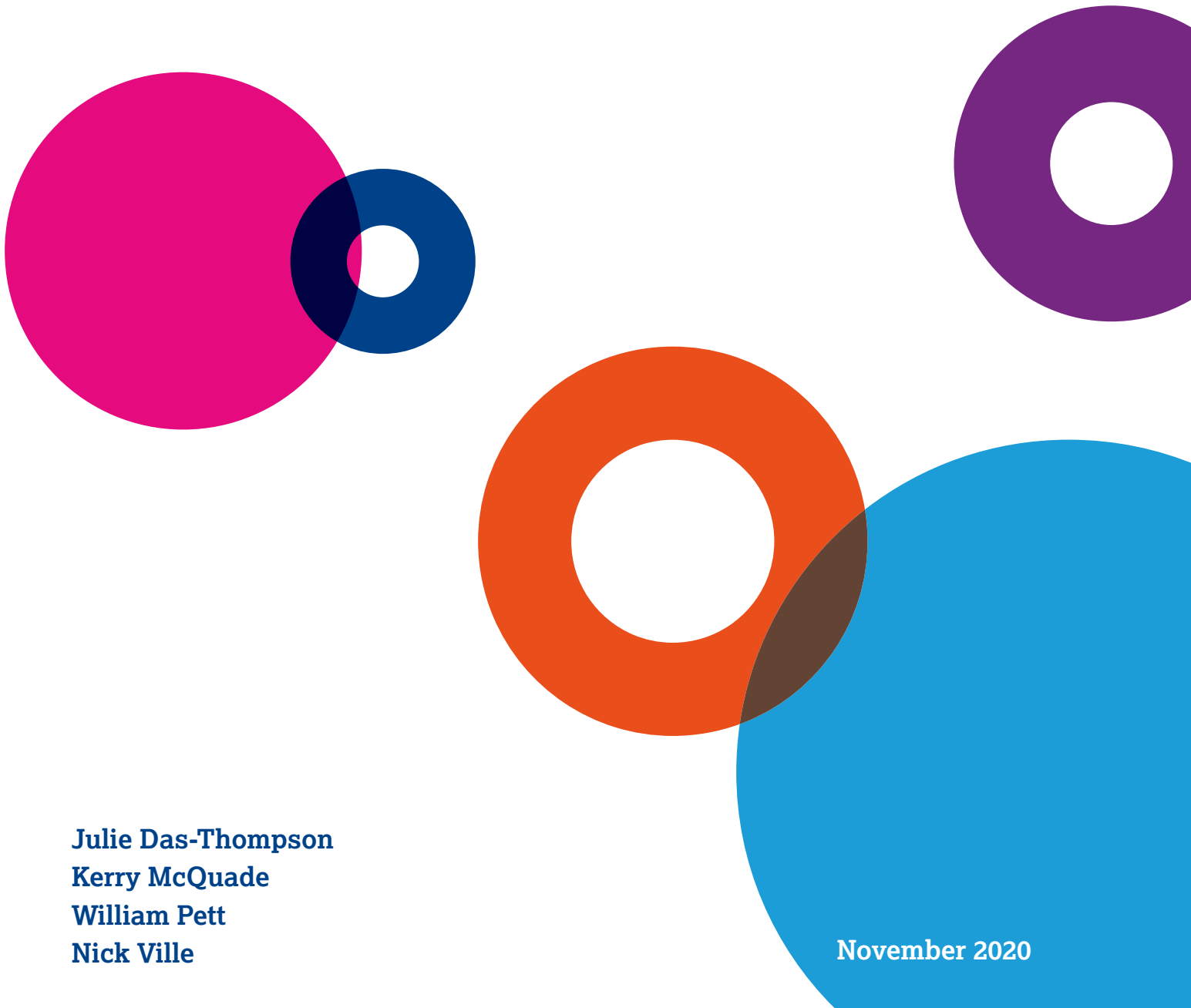
With **all of us** in mind.

Cascading the Brief

Thank you for joining us for the Brief broadcast.

Cascade of the Brief face to face is not possible in your teams at this time. Please use the technology available and be creative.

Thankyou!

The future of integrated care in England

Health leaders' views on how to make system working a success

Julie Das-Thompson
Kerry McQuade
William Pett
Nick Ville

November 2020

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

To find out more, visit www.nhsconfed.org and follow us on Twitter @NHSConfed

Key points

- Over the coming 12 months, the government is expected to table new primary NHS legislation for the first time in nearly a decade. It is anticipated that this will set out a legal framework through which NHS organisations will continue to work together and with others as integrated care systems (ICSs), to deliver the ambitions of the NHS Long Term Plan

- To support the development of new policy and legislation relating to the future of systems, the NHS Confederation has undertaken an extensive six-month engagement process with our members across England. This has included a series of roundtable events with the many different stakeholders across our English membership, a consultation with systems and a cross-member survey.

- The results of this engagement process gave many insights into the extensive progress that has been made with system working over the last five years and the ambition for the future. It is clear that there is a strong appetite among our members for strengthening system working and embedding it permanently into the architecture of the health and care system. The pandemic has reinforced this view further, as the importance of working together has been all too evident. Therefore, any proposed changes to the national policy and legislative framework must build on what has been achieved and support systems to develop further. With this in mind, we believe a future framework for ICSs should be structured around two key pillars:

  1. **That ultimately ICSs should be given a statutory footing through legislation. We are clear, however, that whatever form ICSs take they must embed partnership working and recognise the key role that local government, independent and charitable providers, voluntary sector organisations and community representatives must play in systems alongside NHS services.**

That said, the NHS Confederation considers that more time is needed to work through a number of practical questions about how best to do this and build more agreement about the way forward. For instance, one model that appears to have support among some of our membership is one of statutory partnerships supported by a strong executive team. Local organisations also need time to adjust and work up local ways of working in advance of any new statutory framework. Hence, we would suggest ICSs are introduced in shadow form for a significant period of time before they are given statutory footing.

There is a strong sense among our membership that there should be greater joint commissioning of health and care, however this should not be mandated through a statutory framework. We believe that it should be made as easy as possible for health and care services to be commissioned jointly should they wish to, but forcing them to do so through legislation would be counter-productive in areas where there is little history of joint working.

2. **To incentivise greater joint working across health and care services, a new statutory duty should be introduced on all partners within systems (including local authorities) to deliver against shared objectives. For example, this could centre around health inequalities or some variation on the 'triple aim' set out in the NHS Long Term Plan.**

Our survey found that 8 out of 10 members support the creation of a shared statutory duty on system partners. This shared duty would seek to build on existing partnership working to develop a sense of shared accountability for improving population-level outcomes. A duty of this nature would have implications for foundation trusts. While we do not believe that the foundation trust model should be fundamentally changed, members tell us that a new statutory duty would help clarify expectations of foundation trusts in system working.

- **Any new measures to strengthen system working must be accompanied by radical reform of the current model of NHS oversight. Our members were clear that ICSs need much greater autonomy and head space to focus on delivering what local communities need.** This is not an argument against having clear national priorities and accountability for the NHS, but for oversight to support local solutions and to be outcomes focused, proportionate to each system, risk based, and grounded in the principle of self-directed improvement. The recent pandemic illustrated that when the regulatory burden was reduced, local leaders innovated at speed and developed more agile ways of working. We need a lighter, leaner oversight model to be inbuilt into the NHS that permanently unleashes this energy and creativity.

- The rest of this report explores these issues in more detail and makes further recommendations about the changes to national policy and legislation that might help. We start in section 1 by setting out the views of our members on the purpose of ICSs and then move in section 2 to examine what specific policy and legislative changes they believe might help ICSs to deliver these objectives. And in section 3, we begin to explore what wider enablers the government and NHS England and NHS Improvement (NHSEI) should consider to support system working in future. Where there is general agreement on the direction of travel by all parts of the NHS, we have set that out. But, we have also been transparent about the areas where support is less strong or opinion is divided. Clearly there is more to do in these areas to work though the issues and narrow down areas of difference. Hence, we would encourage the Department of Health and Social Care (DHSC) and NHSEI to make an early start on developing a workable and comprehensive set of specific proposals and to engage with all system partners to draw on their views and expertise.

Introduction

For decades, across successive governments, the legislative framework governing health and care in England has centred around the principle of competition between organisations to improve the quality of services. Yet there is now wide recognition that we need to look to collaboration and integration to improve population health, deliver better quality care, and make more efficient use of resources.

The NHS Confederation welcomes this shift. For too long, the NHS and local government have had to work within an environment that has encouraged the fragmentation of services and a culture of working in siloes. This, in turn, has left us with a landscape that is confusing for patients and insufficiently responsive to the health and wellbeing needs of local communities.

The recent experience of coping with a pandemic has further reinforced the importance of this move. COVID-19 has proven to be the greatest challenge that NHS and local government services have faced in their history, requiring extraordinary efforts from staff across the health and care sector. However, the pandemic has also demonstrated what can be achieved when we move away from individual organisations working in silos and towards true collaborative working within systems. As the NHS Confederation set out recently in NHS Reset: A New Direction for Health and Care, many of the solutions developed in response to issues such as PPE and resource shortages, patient discharge and community outreach have centred around collaboration and partnership working across primary, secondary and community services, and with local government and community partners.

In the words of one executive lead of a system: "We have seen transformation that many people have wanted for ten or 15 years!"

With new legislation expected over the coming 12 months, there is a real opportunity to embed the collaboration we have seen in recent months across the health and care sector in England. The NHS Confederation has therefore sought to gauge health leaders' views on what a future policy and legislative framework for system working should look like.

To do so, we have had an extensive period of engagement on the future of systems with our membership. This has included a cross-member survey that asked a series of questions relating to the principles, objectives and functions of ICSs and how they should help to deliver the ambitions of the NHS Long Term Plan. We have also conducted qualitative engagement with leaders from all parts of the NHS through roundtable meetings and webinars. This has allowed us to understand the nuances of where different stakeholders stand on issues relating to system working and what their fundamental concerns are. Put simply, this report is the culmination of six months of listening.

At the time of writing, our members are set to face some incredibly difficult months ahead, with a second surge in COVID-19 cases adding to existing winter pressures. As ever, the first priority of services must continue to be to meet the health and wellbeing needs of the public. However, with a new model of system working having the potential to significantly improve the capacity and efficiency of health and care services, it is vital for our members that we get it right.

Methodology

To gain a clear understanding of the views of our entire membership on issues relating to system working for this report, we conducted several different methods of research.

In June 2020 we hosted an online event for leaders and chairs of ICSs and sustainability and transformation partnerships (STPs). We undertook live polling at the event and produced a report, [Time to be Radical? The View from System Leaders on the Future of 'System by Default'](). Since then, we have carried out a member survey through August and September 2020, including a series of questions relating to the future of system working. We received 252 responses from NHS leaders across all parts of the health system: hospital; mental health; community and ambulance service trusts; clinical commissioning groups (CCGs); primary care networks (PCNs); and STPs and ICSs.

We also conducted qualitative engagement with leaders from all parts of the NHS through roundtable meetings and webinars. This has helped to reveal not just where NHS leaders stand on issues relating to system working, but crucially why they hold certain positions. Those who have contributed to the research in this report include NHS Clinical Commissioners, the Mental Health Network, NHS Employers, the PCN Network, the ICS Network and the NHS Confederation's equality, diversity and inclusion groups. Bespoke sessions have also been undertaken with providers, programme directors of provider collaboratives, CEOs and chairs.

Finally, the Confederation's ICS Network distributed a discussion paper to all systems asking for detailed responses on different aspects relating to 'system by default.' This enabled us to gain a clear picture on where there are areas of disagreement between systems in different areas, in turn allowing us to develop policy asks that address, and try to bridge, competing perspectives across systems.

1. The principles of system working: what are we trying to achieve?

The success of ICSs will rest on whether they deliver clear benefits for the public in their local communities. It is therefore important to be clear from the outset about what ICSs are seeking to achieve, so that energies are focused on the task at hand and people are brought together around a shared endeavour. Without this, there is a risk that ICSs will in time be consigned to a long list of failed reorganisations in the NHS that did not realise the ambitions of their creators.

Locally, many systems have already articulated the outcomes they are seeking to achieve for their populations. Building on this emerging consensus, we tested a question in our member survey defining four purposes of ICSs, with respondents invited to agree, partially agree, disagree or state that they didn't know. Overall, 8 out of 10 agreed or partly agreed with the purposes of an ICS that we set out. In particular, there is a strong preference for ICSs to address the wider determinants of health in partnership with local government. Those who felt the definition of the purposes of ICSs was not quite complete suggested other purposes that they felt we had missed. The most common among these was that systems should have a role in improving the allocation of finance and resources, given their ability to oversee a large geography of services. As such, we'd suggest this should be included as a fifth objective.

Example responses from individual members:

" We feel that the core role of ICSs should be to integrate health, public health and social care but with a clear focus and strong links to key partners on working together to tackle the wider determinants of health, in particular recognising the impact of deprivation on health outcomes. We feel that the ICS should engage with housing, education, police etc on shared initiatives that impact on health or where health can support other partners, and that much of this would in practice happen at the ICP/place layer of the system rather than at the ICS."

" In considering the purpose of an ICS, local government should be considered equal, core, fully participating founder members of the ICS, not something the ICS decides to 'adopt.' We would want a strong relationship between health and local government anchored in s75 agreements (and building on long history of strong formal partnership working) and so forth, but not structural integration."

" An all-inclusive approach is needed to tackle health inequalities and improve health outcomes. The practicalities on integration require working at an ICS level and an ICP level."

" Imagine the possibilities when you bring a devolution agenda together with an ICS agenda. The difference you can make to local communities cut across economic growth, health and prosperity."

Therefore, there seems to be general support for the purposes of an ICS to be summarised as follows:

> **The purpose of an ICS is to deliver tangible improvements in five areas:**
>
> 1. Overall health outcomes for their population.
>
> 2. The reduction of health inequalities through a targeted, evidence-based approach.
>
> 3. The integration of primary, community and secondary services, physical and mental health services and health with care.
>
> 4. The quality of health and care services and the reduction of unwarranted variation.
>
> 5. Efficiency in how funds and resources are allocated.

In the next section we go on to consider the specific policy and legislative changes members consider might help ICSs to deliver these objectives.

2. How should systems evolve further to deliver these objectives?

Most of the work to develop system working has necessarily been led locally. Much has been achieved through closer working relationships and developing new ways of working that promote integration and tackling shared issues and problems. This process has developed organically over the last five years through a combination of local collaborative clinical, professional and political leadership and a change in the direction of national policy.

However, there is a strong sense among our members that it is now time to consolidate this shift and embed system working permanently into the architecture of the health and care system. How best to do this is not straightforward and views are emergent in parts.

In this section we set out what our members have told us about how national policy and legislation could help systems evolve further and deliver against the ambitions stated in section 1. First, we outline two recommendations that would support the overall delivery and success of ICS objectives: that ICSs should ultimately become statutory bodies that embed partnership working within them, and a new statutory duty should be introduced for all partners within systems. As we will outline, many of the issues relating to system working could be addressed through these two recommendations.

We then explore individual objectives in more detail, proposing some more specific recommendations about how systems should develop further to deliver against them.
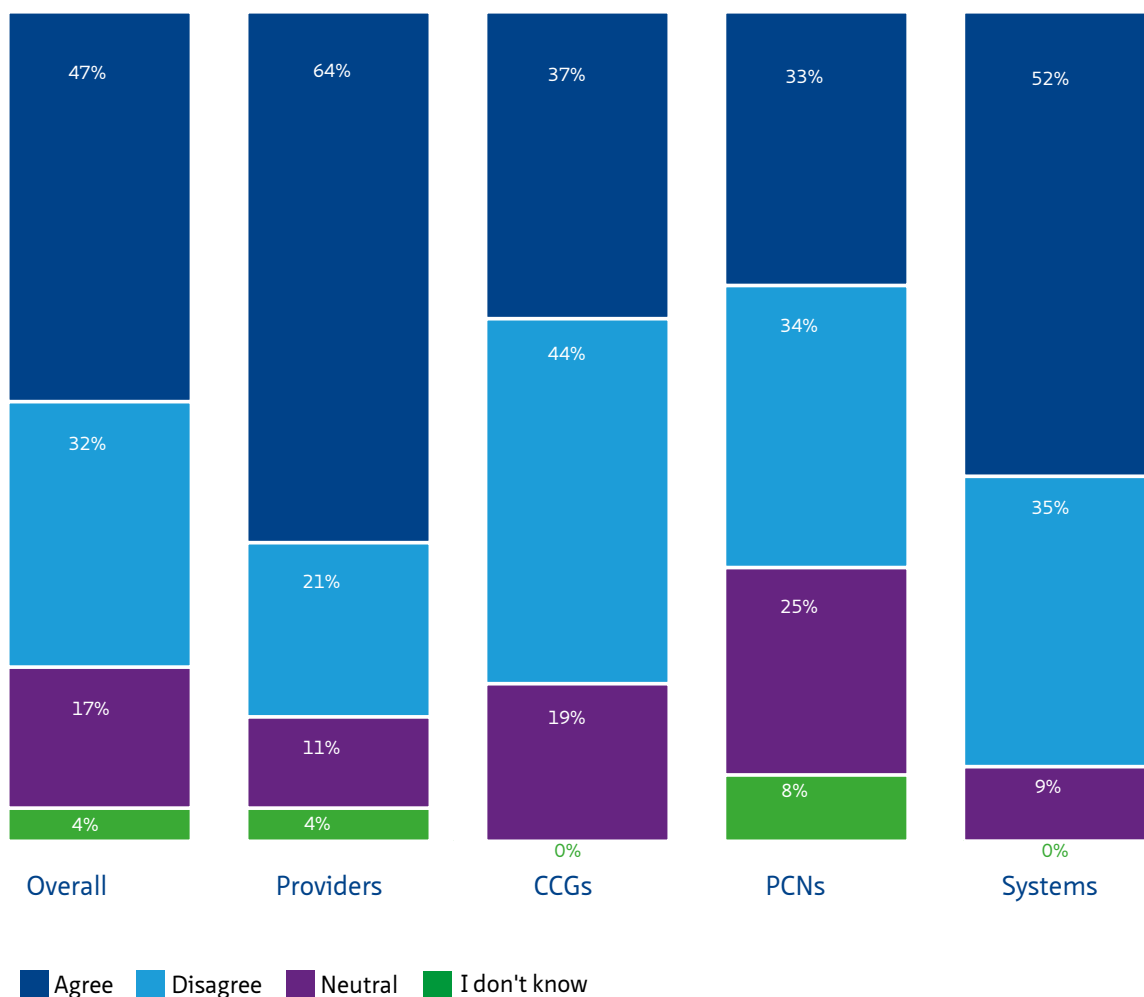
i) The two pillars of a new model for system working

A statutory footing for ICSs that embeds partnership working

Our members are clear that at their heart, ICSs need to enable partnership working where the system 'serves its constituent parts' and its population's needs, and not build a hierarchy of authority. This respects the existing core responsibilities and accountabilities of the partner organisations whilst also acknowledging the need to work together to deliver integrated services to meet the needs of the local population.

Through the survey of our membership, we tested the notion of systems becoming new statutory bodies. While overall this showed significant (but not overall majority) support, there is variation across different stakeholders within our membership:

ICSs should be set up as new statutory bodies and the commissioning functions of CCGs incorporated into them, effectively ending CCGs in their current form.

	Overall	Providers	CCGs	PCNs	Systems
Agree	47%	64%	37%	33%	52%
Disagree	32%	21%	44%	34%	35%
Neutral	17%	11%	19%	25%	9%
I don't know	4%	4%	0%	8%	0%

Legend: Agree, Disagree, Neutral, I don't know

In the qualitative feedback we received from those who were unconvinced, three issues became clear. First, there was uncertainty around what form a statutory body might take, and this uncertainty influenced support for this proposal. Second, our members are concerned about the potential disruption of another top-down NHS reorganisation. And third, many are concerned that if ICSs were to be created as new NHS organisations, then they would not enable the input and investment of time, resources and enthusiasm from the local government, community and voluntary sectors that will be crucial if systems are to achieve the objectives laid out in section 1.

Given the growing appetite for formalised system working, but in light of the above concerns, we would therefore recommend that ICSs are established as statutory bodies but on the basis that they facilitate and embrace partnership working across the wide range of organisations involved in health and care. This will ensure that ICSs remain bodies that are driven by the expertise of stakeholders across health and care and are not simply a delivery arm for the NHS.

There should be an open and transparent consultative process with all partner organisations across health and care in the coming months to determine exactly what such bodies should look like in practice. There are various potential approaches that could be taken to embed partnership working through legislation. For example, one model that some of our members have already indicated support for would be to set up ICSs as statutory partnerships. Whichever form they take, we believe ICSs should be supported and enabled by a strong multi-disciplinary executive leadership team and associated support functions.

The NHS Confederation would encourage DHSC and NHSEI to develop their thinking and ideas on the way forward as soon as is possible, so that we can make a collective early start on addressing these issues. However, we will stress-test any government proposals against the aspirations and concerns identified by our members as outlined above and discussed further below.
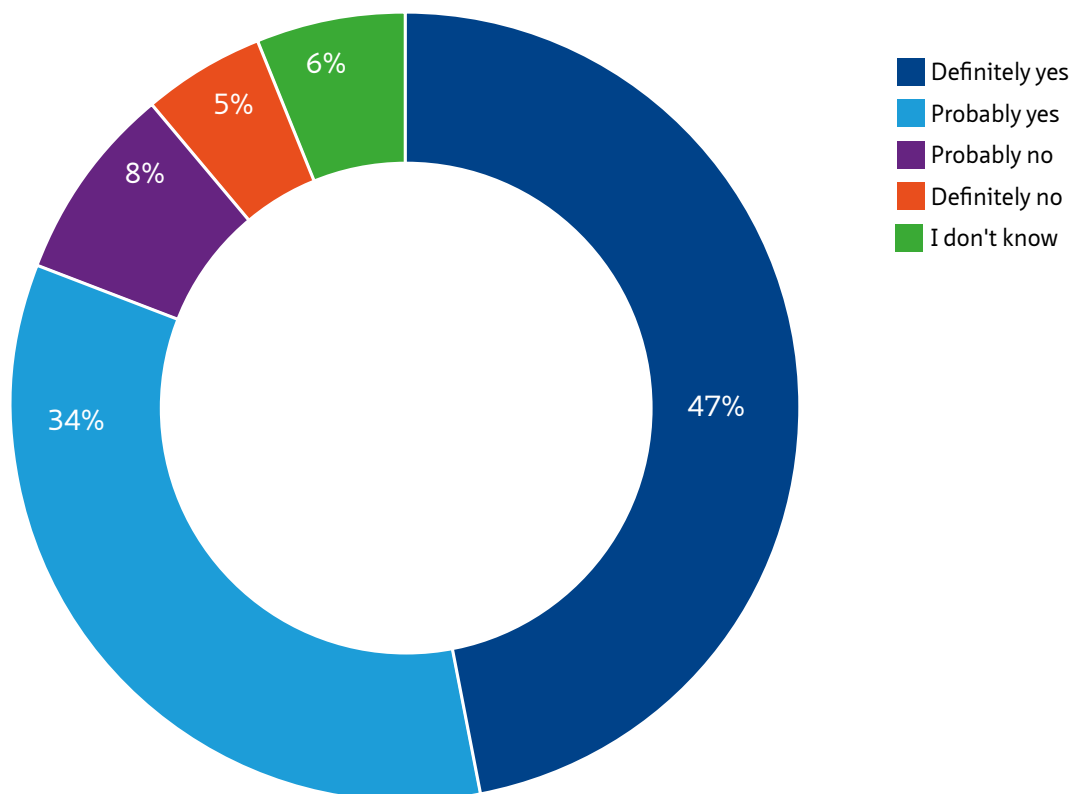
Recommendation

 ICSs should ultimately become statutory to fulfil the purposes for which they have been created but this must embed an inclusive model of partnership working with a wide range of stakeholders.

A shared duty on system partners

Many of our members have identified that in their system it has not always been possible to reach agreement and make the progress needed on shared issues. Historically, poor relationships are often cited as the central cause and where it is not possible to overcome this problem, more formal powers are needed.

To support stronger collaboration, we tested, through our member survey, the statement that there 'should be a shared statutory duty on all partners within ICSs to deliver the triple aim set out in the NHS Long Term Plan.' This was first proposed by NHSEI in its recommendations to government for an NHS bill.[1] There was very strong support for this, with 8 out of 10 members supporting the creation of a shared statutory duty.

The NHS Long Term Plan sets out a triple aim to give CCGs and NHS providers shared new duties to promote the triple aim of better population health, patient experience, and financial sustainability. Do you think there should be a shared statutory duty on all partners in ICSs to deliver this triple aim?

- Definitely yes
- Probably yes
- Probably no
- Definitely no
- I don't know

47%
34%
8%
5%
6%

[1] The NHS's Recommendations to Government and Parliament for an NHS Bill, NHSEI (2019).

The survey question we posed to members asks about a statutory duty in relation to the triple aim, and this is in keeping with what NHSEI has already proposed. However, NHSEI and government may want to consider alternative shared duties too. Some of our members are concerned that the language around the triple aim is very NHS-focused and that a focus on reducing health inequalities and improving population health may be more appropriate for uniting NHS, community, voluntary and local government organisations. It may be that health inequalities are weaved into the 'better population health' component of the triple aim. Another alternative is that the shared statutory duty on system partners mirrors the purposes of a system that we set out in section 1.

Whichever approach NHSEI and the government pursue, our members are clear that some form of shared statutory duty between partners would support a sense of mutual accountability, would incentivise joint commissioning (as we outline in more detail later in this report) and should become a fundamental pillar of future system working.

Recommendation

There should be a shared statutory duty on all partners within systems, including local authorities, that incentivises both commitment to system goals and joint working between partners.

ii) Objective – To improve population health and wellbeing and reduce health inequalities

The important role that commissioning can play in supporting improvements in the health of the population, reducing health inequalities, and preventing illness has been long understood.[2] Yet in practice the traditional view of commissioning in the NHS has been focused on transactional activity between commissioners and multiple providers in the form of routine procurement and contract monitoring. Our members have told us that system working provides a unique opportunity to reposition commissioning as a set of strategic functions at ICS level in keeping with this original intent. These should specifically concern population health, planning, outcomes commissioning and resource allocation. Yet it is also about facilitating new behaviours: collaboration, partnership and shared responsibility.

Evolving commissioner functions to a more strategic level could ensure that the technical expertise of commissioners to plan for different

[2] Purchasing for Health John Ovretveit 1995

populations is used to best effect. In practical terms, CCGs are on a journey, a period of transition where they are merging or establishing joint committees to increasingly work at scale. They are also in the process of streamlining their commissioning functions, agreeing which are undertaken at a system level and what can be more meaningfully done at a smaller population size – either place or neighbourhood. CCGs are increasingly having to balance the demands of their statutory duties with newer system functions. Our NHS Clinical Commissioners (NHSCC) network has developed a support aid for CCGs to support them in this task, titled [Creating A New Normal for CCG Business as Usual: Preparing for System by Default in 2020/21](#).

One of the key questions for the future form of ICSs is whether this strategic commissioning function as it emerges should be brought together with the current executive leadership capacity of ICSs. We tested this within our member survey, as shown above. While many are supportive, there are clear concerns among some networks within the NHS Confederation. This may be because the scale of an ICS is perceived to be too big for the planning of primary care provision (particularly general practice), with CCGs seen as a more viable footprint at place level. Notwithstanding that CCGs were established with a defined membership of GP practices, many systems reflected that maintaining a strong local link with primary care, to ensure its integration to the wider out of hospital care offer, will be critical as CCGs merge.

There are also several other issues that remain unresolved about the future of CCGs:

- There are concerns about the 'loss of place' with the merger of CCGs. In particular, this came through our conversations with local government stakeholders, who value place-level working with CCGs via existing partnership structures such as health and wellbeing boards (HWBs). The combination of political and clinical leadership in times of crisis or to make difficult decisions around service design has proved invaluable for some local areas.

  A good example of this can be seen in Greater Manchester's COVID-19 response, where a combination of local authority and CCG leadership led to a [rapid policy](#) of testing patients for COVID-19 prior to discharge to care homes, created a £500,000 COVID-19 recovery fund for the voluntary and community sector (VCS), and joint work to respond to the disproportionate impact of COVID-19 on different communities in the city.

  It is clear that as CCGs merge there needs to be a system-level consideration of the local government footprints involved to avoid

local authority partners perceiving these mergers as harmful to localised decision making, i.e. by 'taking it up' to an ICS. While there are only 44 STPs and ICSs, there are several times more local authorities currently delivering public health and adult social care functions. To support CCGs to work this through at a local level, NHSCC and the Local Government Association (LGA) have developed a toolkit for CCGs.

- We have also heard mixed views from members about moving to a one CCG and one ICS footprint. In some systems, having a one-to-one arrangement works and clearly makes sense due to the coterminosity of the local authorities and those provider collaborative boundaries operating at place level. However, for others it may not work because the proposed ICS has a large geography and/or large population. The move to one CCG per ICS is a positive ambition, but some flexibility is needed on how it is applied if there is a strong local rationale to do so. Furthermore, it should be local decision-makers who determine the size and footprint, not a top-down, one-size-fits-all edict.

- Another area to work through will be the role of specialised commissioning for system working. Some ICSs will have the scale, patient flows and appetite to take on the commissioning of some specialised services, others will not. The key to making this work is finding an enabling national framework for delegation which gives areas the flexibility to decide their role, possibly using population size as a guide.

With a variety of views about the way forward, more time is needed to work through these issues and for CCGs to work in partnership with ICSs and their local partners to do this. This includes the design and move to strategic commissioning, building on existing joint committees, merging CCGs, supporting the development of PCNs, work with provider collaboratives, helping develop system strategies, removing or moving transactional functions to integrated care partnerships (ICPs) and acting as the legal conduit for funding to flow to the system.

The process of moving to ICSs in statutory form must not be rushed and so we would suggest that they are run in shadow form with new arrangements for a significant period before being formalised as statutory. This will allow partners within systems and executive teams the time that they will need to sufficiently prepare for what may represent a significant culture change in many areas.

> **"** In the interim [until statutory footing] we could use the CCG shell/ wrapper. The reshape of CCGs into one across the ICS footprint helps and we can integrate the commissioning focus with the local authority and the delivery support functions within our delivery partnerships. Cost of any further significant change i.e. closing down CCGs, may be unnecessarily disruptive at this stage." **(A system lead)**
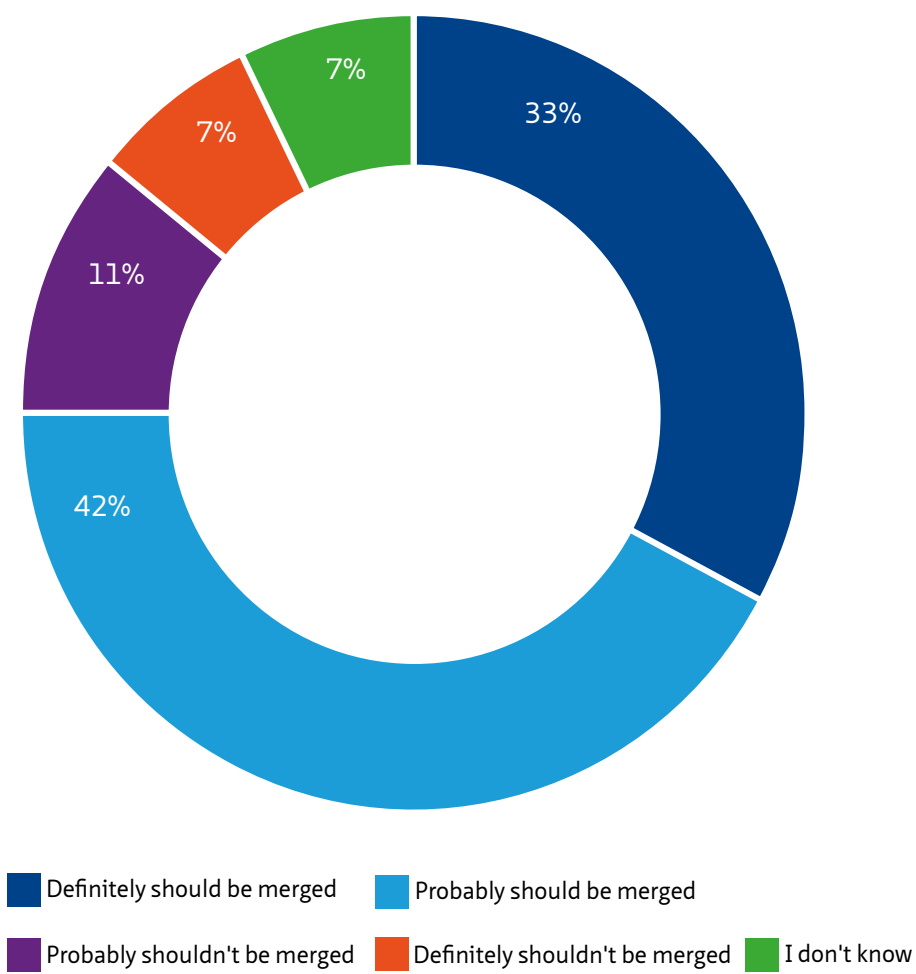
Recommendations

- **The process of moving to statutory ICSs must not be rushed and they should be run in shadow form for a significant period of time before they are formalised as statutory.**

- **CCGs should be supported over the next 18-24 months to transition key strategic functions to an ICS level.**

- **We advocate the move to one CCG per ICS as an ambition but there should be flexibility in how this is applied if there is a strong local rationale for a different approach.**

iii) Objective – To improve the integration of health, care and wellbeing

The recent pandemic has brought home the close interdependence of health, care and wellbeing. In our communities there is a vulnerable population of children, adults and the elderly who need person-centred co-ordinated services delivered by a wide range of health and care professionals. Our members have told us that they have a significantly increased appetite for close collaboration with local authorities on the delivery of health and care to these groups.

In our member survey, this was reflected in the extent of support for joint commissioning. Exactly three quarters believe that the commissioning of health and social care should 'definitely' or 'probably' be merged in some form. This is also reflected in the qualitative responses we received, which highlight that CCGs and local authorities were keen to align their commissioning strategies where it made sense. The preferred form that this should take was joint committees of the NHS and local authorities that respected the differing accountabilities but that planned services together.

Some people suggest that the commissioning of health and social care should be merged. Which of the following best describes your view on whether this should be the case?

- Definitely should be merged
- Probably should be merged
- Probably shouldn't be merged
- Definitely shouldn't be merged
- I don't know

Section 75 (s75) of the NHS Act 2006 already enables the NHS and local authorities to pool budgets and commission jointly. However, there is a sense that the current s75 powers alone are not sufficient to incentivise integration between health services and local authorities. Almost 7 in 10 respondents believe local authorities and the NHS need more statutory powers to pool budgets and commission services jointly beyond the current s75 agreements.

Local authorities and the NHS need more statutory powers to pool budgets and commission services jointly beyond the current s75 agreements
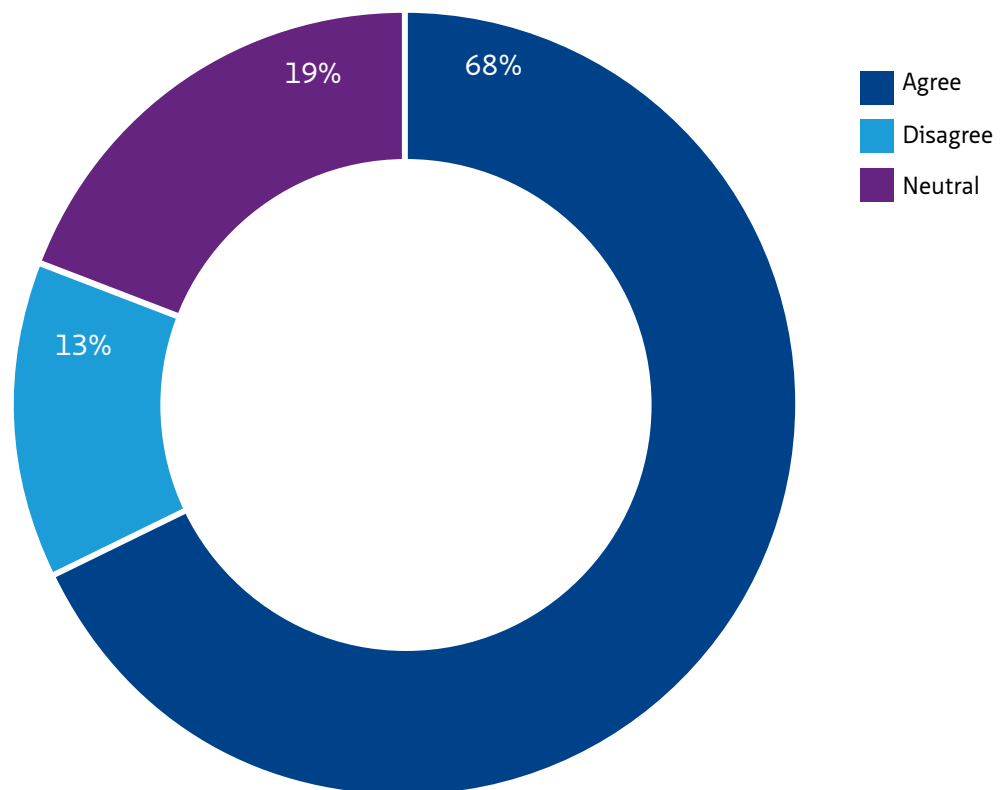
The qualitative responses suggested more exploration is needed of what constitute effective models of joint commissioning. There is also greater need to understand the art of the possible using s75 agreements, and specifically whether their limitations are real or perceived. Case study material of places that have successfully used s75 to enable transformative change would be helpful for promoting greater awareness of what is possible.

Beyond the above there is appetite to facilitate closer joint working by incentivising the right organisational behaviours. As we outline above, the government could consider introducing a legal duty for all system partners to deliver against a shared goal (such as health inequalities) within their populations. This would ensure this is a priority for all and encourage more joint commissioning arrangements with local authorities.

> " The issue is how people are incentivised to lead and deliver together e.g. sharing risk, joint accountabilities and common purpose." **(A system lead)**

Importantly, the NHS Confederation does not recommend statutory integration of health and social care services. We believe that it should be made as easy as possible for health and care services to merge should they wish to, but forcing them to do so through legislation would be disastrous in areas where there is little history of joint working and would undermine the key role that local authorities play nationwide. There is much we could do to build on the mechanisms we already have to bring together the delivery of health and care services, including HWBs and their duty to promote integration and the Better Care Fund, which has seen CCGs and local authorities agreeing to share substantially more in many areas of the country.

> " It is our understanding that much can be achieved in developing and delivering high-performing integrated health and social care systems within current legislation. More fundamental to success is uniting partners behind a common purpose and creating the capacity, capability and resource (at every level of the system) for best practice care and optimal enabling infrastructure. Whilst more statutory powers for local authorities and NHS to pool budgets and commission services jointly (beyond s75 agreements) might be helpful, such legislation is not a guarantee of success." **(A system response to consultation)**

Finally, there is a strong sense across the NHS and local government that national policy and thinking on health and care needs to be much better aligned if closer joint working at local level is to become a reality. Government policy on devolution seems to take little account of the opportunities to devolve health and care responsibilities. The continuing extreme financial pressures on social care can also place a strain on local relationships and, most importantly, on effective coordinated service provision.

Recommendations

- **Strong relationships are critical for effective joint working with local authorities, but local systems need more support to develop effective models of joint commissioning.**

- **s75 powers for local authorities and the NHS to pool budgets and jointly commission services should be reviewed to see whether they need to be strengthened or alternative arrangements developed.**

- **To make s75 more accessible, good practice guidance and examples should be developed on the use of s75 powers to improve the integration of health and care.**

iv) Objective – To optimise the use of health and care resources

In meeting the needs of their local populations, ICSs need to come together to make decisions about how they can make best use of the collective resources they have available to them: money, people, infrastructure, knowledge and expertise. Our members have told us that the most effective way of working is through strong local relationships built around shared purpose and values. This needs time and investment to achieve but can make significant breakthroughs when relationships are mature.

As outlined, however, our members also tell us that more needs to be done in creating the right incentives and duties for partners to work together if we are to ensure that system working is embedded across health and care organisations.

Finance

Our members have broadly welcomed the development that systems are to direct the financial allocations for the second half of 2020/21, with funding tied to the performance of systems rather than individual organisations. This can act as an important incentive for all partner organisations to support the overall system. Longer term, systems – statutory or otherwise – should continue to have as much authority as possible over how their funding allocations are used. More work is needed to develop and embed this approach and greater involvement from our members is required.

The move towards system-wide funding has, however, been accompanied by concerns from some member groups about fair distribution. Specifically, there is a sense among some that finance has broadly followed an 'acute first' model at the expense of investment in, for example, primary, community and mental health services. We must ensure that in future the money 'follows the patient' and supports tools such as risk-share agreements to promote mutual financial accountability between partners.

Workforce

The direction envisaged by the forthcoming NHS People Plan accepts that, as the NHS Confederation has argued in Growing Our Own Future: A Manifesto for Defining the Role of Integrated Care Systems in Workforce, People and Skills, ICSs should be the default level for future workforce decision-making in health and care. They should be given greater capacity and influence over investment in the supply and development of local health and care workforce and have an improved ability to affect local labour markets. This would enable increased autonomy over the development of local system architecture, responsibility for managing strategic external relationships and, critically, control of dedicated funding streams. However, this should be subject to a consultation to allow stakeholders such as councils and social care providers the opportunity to offer their views on the notion of workforce planning across health and care.

> " We have seen that you can achieve real integration and a whole-system approach to service delivery when staff across health, social care and our broader caring communities, such as volunteers, personal assistants and carers, are able to work differently together around the needs of local residents.

> " So, it's clear that workforce transformation approaches that support integration must focus on all elements of this caring community. However, national policy does not consistently support whole-system approaches." **(Alison Lathwell, Bedfordshire, Luton and Milton Keynes ICS Strategic Workforce Transformation Lead, writing on NHS Voices)**

Creating opportunities to attract, train and deploy staff across a health and care system will support better workforce development, enhance service delivery and a focus for partners on the place rather than organisations. Tools such as the staff passport and widening access for online training can help, as will system-focused regulation processes.

Whilst systems should have autonomy over planning their workforce, there also needs to be recognition that there will be areas that need to be given particular attention and priority such as mental health, learning disability and community services, all of which have high vacancy levels and are fundamental to delivering the changes set out to transform the NHS as part of the NHS Long Term Plan. It is also important to recognise not all service providers fit neatly within a place and may cross multiple boundaries, for example ambulance services.

Finally, there will continue to be the need for national workforce planning and long-term investment in education and training.

Recommendations

- **ICSs should have increased autonomy and flexibility in how they use and direct funding. This would support and incentivise more innovative, efficient and collaborative working, for example alliance contracting and blended tariffs.**

- **ICSs should be the default level for future workforce decision-making in health and care. They should be given greater capacity and influence over development and deployment of local health and care workforce and have an improved ability to influence investment in supply and local labour markets. However, this should be subject to consultation stakeholders across health and care.**

v) Objective – To improve the quality of health and care services and the reduction of unwarranted variation

There are many ways in which systems can work to improve the quality of services and reduce unwarranted variation. However, it is generally understood that health and care services deliver the best outcomes when they are planned and delivered at the most local level possible and closest to the people they serve.

Place and neighbourhood levels are the centre of gravity for service delivery in most ICSs. These feel 'natural' for joint-working between local authorities and providers. They are well-understood by local communities as being where different partners come together to deliver care and support to populations of vulnerable children, adults and the

elderly. Our members are clear that this is where some of the greatest improvements in service delivery are possible. It is at place level that the best joint solutions will be found:

> **"** I am very clear that my system is across the city. This is where I concentrate my energy in developing partnerships and delivering change. I am part of an ICS, but my system is the city." **(NHS community services trust CEO)**

At neighbourhood level, some of our PCN members are already working collaboratively with secondary schools in their area to discuss future health and wellbeing needs for young people.

What is clear from our engagement with members is that successful collaboration at place and neighbourhood levels is about identifying common goals, outcomes and values to work towards and involving the expertise of all delivery partners/providers including local government, primary care, community services and VCS. ICS leadership may be required to resolve issues that span large geographical footprints, for example in the provision of specialist services or agreement of ambulance service contracts. Any leadership by the ICS should, where possible, be driven by the needs of its constituent places.

However, 'place' is a complex concept. We have found through our member engagement that the definition of place can differ between systems and system partners. These were identified as:

- the footprint of provider collaboratives or ICPs

- the footprint of local authorities

- a population-level sense of place defined by a geography i.e. a city/town, etc.

These definitions are a mix of boundaries that may not be coterminous with each other – a mix of organisational groupings, populations and geographies. For local government this can be hard to navigate, especially when there are existing statutory structures in place, such as HWBs.

It is important for systems to have a shared view of place that is owned by its partners to ensure the right leaders come together to integrate delivery and improve population level outcomes. This view must, in turn, be clearly understood by the local communities that partners are delivering for.

Recommendations

- **The principle of subsidiarity is embedded in system, place and neighbourhood level working in ICSs so that the decision-making is 'local by default' i.e. anything that is best determined at the level of neighbourhood and place is done at those levels.**

- **There should be flexibility in the definition of place and the collaboration that goes around it. Local authorities must be embedded as equal partners within systems to best ensure integration of health and social care at place level.**

3. Enablers: what will help systems to be effective?

In the previous section we explored what our members have told us about the changes in the national policy and legislative framework that would strengthen system working and embed it permanently into the architecture of the health and care system. However, on their own they are unlikely to be sufficient to guarantee the success of ICSs, so wider changes are also needed.

Our members believe the model of oversight and accountability in the NHS needs radical reform for ICSs to be successful. Much more thinking is required about the role of providers in systems, so the strengths and knowledge of providers are built into future ways of working and more support is needed to develop and institutionalise the necessary leadership culture.

i) Moving to a proportionate and risk-based model of oversight and regulation in the NHS

ICSs bring together a set of organisations with differing accountabilities. NHS organisations are in the main accountable nationally to NHSEI via regions, although there are also lines of accountability to ministers and parliament. There are local accountability mechanisms such as foundation trust boards of governors, scrutiny committees and local Healthwatch organisations, but in practice these have less influence than the centre on most aspects of NHS activity. Local authorities are accountable to their local communities through locally elected representatives. However, there is some central government oversight of local authorities for key national priorities.

The power of ICSs lies in their ability to work together to meet the needs of their local communities and identify solutions locally to the problems

they face. But, our members tell us that the centralising tendencies of the NHS significantly undermine this vision and they are concerned that ICSs are in danger of being subsumed into a centralised NHS machine. Not only is this amount of oversight a significant and unnecessary overhead, it also undermines local partnership working and the quality of decision-making. If ICSs are to fulfil their potential, they need to be liberated to do their job. This is not an argument against accountability or intervention when it is needed, but for oversight to be proportionate, thoughtful and risk-based. Without radical reform of the oversight model in the NHS, ICSs will fail.

ICSs should have increased autonomy and greater local discretion over how national priorities are implemented.
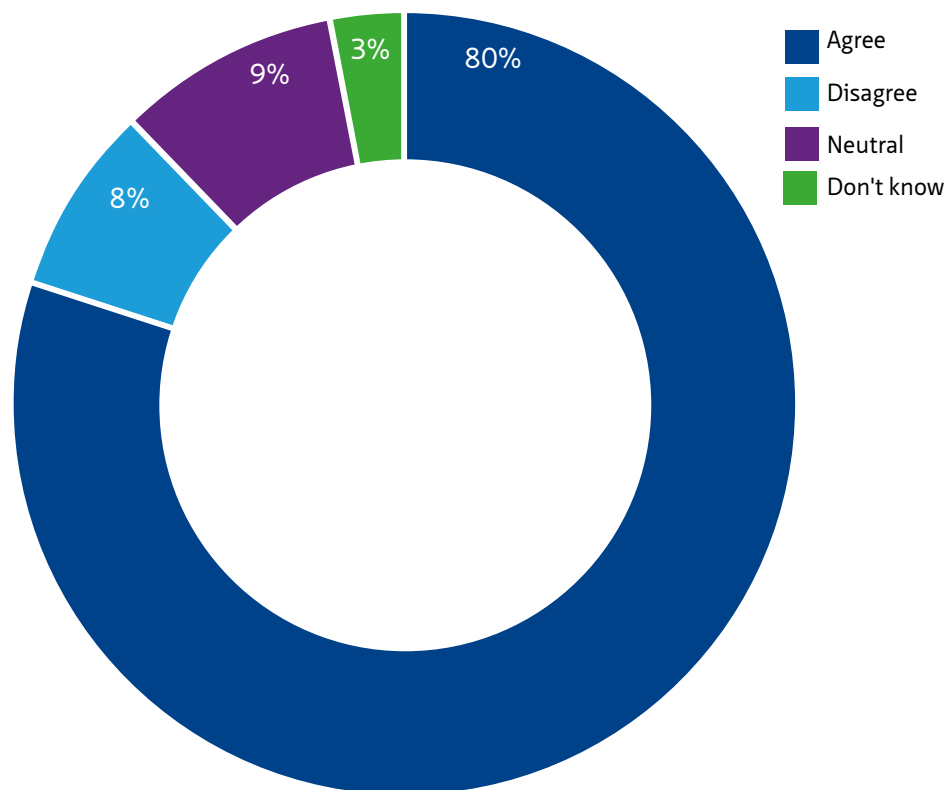
There have been previous attempts to reform oversight in the NHS and devolve decision-making closer to the front line.[3] In particular, the oversight model developed for foundation trusts by Monitor presents a potential way forward. This gave foundation trusts the freedom to self-manage and Monitor only intervened when performance fell below certain levels. A similar model could be introduced for ICSs. There are also lessons from the recent pandemic, which by necessity forced a lean, light and agile culture of regulation and oversight.[4] This allowed the health service to make significant changes very rapidly as it gave leaders and clinicians the space to transform patient care. There is also potential to learn from

[3] Shifting the Balance of Power in the NHS, Department of Health (2001).
[4] NHS Reset: A New Direction for Health and Care, NHS Confederation (2020).

the experience of local government, which has operated under a very different oversight model for a number of years. In particular, the model of peer review might be worthy of adopting in the NHS context.

As part of this, careful thought will also need to be given to the future relationship of ICSs with the NHSEI regional offices. We have long heard from members that performance management, or 'oversight', processes through the NHSEI regional teams are unclear and time-consuming, often with duplication in how reporting works. The move towards system working and the prospect of forthcoming legislation allows for a fundamental re-think.

> **"** We could and possibly should reduce regions and performance discussions but accept they will always exist. Regions are too close to centre and not pushing back, thereby not adding anything positive to the mix for systems. Some national directors still bypass the regions and systems to talk to trusts and providers directly." **(System consultation response)**

There are differing views about this that will need to be worked through. One view is that the current roles and responsibilities of the regions could be devolved to ICSs and that they could move to an arm's-length relationship with NHSEI HQ along the lines that foundation trusts previously enjoyed with Monitor. However, some members expressed concern that reporting into NHSEI HQ could lead to a more strained relationship between systems and the partner organisations within them, in turn jeopardising the relationships that will be crucial to the success of system working. An alternative view is for the oversight role to remain with the NHSEI regional team, so that systems can focus more on system transformation and supporting partner organisations to deliver that. The ICS would have an arm's-length role with the NHSEI regional office, who would have step-in rights where there were performance problems.

The reform of the NHS oversight model would also bring the opportunity to strengthen engagement with local communities and to strengthen links to HWBs. The NHS Confederation has long been clear that local public and political oversight is vital. Local authority HWBs already have responsibility for conducting a joint strategic needs assessment and developing a health and wellbeing strategy. Does the contribution of place-based collaboratives to HWBs (and vice versa) need to be articulated locally and promoted publicly? Should HWBs have some decision-making powers over health and care services? There is also the question of what form local accountability for health services that serve large populations and straddle multiple authorities might take.

> **"** We envisage that at an ICS level (the strategy is driven by population health management data) to include public decision-making and link it to HWBs. At an ICP level (delivery), public decision-making on the use of resources and clear accountability to the ICS and partnership with local councils." **(A system lead)**

In terms of regulation, our members are of the view that inspections need to remain a central pillar of future ways of working to ensure patient safety across all areas of healthcare. This should continue to be led by the Care Quality Commission (CQC) and be outside the scope of systems. Our members consider that the central focus for the CQC in future should be on how patient care is experienced across the system (i.e. from GP to acute to community). Current regulation of individual providers is acting as a barrier to integration, with limited incentives to encourage wider performance implications at system level.

> **"** Shifting the regulatory accountability away from individual provider organisations to system-level performance would help encourage more integrated working at ICS level." **(A mental health foundation trust CEO)**

We have the opportunity to significantly reform the model of oversight and regulation in the NHS, but the nettle has to be grasped.

Recommendations

- **The model of oversight in the NHS should be radically reformed to give ICSs the autonomy and space they need to deliver.**

- **The future oversight regime for ICSs should be proportionate and risk-based, grounded in the principle of self-management and with transparency about the triggers for intervention.**

- **ICSs should have a clearer relationship with HWBs, although the detail of this relationship needs further exploration.**

- **The CQC's model of regulation should more rapidly move to a focus on how patient care is experienced across the system.**

ii) Creating a positive vision for the contribution of providers to system working

One of the more potentially contentious issues for systems is the future of the foundation trust model and its compatibility with system working. The foundation trust model was created against the backdrop of a very different vision for the management of the NHS and some members expressed concerns about whether the freedoms and flexibilities that come with foundation trust status might be at the expense of wider system interests. At the same time there have been clear benefits to organisations who have been foundation trusts, and many are active participants in system working and collaboration.

At present, a majority of NHS leaders (6 out of 10) want foundation trust status to be slightly revised to support system working, rather than abolished.

> " FTs have provided significant innovation and have engagement with the public through members and governors. However, there should be tweaking to ensure that they are not pulled in different directions." **(System response)**

Under the future of system working, some changes may be proposed to the foundation trust model. Which of the following best describes your view on the future of the foundation trust model?

	Overall	Providers	CCG	PCN	ICS
Remain in its current form	4%	5%	0%	6%	0%
Be tweaked to make it more compatible with ICS working	57%	67%	61%	51%	52%
Be abolished	32%	25%	26%	37%	43%
Other (please state)	7%	3%	13%	6%	5%
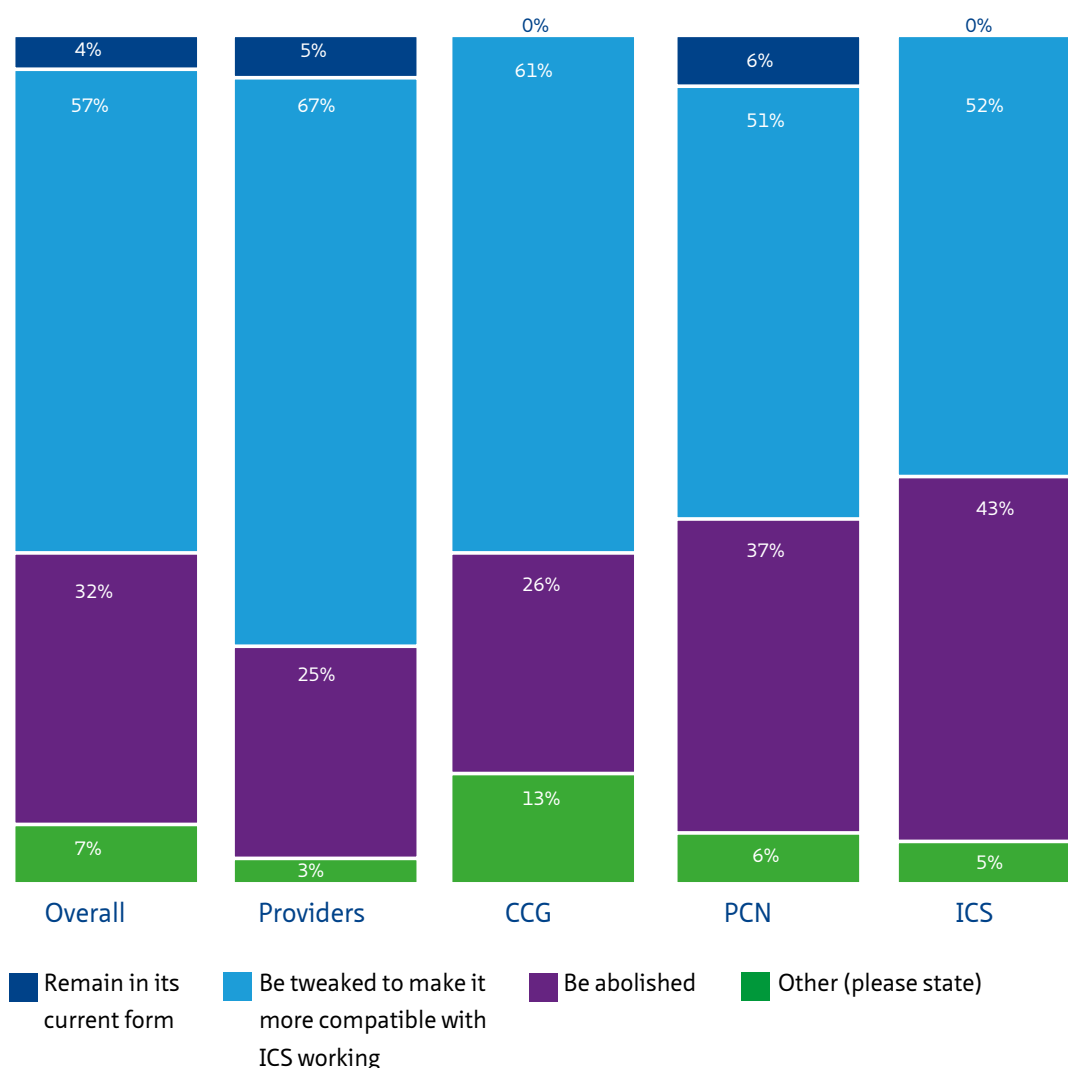
Some of the areas where our membership has suggested the foundation trust model could be amended include:

- adding a specific legal duty to foundation trusts to cooperate and integrate with system priorities

- adapting the governor and membership model of foundation trusts to a broader-based system version that strengthens local accountability

- 'levelling out' the differences and potential benefits that foundation trust autonomy creates when put alongside other NHS providers, for example powers to form subsidiary companies.

It may be the case that a shared statutory duty for foundation trusts, as discussed earlier, may be sufficient but more work is needed to explore these issues further. However, our members felt that any proposed changes should be part of developing a wider and more positive view of providers in systems rather than being 'retaliation legislation.' It is important to remember that the freedoms and flexibilities accorded to foundation trusts have in many areas enabled a stronger focus on delivering good care and improving the services they offer. Moreover, much of the expertise and knowledge about service delivery rests within provider organisations and they have the capacity to make real change happen. The needs of providers should be at the heart of ICS decision-making rather than at the sidelines.

From discussion with our provider members we know that many are keen to engage and drive transformation and integration. This is happening at several levels:

1. Providers that span multiple system geographies collaborating together to share best practice, enable innovation and reduce costs. For example, the Northern Ambulance Collaborative.

2. Similar provider organisations such as acute trusts collaborating at system level to design clinical pathways, share resources such as clinical staffing, or drive cost savings such as shared back office functions.

3. Providers collaborating at place and neighbourhood level to respond to local demands. For example, acute trust, local authority, PCNs, VCS and other partners collaborating via a memorandum of understanding or alliance model to deliver services across a place.

In conversation with provider CEOs and chairs, it was the latter of the three collaborative models that was seen by the majority to deliver some of the greatest wins.

Recommendations

- **The current statutory framework for foundation trusts and licence conditions should be reviewed to ensure it is compatible with and supports system working, but should not be fundamentally changed. The strength and quality of relationships with system partners, not the details of legislative reform, will most determine how well foundation trusts integrate into systems in the future.**

- **A vision for the future role of providers, and specifically provider collaboratives, in systems should be developed that sets out how their expertise and knowledge can be used most effectively in support of partnership working.**

iii) Support for developing a new style of system leadership and changing behaviours

System leadership

A consistent theme in our member engagement was that the leadership style of systems is a critical factor in their success. To avoid the feeling of a top-down hierarchy at system level, ICS leaders play a critical role in bringing system partners together, building the right relationships, working with complexity and 'focusing on where the energy is' (a commissioner) to build collaboration.

This is no easy task. Many of our members talked about the collaborative leadership skills demanded of system leaders as being among the most stretching that they had experienced in their careers. It requires a more distributive and transformative leadership style, one that is 'earned by taking organisations out of their silos and into new ways of working – focusing on common goals and shared solutions.' (A commissioner). More collaborative mindsets and ways of working are becoming the new norms of the NHS and partner organisations, resulting in more supportive cultures and behaviours. For example, systems having one version of the truth when reporting assurance or self-led improvement.

The building of relationships and a new leadership style and way of working takes time, support and investment. Such capacity and capability building has received some support and investment from NHSEI, but systems need more support to develop their own leadership capabilities and delivery mechanisms. This could include system leadership development, shadow boards, peer review or tailored organisation development interventions. Systems themselves should be able to shape and determine the investment and support they need and it should not be driven by the centre. Future recruitment of leadership positions should recognise the importance of system-wide transformational skills, alongside the ability to lead individual organisations. As one member commented: "It doesn't matter so much about the regulatory framework you work within, it is about the behaviour of the leader and how they interact with the system."

Clinical leadership across system and place

Our members believe that clinical leadership is an essential component of system working and should be fundamental to any future model of ICSs. We should strive to build a leadership triumvirate encompassing managerial, clinical and lay leadership, as all three components are complementary and essential.

The role of clinical leadership in systems is critical to ensure the design of evidence-based practice, reduce unwarranted variation and drive up quality. Effective clinical leadership should encompass a broad range of professionals (including nurses, pharmacists and allied health professionals) across secondary care, mental health and community services, as well as general practice.

CCGs are particularly keen to ensure the clinical leadership they have facilitated for a number of years is not lost in the transition towards system working, as they feel this has added a level of local credibility to planning, particularly at a place level. One way this is being managed during transition is where CCG clinical leads are moving into locality leadership roles through organisational mergers, and the emergence of PCNs ensuring that consistent clinical expertise informs place-level working with local government and primary care.

Clinical engagement in service redesign is essential. Our engagement with members has shown some areas are already in the process of establishing system-level clinical networks to align clinical strategies, standardise professional practice and prioritise pathways for redesign. The ambition being that this high-level strategy would be complemented at place level by ICPs, which take up the more detailed work around the redesign of specific clinical pathways. Members felt this was more empowering to clinical teams and embedded clinical leadership at all levels of the system. It is clear that clinical leadership is needed at all levels not only to support the pathway design, but to be involved at the strategic level. Cogent clinical leadership makes the strategy achievable.

Recommendation

The move to statutory ICSs is accompanied by a significant programme of investment in managerial, clinical and lay leadership development across health and care, to build the capacity and capability needed for ICSs to succeed. This programme should be designed and tailored by the systems themselves to meet their local requirements and aspirations.

iv) Size and governance of systems

There is a wide spectrum of population size and geographies across systems, which presents challenges and opportunities. The NHS Confederation believes this range of size is not a problem in itself and we would not advocate the imposition of minimum and maximum sizes for systems, nor do we believe boundaries should be changed unless there is a strong reason to do so and the case for change is driven by the system itself.

However, the challenge is around how systems reconcile population size with what happens at system and place levels and find appropriate solutions to navigate between them. Our members expressed a fear that 'ICSs could become too big and distant' from their populations to support place-based working, manifesting more like performance-driven strategic health authorities than a platform for partnership working and alignment to population-driven goals. For other members, some systems were 'too small to have any meaningful impact and need to be rationalised to enable systems to have real impact and a relationship with the centre.'

Regardless of size, to ensure that systems operate effectively across system, place and neighbourhood levels, it will be important that there are effective governance structures in place.

The Audit Commission (2002) defined governance within the NHS as: 'The systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives and by which they relate to their partners and wider community.'

As we begin to consider what governance may look like within systems in future, the NHS Confederation believes that a one-size-fits-all approach to governance will be unworkable and ineffective. Given the significant diversity in both the geographical and population size of systems, there should continue to be flexibility in how different systems operate and the governance models they adopt.

However, some of our members have spoken about their confusion in understanding how their system works or what it is trying to achieve. As such, all governance models across systems should adhere to certain principles. Governance, for instance, should:

- be streamlined where possible to enable quick decision-making at place level

- reflect the principle of 'local by default', whereby any roles and responsibilities that can be devolved down to a more local level, are devolved down

- be transparent and clearly communicated to all partners within systems. At present, many organisations – particularly PCNs – feel uncertain about how their system works, what their role is within it and the specifics of accountability

- embrace the notion of mutual accountability between partners to foster interdependency

- include representation at system and place levels for providers (including PCNs) and local authorities. While the NHS Long Term Plan includes a commitment that these groups must be represented on partnership boards, this should be strengthened so that, for instance, such groups have a role in producing system strategies and contributing to system-wide conversations about issues such as workforce.

Recommendations

- **To ensure that there is clarity across all partners within systems, as well as between neighbourhood, place and system levels, there should be a minimum set of criteria that governance structures must meet within ICSs to be simple and transparent.**

- **The NHS Confederation recommends that appropriate governance arrangements are developed and put in place within each system during the transitionary period before ICSs become statutory, to ensure that there are clear roles, accountabilities and processes for how systems, CCGs and providers interact in the intervening period.**

Conclusions and next steps

Opportunities to make significant changes to the legislative framework governing health and care are infrequent, partly due to both the political and operational sensitivities of doing so. This means it is important that NHSEI and the government get the detail of system by default right in any forthcoming legislation. The NHS Confederation understands the significance of this moment for our members and has gone to great lengths to draw on their knowledge and expertise to develop a considered view of what is needed.

In some areas, our members have a clear view of the way forward in making any changes to the national policy and legislative framework that will help strengthen system working. However, there remain issues where the way forward is not yet clear and our membership has differing views. Further work will be needed over the coming months to work through these issues to discover the best way forward. The NHS Confederation will be working proactively not only with our members, but also with stakeholders including the Local Government Association, NHSEI and DHSC, as we seek to find solutions to these issues.

This report is part of an ongoing conversation about the future of system working and we have attempted to faithfully reflect the views and opinions expressed to us on what is a difficult and complicated subject. We anticipate that there will be further discussion and dialogue over the coming year to try and find the best solutions for the health and care system, as and when DHSC and NHSEI put forward any proposals for change.

To offer your views on any of the issues explored above and/or to contribute to our future work on system working, please get in touch by emailing Nick Ville, director of membership and policy:

nick.ville@nhsconfed.org

How to stay in touch

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- Media summaries
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- NHS European Office Update
- Mental Health Network Update
- NHS Clinical Commissioners Update
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NHS CONFEDERATION

Title:	Integrated Performance Report
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Finance, Investment & Performance Committee with the Integrated Performance Report (IPR) for October 2020.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	- IPR is reviewed at Trust Board each month - IPR is reviewed regularly at the Finance Investment & Performance Committee (FIP) - IPR is reviewed at Executive Management Team (EMT) meeting on a monthly basis
Executive summary:	The IPR for October has been prepared in line with the framework discussed at the March Trust Board meeting so as to focus on: - Covid-19 response - Other areas of performance we need to keep in focus and under control - Locality reports that focus on business continuity - Priority programmes report that focus on those programmes supporting the work on Covid-19 **Quality** - Majority of quality reporting metrics continue to be maintained during pandemic - Safer staffing levels on inpatient wards maintained, registered nurse shortfalls have resulted in skill mix dilution in some areas - Increase in restraint figures has been reviewed and support/advice provided - Number of under 18s admitted to adult wards and length of stay remains a concern - Complaint response times are under pressure **NHSI Indicators** - Two young people under the age of eighteen were admitted to an adult ward in October for a total of ten days which is reduced compared to September, but higher than the trend in the earlier part of the year - Inappropriate out of area bed usage reduced to 106 days in October from 177 in the previous month

With **all of us** in mind.

- The percentage of service users seen for a diagnostic appointment within 6 weeks improved to 72.7% which whilst below target represents a continuing recovery
- Typically, performance against nationally reported targets remains positive

Locality
- Work progressing to improve approach regarding access to out of area locked rehabilitation beds (including associated financial pressures)
- Trend in CAMHS waiting numbers from referral to treatment in Barnsley and Wakefield remains positive.
- Significant bed and staffing pressures at Barnsley hospital impacting on community services and particularly crisis response and discharge to assess (D2A) team
- Significant increase in Covid-19 positive in care homes, increasing the wrap around from our Barnsley community teams for quite poorly residents
- High demand for inpatient beds continues
- Cohorting standard operating procedures that support the separation of people with symptoms or a positive Covid-19 diagnosis are in place for acute and older people's services
- The IAPT teams continue to implement digital solutions and have robust plans in place to manage wait times and increase access
- Development of the forensics lead provider collaborative continues to progress. Panel date with NHSE now in diary for the end of November
- Acuity on Horizon ward is very high
- Community therapy teams consistently reviewing patients requiring rehabilitation support workers (RSW) which has enabled a consistent daily capacity of available RSW to keep the flow of patients being discharged from the hospital into community services
- All services flexing across the system to enable services to manage the increased number of staff isolating due to symptoms of Covid-19

Priority Programmes
- The Arts and Health Programme Manager for Calderdale has commenced delivery of the agreed plan which aims to ensure that arts, creativity and culture is used across Calderdale to support people's health and well-being
- Work has commenced on modelling changes to mental health demand with partners through our mental health intelligence and insight group, as part of recovery and stabilisation.
- For PICU a new standard operating procedure has been developed and will go through internal governance. New processes set up for admissions to PICU beds and any required gender specific placement
- Work is ongoing with Barnsley CCG regarding the demand and capacity modelling for the new CAMHS service model and joint monthly steering meetings are continuing

- The go-live date for EPMA is being moved to January 2021 with the first roll out planned for Poplars ward, Lyndhurst ward and Ward 18

Finance
- October represents the first month of updated financial arrangements being in place
- October was also the first month the new SBS system was used for month-end accounting and reporting
- Trust budgets have been updated in the month to reflect the new plans and arrangements. Given the mechanics of this process in month variances to plan are not representative for this month only
- A £69k surplus was recorded in the month compared to a planned deficit of £0.2m
- Income was in line with the updated plan
- Pay costs were of a similar value to September at £16m with an increase in bank staffing numbers seen, particularly in inpatient and forensic services
- Agency staffing costs remained at approximately £0.6m in the month. There are currently 18 agency medics in place, 8 of which are employed in CAMHS and learning disability services
- £382k of costs identified as being reasonably incurred as part of the Covid-19 response, which is a little lower albeit broadly in line with previous months
- Out of area bed costs were £135k representing the lowest monthly cost since June. In addition to this expenditure there continues to be high spend on locked rehab in Barnsley
- Capital expenditure totalled £0.5m in the month (£1.2m year-to-date) as the scale of project work picked up in line with our revised plan of work The cash balance increased to £64.9m given the timing of receipt of system allocated income. The advance of one month's income is expected to unwind by the end of the financial year.
- 80% of all third-party invoices were paid within 7 days of receipt of goods or services, with 97% paid within 30 days.

Workforce
- As at November 24th there were 161 staff off work Covid-19 related and not working compared to 108 one month earlier
- Non Covid-19 sickness remained at 3.9% in October
- 398 staff have tested positive for Covid-19, 181 of which tested positive in the last month
- Staff turnover increased to 9.3% in October
- Compliance with training targets is positive with a review taking place of food safety training requirements and means of delivery
- Little change overall in staff receiving supervision although improvements have been noted in some BDUs, particularly Wakefield, Kirklees and Calderdale

	Covid-19 response
	In addition to the points identified in the sections above:
	• Sufficient PPE remains in place
	• The Trust continues to fully engage with the Covid-19 response in all the places and systems it provides services in
	• Symptomatic patient testing continues to be undertaken
	• Lateral flow testing for staff commencing at the end of November
	• Significant support to care homes is provided by our community teams in Barnsley
	• The Trust Opel level has changed to 3 given increased prevalence in the Trust and wider system and higher staff absence
	• National guidance continues to be monitored, reviewed and adopted
	• National Covid-19 benchmarking information beginning to be used to support reset and restoration
	• A range of staff and wellbeing support offers continue to be available and used
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

**Integrated Performance Report
Strategic Overview**

October 2020

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for October 2020. Continuing with the approach established in March the report considers the response to Covid-19 as well as the majority of other regular reporting sections. In particular the aim is to provide a report that provides information on:
• The Trust's response to Covid-19
• Other areas of performance we need to keep in focus and under control
• Priority programmes in so far as they contribute to the Trust response to Covid-19
• Locality sections in terms of how business continuity plans are operating
• Restoration and reset of services

This approach has necessitated a review of the sections and metrics reported previously. Following that review a number of changes have been made to the executive dashboard to add in key metrics related to the Covid-19 response and suspend the appearance of some other metrics whilst the focus has moved to managing the Covid-19 outbreak.

A separate section for the Covid-19 response has been added. The structure of this section focuses on:
• Managing the clinical response
• Supporting our staff and staff availability
• Supporting the system
• Standing up services
• Restoration and reset

It must also be recognised that given the focus of all staff on responding to Covid-19 and the increased level of staff absence not all the normal information is necessarily readily available for the report.. The quality section remains largely unaltered given the need to ensure the Trust retains focus on the provision of its core services. The report on national metrics is again unaltered as national reporting requirements remain unchanged. Other sections remain in place sometimes with reduced content. Consideration is also being given with regard to how performance against service reset and restoration can be provided. It should be emphasised that the majority of services have continued to be provided during the pandemic, although in some cases in a different manner such as less face to face contact and in some cases referrals have been lower than historical averages. Initial information is being developed to demonstrate how representative access to services is compared to the local population. A further update is expected for the next IPR.

With reference to key information relating to Covid-19 where possible the most up-to-date information is provided as opposed to the October month-end data. This will ensure that Trust Board can have a discussion on the most current position available as opposed to the position four weeks earlier. Given the fact different staff provide different sections of the report there may be some references to data from slightly different dates.

It is worth reminding the reader of the report of the Trust's four strategic objectives against which our performance metrics are designed to measure progress. These are:
• Improving health
• Improving care
• Improving resources
• Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
• Executive summary
• Covid-19 response
• Quality
• National metrics
• Priority programmes
• Finance & contracting
• Workforce

Our integrated performance strategic overview report is publicly available on the internet.

The IPR has evolved and grown significantly in recent years. A review is taking place to ensure the report remains meaningful and meets its intended purpose.

NHS South West Yorkshire Partnership NHS Foundation Trust

This dashboard represents a summary of the key metrics identified and agreed by the Trust Board to measure performance against Trust objectives. They are deliberately focussed on those metrics viewed as key priorities in 2019/20. Any change in requirement for 2020/21 will be reviewed in the coming weeks. Given the outbreak of the Covid-19 pandemic, a number of additional metrics are included in this report. These relate to the actual data as at 24th November as opposed to the end of September. A small number of metrics have been removed from the dashboard to enable greater focus on the Trust response to Covid-19. It should be noted that as well as these specific metrics many of the standard metrics used will be strongly influenced by the impact of Covid-19.

KPI	Target	As at 23rd April 2020	As at 19th May 2020	As at 17th June 2020	As at 22nd July 2020	As at 24th August 2020	As at 22nd September 2020	As at 20th October 2020	As at 24th November 2020	Notes
Additional Metrics to Highlight Response to and Impact of Covid-19										
No of staff off sick - Covid-19 not working 7		**154**	**204**	**112**	**48**	**26**	**82**	**108**	**161**	
Shielding		54	59	52	37	0	0	0	29	
Symptomatic		69	118	46	5	14	31	57	51	
House hold symptoms		26	24	13	4	7	29	31	25	
OH Advised Isolation		5	1	0	0	1	1	2	2	
Test & Trace Isolation		0	0	0	0	0	0	0	0	
Other Covid-19 related		0	2	1	2	4	21	18	54	
No of staff working from home - Covid-19 related 8		**125**	**136**	**107**	**90**	**7**	**53**	**79**	**147**	
Shielding		76	78	72	71	0	0	0	77	
Symptomatic		13	28	13	5	1	14	29	16	
House hold symptoms		29	23	13	1	0	26	21	33	
OH Advised Isolation	N/A	7	6	7	3	0	1	5	1	
Test & Trace Isolation		0	0	0	7	0	0	0	0	
Other Covid-19 related		0	1	1	3	6	12	24	20	
Number of staff tested 9		89	783	1798	2038	2162	2294	2498	2917	Cumulative
No of staff tested positive for Covid-19 10		23	103	128	130	133	149	217	398	Cumulative
No of staff returned to work (including those who were working from home)		683/962 = 71%	921/1246 = 73.9%	1183/1393 =84.9%	1310/1448 =90.5%	1498/1531 =97.8%	1547/1681 =92.0%	1771/1954 =90.6%	2027/2321 =87.3%	
No of staff returned to work (not working only) 13		445/599 = 74%	609/807 =75%	800/908 =88.1%	872/928 =94.0%	952/979 =97.2%	992/1079 =91.9%	1122/1239 =90.6%	1295/1480 =87.5%	
No of staff still absent from work who were Covid-19 positive 12		Data Unavailable	27	11	2	1	5	29	32	
No of Service users tested (ward)		41	65	103	104	109	125	148	174	Symptomatic
No of service users tested positive (ward)		9	10	29	29	29	29	38	60	Cumulative
No of service users recovered		8	9	28	28	28	28	30	60	One patient died not in SWYFT care
Additional number of staff enabled to work from home		900	900	937	1003	1024	1043	1069	1095	Cumulative
Calls to occupational health healthline		178	576	921	1230	1450	1536	1780	1967	Cumulative
Making SWYPFT a great place to work	Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Forecast
Sickness absence	4.5%	3.8%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	
Staff Turnover	10%	11.9%	8.5%	7.9%	9.8%	8.4%	9.1%	8.9%	9.3%	
Actual level of vacancies	tbc		8.7%	6.9%	6.0%	6.8%	7.4%	8.4%	8.0%	
Improve people's health and reduce inequalities	Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Forecast
% service users followed up within 7 days of discharge	95%	105/107 =98.1%	90/92 =97.8%	102/102 = 100%	105/105 = 100%	110/110 = 100%	84/85 =98.8%	106/107 =99.1%	97/98 =98.9%	1
Out of area beds 1	20/21 - Q1 247, Q2 165, Q3 82, Q4 0	350	167	108	140	336	224	177	106	2
IAPT - proportion of people completing treatment who move to recovery 4	50%	55.7%	51.4%	49.1%	42.8%	50.1%	54.3%	54.1%	55.4%	1
Delayed Transfers of Care	3.50%	1.9%	2.0%	1.7%	1.4%	1.3%	1.1%	1.5%	1.6%	1
Improve the quality and experience of care	Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Forecast
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) 3	trend monitor	20	34	35	41	31	27	24	18	
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	6	15	20	14	25	17	19	12	
Total number of Children and Younger People under 18 in adult inpatient wards	TBC	2	1	2	1	0	3	3	2	
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 2	trend monitor	41.3%	41.6%	46.6%	48.4%	48.6%	48.0%	57.0%	64.7%	
Improve the use of resources	Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Forecast
Surplus/(Deficit)	In line with Plan	(£968k)	-	-	-	-	-	-	£69k	(£2.1m)
Agency spend	In line with Plan	£613k	£469k	£507k	£518k	£558k	£606k	£588k	£604k	£7.0m
Single Oversight Framework metric	2	2	2	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green

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

Notes:

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

2 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Data refreshed back to April 20 each month. Excludes ASD waits and neurodevelopmental teams. Treatment waiting lists are currently impacted by data quality issues following the migration to SystmOne. Data cleansing work is ongoing within service to ensure that waiting list data is reported accurately.

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

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

5 - Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other

6 - Data taken from the Trusts Covid-19 sickness absence recording system as at 24th November broken down by those staff that are reported as being absent from work and being either symptomatic, shielding or household symptoms

7 - Data taken from the Trusts Covid-19 sickness absence recording system as at 24th November. Staff not working due to Covid-19 related issues.

8 - Trusts Covid-19 sickness absence recording system as at 24th November. Staff working from home but recorded as having either symptomatic, shielding or household symptoms.

9 - Count of tests undertaken for staff and/or staff family member up to and including 24th November.

10 - Number of staff and/or family member tested positive for Covid-19 out of those that have been tested.

11 - Number of staff that have returned to work who were reported as being off work due to Covid-19 related issues as at 24th November.

12 - Number of staff that have returned to work who were tested positive for Covid-19 as at 24th November.

13 - Number of staff who have returned to work who were unable to work during their absence.

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

Quality
• Majority of quality reporting metrics continue to be maintained during pandemic
• Safer staffing levels on inpatient wards maintained, registered nurse shortfalls have resulted in skill mix dilution in some areas
• Increase in restraint figures has been reviewed and support/advice provided
• Number of under 18s admitted to adult wards and length of stay remains a concern
• Complaint response times are under pressure

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• Two young people under the age of eighteen were admitted to an adult ward in October for a total of ten days which is reduced compared to September, but higher than the trend in the earlier part of the year
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• Pay costs were of a similar value to September at £16m with an increase in bank staffing numbers seen, particularly in inpatient and forensic services
• Agency staffing costs remained at approximately £0.6m in the month. There are currently 18 agency medics in place, 8 of which are employed in CAMHS and learning disability services
• £382k of costs identified as being reasonably incurred as part of the Covid-19 response, which is a little lower albeit broadly in line with previous months
• Out of area bed costs were £135k representing the lowest monthly cost since June. In addition to this expenditure there continues to be high spend on locked rehab in Barnsley
• Capital expenditure totalled £0.5m in the month (£1.2m year-to-date) as the scale of project work picked up in line with our revised plan of work The cash balance increased to £64.9m given the timing of receipt of system allocated income. The advance of one month's income is expected to unwind by the end of the financial year.
• 80% of all third party invoices were paid within 7 days of receipt of goods or services, with 97% paid within 30 days.

Workforce
• As at November 24th there were 161 staff off work Covid-19 related and not working compared to 108 one month earlier
• Non Covid-19 sickness remained at 3.9% in October
• 398 staff have tested positive for Covid-19, 181 of which tested positive in the last month
• Staff turnover increased to 9.3% in October
• Compliance with training targets is positive with a review taking place of food safety training requirements and means of delivery
• Little change overall in staff receiving supervision although improvements have been noted in some BDUs, particularly Wakefield, Kirklees and Calderdale

Covid-19
In addition to the points identified in the sections above:
• Sufficient PPE remains in place
• The Trust continues to fully engage with the Covid-19 response in all the places and systems it provides services in
• Symptomatic patient testing continues to be undertaken
• Lateral flow testing for staff commencing at the end of November
• Significant support to care homes is provided by our community teams in Barnsley
• The Trust Opel level has changed to 3 given increased prevalence in the Trust and wider system and higher staff absence
• National guidance continues to be monitored, reviewed and adopted
• National Covid-19 benchmarking information beginning to be used to support reset and restoration
• A range of staff and wellbeing support offers continue to be available and used

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

Inappropriate Out of Area Bed Days
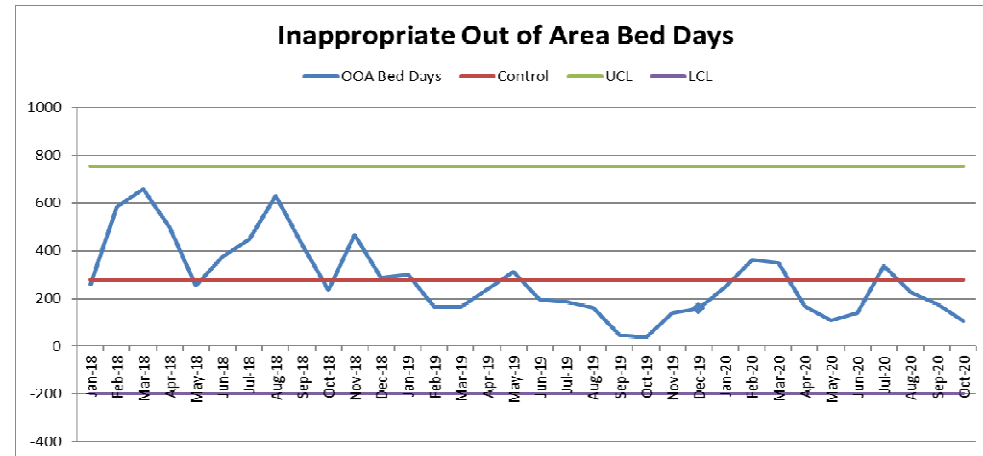
Inappropriate Out of Area Bed Days

Legend: OOA Bed Days — Control — UCL — LCL

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

Staff Sickness Absence
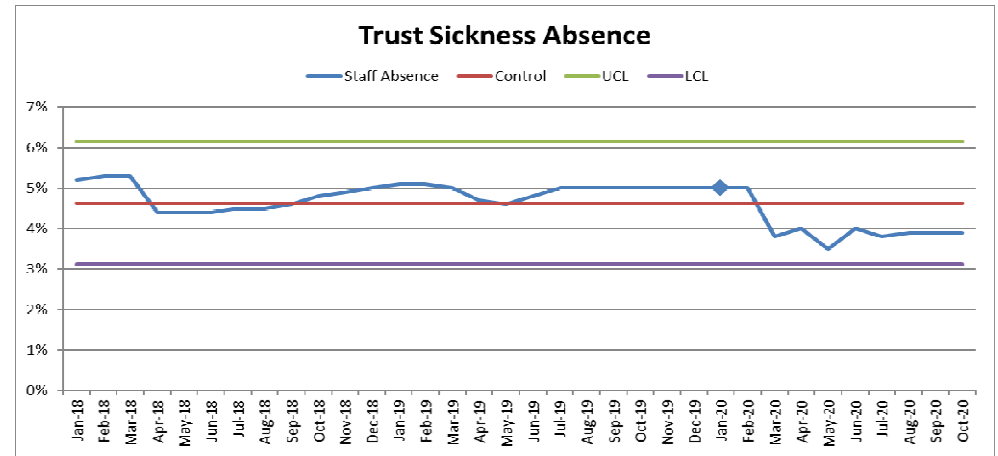
Trust Sickness Absence

Legend: Staff Absence — Control — UCL — LCL

SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in January 2020 has been highlighted for this reason.

Staff Turnover

Trust Staff Turnover

Legend: Turnover — Control — UCL — LCL

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

Agency Spend

Trust Agency Spend

Legend: Agency Spend — Control — UCL — LCL

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

Incidents

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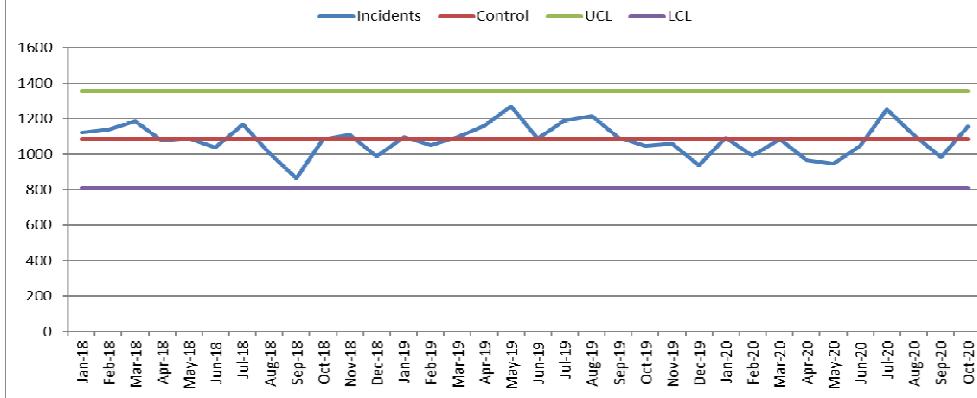
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

Total bed days of CYP on adult wards

Total Bed Days of CYP on Adult Wards
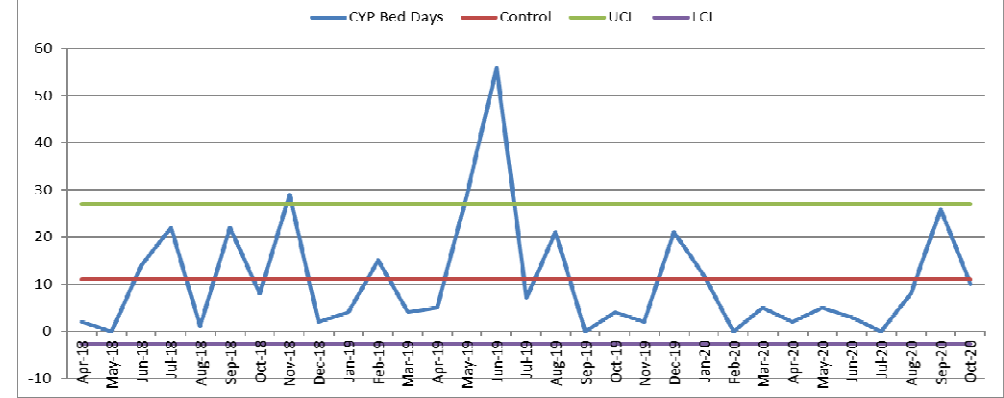
The majority of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported bed days are within the expected range with the exception of Nov-18 and Jun-19.

IG Breaches

Total Number of IG Breaches
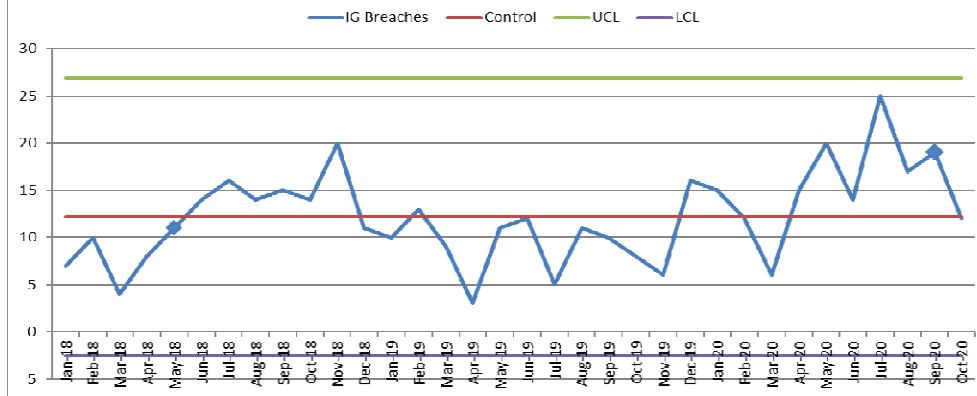
The data point in May 2018 has been highlighted to indicate the introduction on GDPR.
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in September 2020 has been highlighted for this reason.

CAMHS Referral to treatment waiting times

CAMHS Referral to Treatment Waiting Times
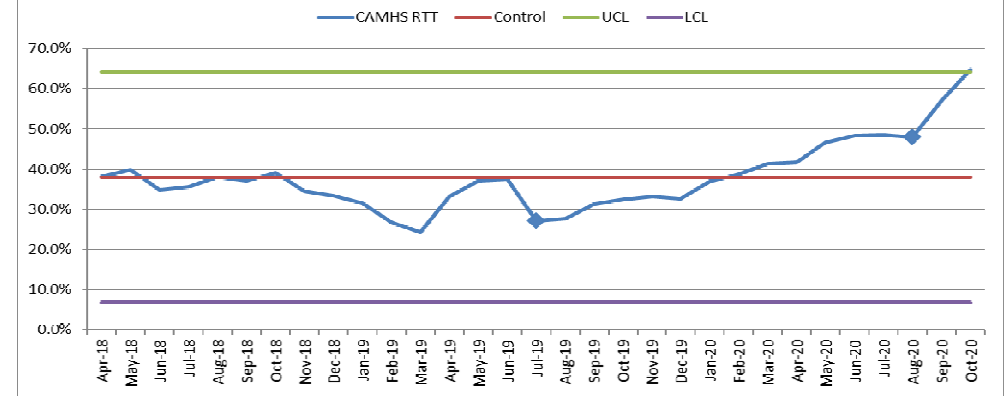
The data point in July 2019 has been highlighted as the neurodevelopmental teams have been excluded from this point onwards.
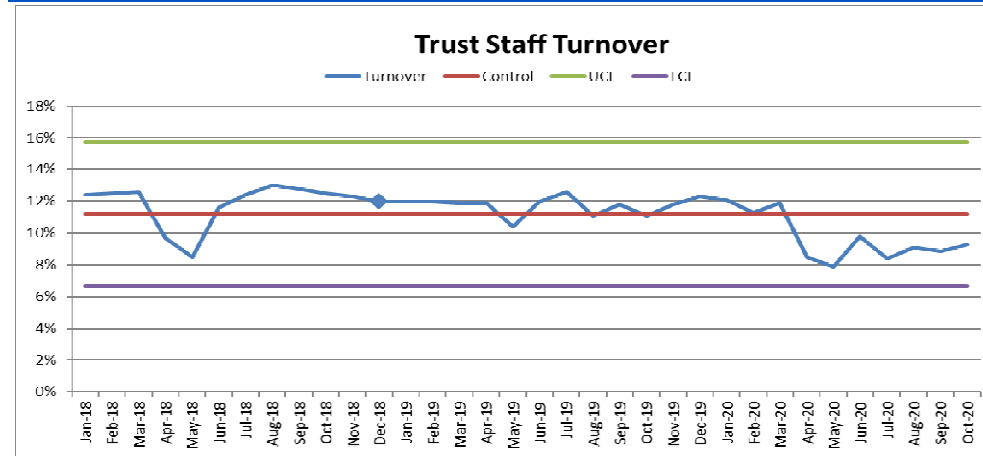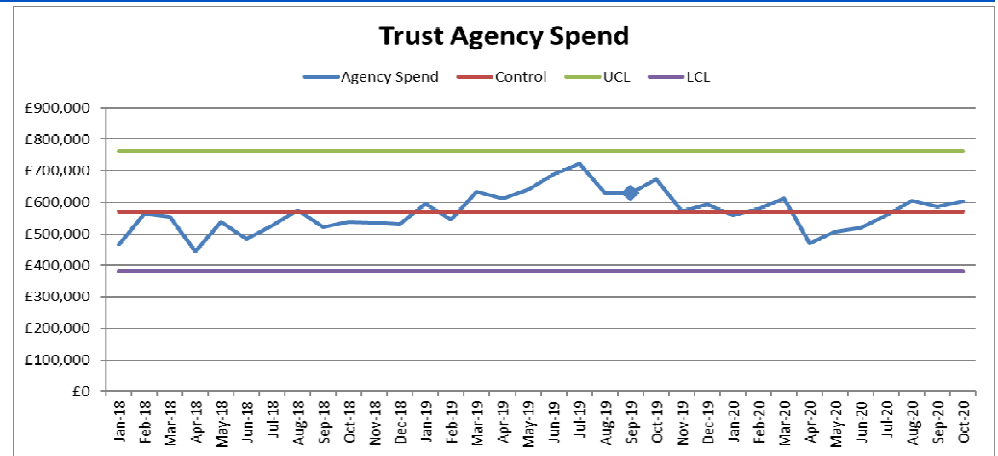SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in August 2020 has been highlighted for this reason.

Covid-19 response

This section of the report identifies the Trusts repose to the Covid-19 pandemic and in particular the 6 items identified by Simon Stevens that are critical to being able to work through the national crisis.

Managing the clinical response

IPC response – guidance
IPC team continue to review and respond to guidance issued which is then implemented via silver command.

Patient testing & pathway/Outbreak response & management
Symptomatic patient testing is being undertaken and revised regime under review.
One outbreak on Hepworth which is being managed with support from the IPC team.

Covid-19 clinical risk scan
Please refer to the Covid-19 related incident reporting section in the quality report

PPE position
• National deliveries of PPE have been sufficient to maintain good stock levels
• Medium size gloves are most commonly used and we have 30 days worth of stock
• Internal audit advisory report received with some control improvements being implemented

PPE Levels	days stock as at 14-Jul	days stock as at 17-Aug	days stock as at 15-Sep	days stock as at 13-Oct	days stock as at 10-Nov
Surgical masks	30	22	12	14	33
Respirator masks	80	23	39	90	100
Aprons	11	8	20	25	33
Gowns	95	132	119	115	14
Gloves	28	26	24	32	41
Visors	100	115	156	121	46

Supporting our staff and staff availability

Testing approach
Current position
Patients:
• Swabbing for symptomatic testing through Pillar 1 inpatient and through Pillar 2 if required for community setting.
• Asymptomatic takes place on admission, 5-7 day post admission and discharge (to adult care facilties) testing is being undertaken. Also testing for service users prior to going for a planned operation/ treatment/ procedures testing being undertaken through Pillar 1.
• Outbreak and hotspot management testing is provided through an internal testing route, with adequate capacity from local labs.
• Testing some mental health and general health community patients if they require admission to adult care home, or admission to hospital.
• Swabbing for outbreaks in care homes - SOP produced and commencement date to be finalised.

Staff
• Swabbing for symptomatic testing - access via pillar 2 or through internal testing route. Testing staff per and post-operative and procedures
• Hotspot outbreak management testing is provided through internal testing route, with adequate capacity from local labs.
• Trust committed to the national SIREN study, which will include fortnightly swabbing and antibody testing.
• Barnsley BDU staff that visit over 65s carehomes are subject to weekly antigen testing.

Staff testing report – current position
All staff requiring a test continue have their details taken and are contacted to ensure a test has been sought and monitor when result received.

Results
Most of the results have been returned within one day from testing, no one has waited longer than 72hrs or their test resuts.

Future plans for testing staff
• We continue to test our own staff where appropriate in line with Pillar 1, but staff are also accessing Pillar 2 testing through the National route.
• For Trust infection prevention & control (IPC) staff have oversight of the staff absence as a result of Covid-19 so they can monitor results and advise as necessary.
• Any member of staff who is unable access a national test will be considered for local testing via the nursing, quality and professions directorate.
• The Trust will be commencing 27th November lateral testing twice weekly for a period of 12 weeks for all frontline/clinical staff.

Covid-19 response

Staffing Issues

Our current response to the increase in infections, local restrictive measures and increased pressures on service areas

• Review message and guidance about protecting the most vulnerable staff
• Updating vulnerable and BAME staff risk assessments
• Review BCPs including staff escalation plans
• Review staff bank capacity in light of recent increase in recruitment
• Consider return and retire initiative
• Review talent pool arrangements in readiness for possible increase in demand
• Inform all support services to standby to stand-down non-essential services

Reason for absence trend

Legend: Symptomatic, Household Symptoms, Shielding, OH advised isolation, Other COVID-19 related, Test & Trace Isolatio..., Test & Trace Isolatio..., Elective Surgery Is..., Elective Surgery Is..., Travel to Spain ..., Plasma donation, Holiday isolatio...

Reason for absence trend

Legend: Symptomatic
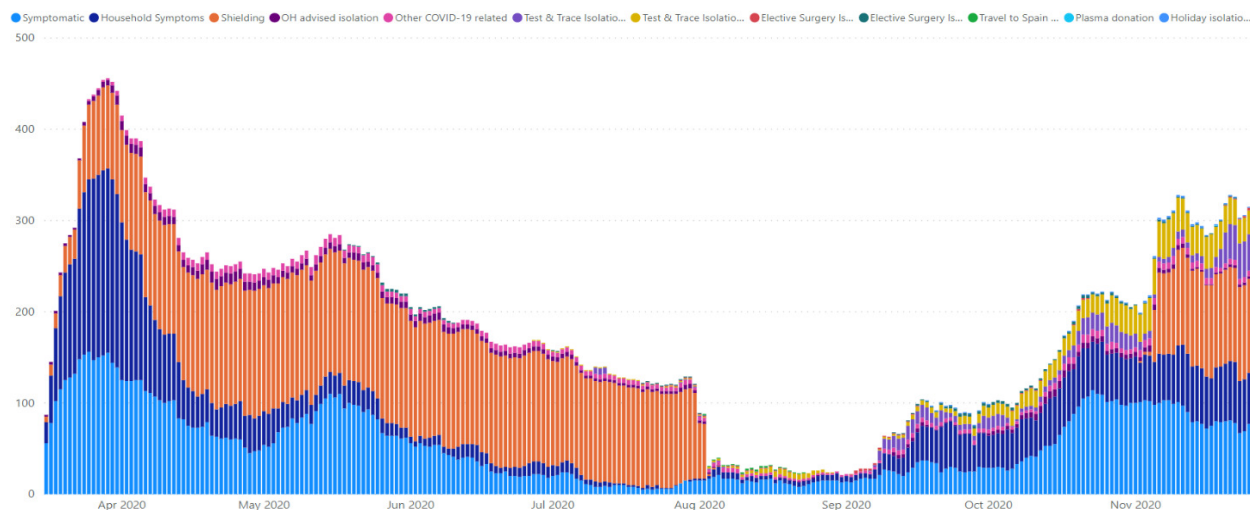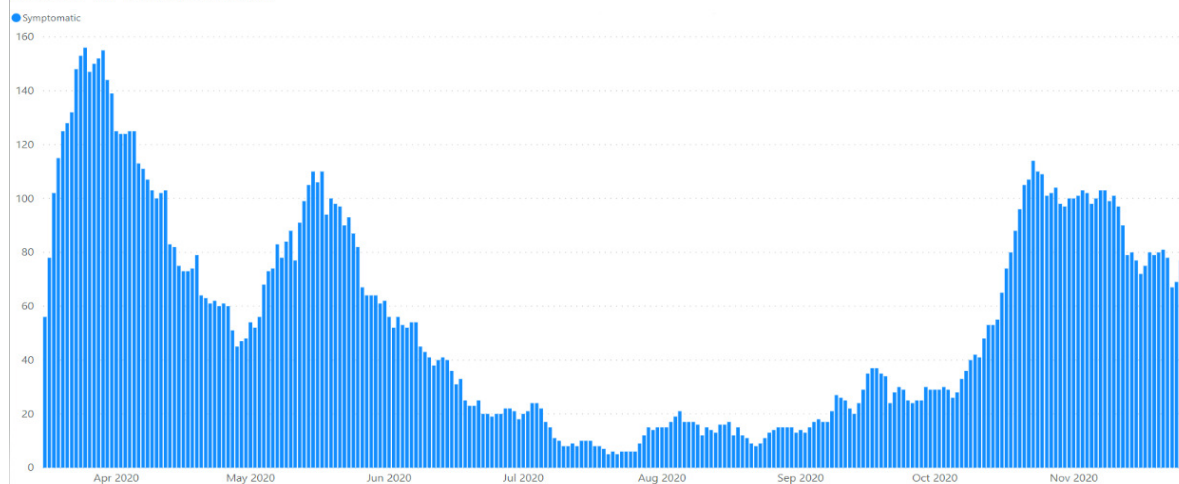
Covid-19 response

Staff Absence by BDU

BDU: ● Adult ADHD/ASD ● Barnsley ● Barnsley General Ops ● Calderdale and Kirklees ● CAMHS ● Creative Minds and Museum ● Forensic ● LD ● Support Services ● Trust Bank/Pastoral Care ● Wakefield
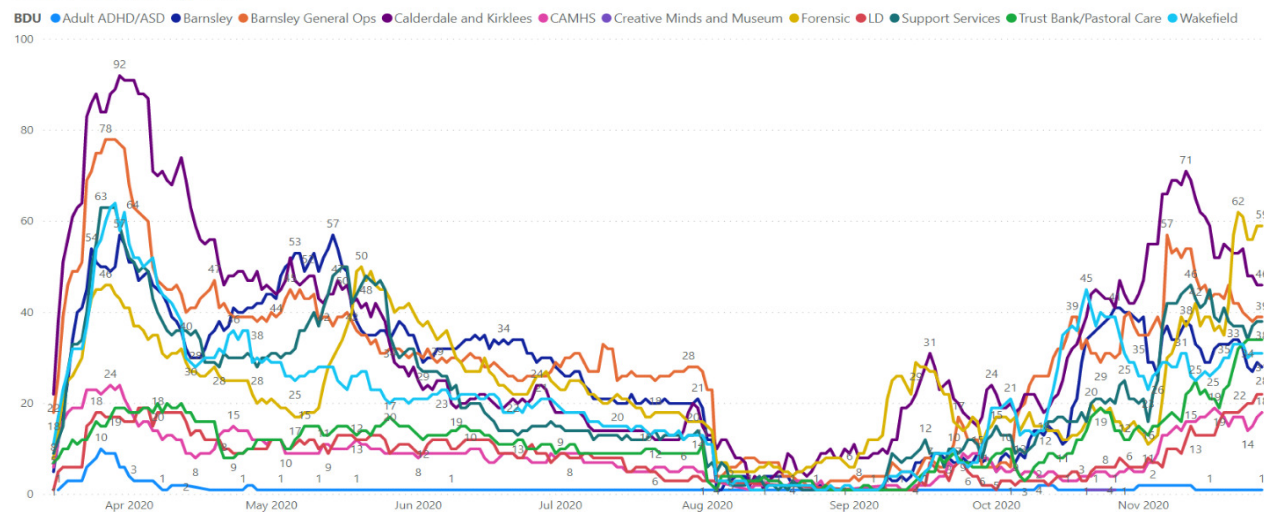
Supporting the system

The Trust continues to fully engage with the Covid-19 response in all places and systems it provides services in.

Care home support offer
• Significant support to care homes is provided from the general community team in Barnsley.
• Support includes testing (for both staff and residents), training and advice. This requires significant capacity, especially where there have been clusters/outbreaks.
• Support also includes direct care from community staff including our specialist palliative care teams , District Nurses and matrons and our out of hours nurses.
• SWYPFT is part of the mutual aid response to care homes to ensure they have adequate PPE
• Mental health and learning disability support has also been provided into care homes across the whole of the Trust footprint to support the residents

ICS stress test and outbreak support
• SWYPFT were part of ICS stress testing workshops in both South Yorkshire & West Yorkshire as part of the place based response
• We continue to work closely with partners in outbreak support response in each of our four places
• Strong leadership from the Infection Prevention & Control (IPC) team continues so we ensure appropriate IPC measures are in place
• We provide input and support in to the communication and engagement cells in each of our places to support the covid management and outbreak response.
• Stress test/managing concurrent events exercise udnertaken internally, identifying actions to update business continuioty placns (BCPs) and also to prepare for impacts from Covid-19 during winter months.

Covid-19 response
Standing up services

A number of areas have been highlighted in the NHS repsonse to phase 3 of the covid-19 pandemic. The Trusts position on this has been highlighted in the appropriate sections below:

Trust activity and demand (phase 3 response)
• Referral information for Trust services is now being used by the reset and restoration group. The previous month's IPR provided some information regarding the value of service referrals over time. This information is being used to support how we plan for service recovery and enable access to service to be prioritised. The Trust is generally seeing an increase in referrals back to pre-covid-19 levels across the majority of areas. Some work is being undertaken in the Trust to look at forecast surpressed demand and to review the impact this may have on services.
• This section of the report will be developed over the next few months.

Children and Young People access measures
• Work is taking place to validate the local data related to this - it is anticipated data will be avalable in quarter 4.

8 urgent actions to address inequalities
The Trust is identifying means of determining how it can report progress against the eight urgent actions for addressing inequalities, recognising that a step-change in recording of information and both interpreting and reporting is required. The eight urgent actions focus on:

1. Protecting the most vulnerable from Covid-19 with enhanced analysis and community engagement
2. Restoring NHS services inclusively
3. Developing digitally enabled care pathways in ways which increase inclusion
4. Accelerating preventative programmes which pro-actively engage those at greatest risk of poor health outcomes
5. Particularly supporting those who suffer mental ill-health
6. Strengthening leadership and accountability
7. Ensuring datasets are complete and timely
8. Collaborating locally in planning and delivering action

A number of activities are already in place and other actions have been identified in order to meet these priorities. A group has met to identify which data sources already exist and where additional information is required, either internally or externally, with the aim of providing more information in the IPR with regard to how we are performing against each of the actions. Tim Breedon is the confirmed executive director lead. In addition to the work being carried out internally the Trust is working with partners in all places to respond to this challenge. As well as the worl to include inequalities data and analysis, the group is also developing reports and analysis to meet all the phase 3 letter criteria. The next stage of development is to identify the proportion of each places population attributable to these classifications so as to help understand how representative service delivery currently is and where there could be under-representation. We expect to report on this in January.

Staff Health & Well Being
• To ensure the health, safety and wellbeing of our workforce a comprehensive risk assessment has been completed for all BAME colleagues, pregnant staff, staff who have been shielding and over 70s. Managers have been asked to keep these under constant review. All Trust employees and bank only colleagues have been offered a risk assessment. A self-assessment questionnaire has been circulated to all staff which indicates their personal risk level, those in medium/high risk levels are offered a full risk assessment . Over 4000 colleagues have completed either a full risk assessment or a self assessment. In addition, we have maintained contact with all shielded staff via Trust managers and an Occupational Health well-being check. We also have a working from home/MSK risk assessment process.
• To accelerate preventative programmes for our workforce who are at greatest risk of poor health outcomes we have established a BAME health and wellbeing taskforce and have invested in our Occupational Health service by appointing a Health and Wellbeing practitioner for the BAME workforce. We also offer our colleagues support to maintain a healthy weight and offer smoking cessation support. There is a robust plan for this year's flu vaccination in place and the Trust has met its targets for vaccinations in previous years. The Trust has conducted our wellbeing at work survey with Robertson Cooper to inform our planning and results of this are now being analysed and formulated into action plans. We have a number of staff networks which support the Trust to address health inequalities and improve staff experience.
• To support our colleagues who experience mental ill health we have an in house occupational team including advisors, mental health nurse and an occupational therapist. We also provide an in house staff counselling service providing a range of therapies.

Flu vaccinations
• current uptake at 55% (1705 frontline staff members). All vaccines delivered into the Trust today to finalise programme – the programme is being accelerated in light of the COVID-19 vaccine, with a view to vaccinate all staff by 1 December 2020.

Volunteers
• All volunteers are being risk assessed using the staff risk assessment tool prior to reintroduction back into Trust services
• Currently we have 176 volunteers, 7 are active and a further 47 are waiting to be processed or have been placed on hold

Operational services delivery update
Please refer to the localities section of the report

Workplace risk assessments
• Environmental risk assessments have been carried out across the Trust, including the identification of Covid secure locations

Emergency prepardness, resilience and response (EPRR) update inc Opel levels
• The Trust is operating at OPEL 3 due to staffing pressures and the number of active outbreaks across the Trust. This will support decision making and the standing down of non-essential services to support critical functions. A piece of work is underway to outline the Trust's priorities and subsequent support mechanisms. Silver command calls have increased to 3 per week and Gold meetings are twice weekly. The ICC/SPOC has been stood up 7 days per week. The ICC/SPOC and Silver Command meetings all now cover COVID-19, EU Exit and Winter Pressures

Covid-19 response

Restoration and reset

Key priorities and progress made
• Review and revise governance systems in light of learning from covid. Learning from Covid has been pulled together and shared with each subcommittee of the Board
• Progress the identified clinical priority areas for restoration and reset
• Evaluate estate requirements and capacity in light of health & safety restrictions
• Work with partners in each place as well as both ICS systems to support restoration and recovery in each place
• Evaluate the new clinical models and digital approaches that we have used during the pandemic. Recovery planning toolkit developed, agreed and now being used
• Continue work to ensure this is great place to work
• Deliver the requirements in the phase three planning guidance. Work has been undertaken to analyse and plan for the requirements in phase three
• Updated priority programmes have been agreed by the Trust Board.

Race equality response
• Our refresh of the Equality, Inclusion and involvement strategy and Trust Approach is already underway - Integrated systematic approach underpinned by involvement since October 2019
• Leadership and Stronger governance /delivery structure
    – Board leadership
    – E&I committee and task force
    – BAME workforce task force
    – BAME Network participation in task force
• Strengthened our processes to capture insights, data, impact and informed decision making
    – WRES/WDES/EDS2 – action plans currently being updated based on NHSE/I requirement templates
    – Covid-19 Trust wide equality impact assessment (EIA) and action plan
    – Covid-19 Trust wide intelligence tool
    – EIA quick decision tool to support decision making and change
    – EIA form and intelligence supported decision making in Silver command structure
    – Equality and engagement team as advisors in silver command – latter from July 2020
    – EIA and insight work from strategy refresh to inform Priority programmes and planning as part of stabilisation and recovery
    – Mapping representation in meetings (awaiting data)
• Targeted and accessible communications, messaging and materials
    – Translation services promoted – translated Covid-19 materials
    – Use of easy read materials developed and promoted
    – Website and intranet tools
    – Targeted messages to communities

Digital response
• Service desk activity remains high, largely due to the implementation of office 365.
• The usage of Microsoft Teams continues to increase.
• The number of video consultations remains at similar levels to recent months.
• Digital consultation solutions currently being assessed and evaluated.

Digital - Summary Metrics	Apr	May	Jun	Jul	Aug	Sep	Oct
Total numbers of tickets logged with service desk:	5,914	4,186	4,424	4,849	4,539	6,044	6,065
Total phone calls to service desk:	2,733	1,644	1,744	2,176	2,503	3,121	3,387
Number of SystmOne tickets (day to day system requests/amendments):	321	320	298	381	375	408	536
Number of smartcard related tickets:	367	308	296	407	251	366	255
Additional VPN licences since March	888	937	1,003	1,024	1,043	1,069	1,095
Average number of daily VPN connections	2,674	2,430	2,731	2,347	1,958	2,144	2,150
Microsoft Teams - meetings participated	10,535	7,201	15,450	14,604	14,701	14,845	17,070
Airmid video consultations (average/week)	54	187	15	5	1	1	0
AccuRX video consultations (average/week)	0	146	111	148	164	177	185

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	41.6%	46.6%	48.4%	48.6%	48.0%	57.0%	64.7%	N/A
Complaints	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	10.0%	0% 0/14	17% 5/29	12% 3/25	30% 8/27	19% 6/32	4% 1/24	1
	Number of compliments received	Improving Health	Caring	TB	N/A	13	13	41	34	18	19	21	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	trend monitor	39	33	39	33	29	16	Due Dec 20	
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	trend monitor	2	2	10	6	5	1		N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	0	0	0	0	0	0		1
	% Service users on CPA offered a copy of their care plan	Improving Health	Caring	CH	80%	40.3%	40.2%	40.4%	39.6%	39.3%	39.5%	39.2%	2
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=9	15	20	14	25	17	19	12	2
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	3.5%	2.0%	1.7%	1.4%	1.3%	1.1%	1.5%	1.6%	1
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	95%	90.4%	91.5%	89.4%	84.3%	93.4%	81.0%	Due Dec 20	N/A
	Number of records with up to date risk assessment - Community [11]	Improving Care	Effective	CH	95%	71.2%	83.3%	79.1%	70.0%	74.6%	77.4%	Due Dec 20	N/A
Quality	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	968	946	1047	1251	1110	981	1155	
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	32	27	30	22	19	21	12	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	1	3	3	4	3	1	2	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	1	5	8	5	5	2	4	
	MH Safety thermometer - Medicine Omissions [15]	Improving Care	Safety Domain	TB	17.7%	No longer available							2
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	115.1%	119.4%	123.3%	120.5%	118.0%	114.4%	114.0%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	95.7%	94.3%	93.9%	90.9%	88.6%	85.6%	90.1%	
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	trend monitor	45	44	36	29	34	38	35	
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	0		3	0	0	0	0	0	1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less [8]	Improving Care	Safety Domain	CH	80%	93.0%	91.5%	90.0%	80.0%	94.5%	94.0%	87.5%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	38	45	46	35	48	43	51	
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	121	111	137	188	138	125	165	
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	95.3%	91.5%	90.2%	87.8%	84.4%	94.1%	92.7%	
Infection	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	0	0	0	0	0	
Prevention	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	

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

1 - Attributable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary

2 - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage

3 - The IG breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches

4 - These incidents are those where Duty of Candour is applicable. A review has been undertaken of the data and some issues identified with completeness and timeliness. To mitigate this, the data will now be reported a month in arrears. Target only applicable to breaches.

5 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Data quality (DQ) issues are impacting on the reported data from March 19. Some improvement in dq has seen in recent months and this is expected to continue. Excludes ASD waits and neurodevelopmental teams.

8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.

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

9 - Patient safety incidents resulting in death (subject to change as more information comes available).

10 - In the 2017/18 mandate to NHS England, the Department of Health set a target for delayed transfers to be reduced to no more than 3.5 per cent of all hospital bed days by September 2017. The Trust's contracts have not been varied to reflect this, however the Trust now monitors performance against 3.5%.

11. Number of records with up to date risk assessment. Criteria used is - Older people and working age adult Inpatients, we are counting how many Sainsbury's level 1 assessments were completed within 48 hours prior or post admission and for community services for service users on care programme approach we are counting from first contact then 7 working days from this point whether there is a Level 1 Sainsbury's risk assessment.

14 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return and is monitored under the NHS oversight framework.

15 - The medicine omissions data was taken from the NHS Safety thermometer tool. This data collection ended at the end of March 20 and therefore data for this metric is no longer available.

Quality Headlines

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

• Number of restraint incidents - the number of restraint incidents during October increased to 165 from 125. Further detail can be seen in the managing violence and aggression section of this report.

• NHS Safety Thermometer - medicine omissions. It has been decided by NHS Improvement that the safety thermometers are to cease being used and they are currently working on a replacement. Therefore staff no longer need to collect monthly data or input onto the national site. Alternative patient safety measures are being explored.

• Number of falls (inpatients) – A slight increase in reported incidents in October compared to September from 51 from 43 . All falls are reviewed to identify measures required to prevent reoccurrence and more serious falls are subject to investigation.

• Staffing fill rates are provided for the last 2 months where new planned staffing in acute mental health wards is included and fill rates measured against these.

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

• Duty of candour - there were no breaches

• % Service users on CPA offered a copy of their care plan - Reporting has now been developed to enable us to monitor performance against this metric. To meet the standard all care plans for an individual have to have been identified as offered to the service user. For example, if an individual has 5 care plans, all of these must be marked as offered to the service user for this to acheive the standard. Work is ongoing to improve data quality.
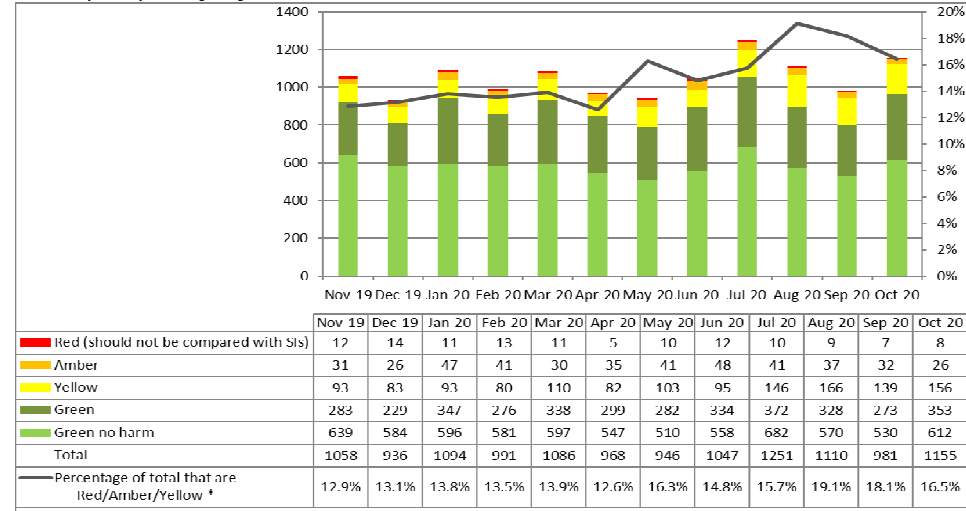
NHS Improvement - the development of new programmes introduced in the NHS patient safety strategy are either continuing with amended timescales to be confirmed, or paused. In October, the Trust provided a response to the consultation on a 'Framework for involving patients in patient safety'. The Trust has to provide names of our nominated patient safety specialist/s to NHS England by 30/11/20.

The Trust is taking part in the Serious Incident Review Accreditation Network to work towards having our serious incident investigation process accredited by the Royal College of Psychiatrists. We are currently going through a period of self review, with a peer review planned for 22 December 2020. This will involve contacts with BDUs and staff involved in SI investigations.

360 Assurance audit of Patient safety - focus on incidents; The Trust received Significant Assurance. Work is underway to implement actions. We have requested an extension to timescales to allow for any recommendations arising from the accreditation process to be incorporated into policy reviews. Changes to Datix will also be required. We will share the required changes with BDUs as part of the consultation process.

Safety First

Summary of Incidents November 2019 - October 2020

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

	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Red (should not be compared with SIs)	12	14	11	13	11	5	10	12	10	9	7	8
Amber	31	26	47	41	30	35	41	48	41	37	32	26
Yellow	93	83	93	80	110	82	103	95	146	166	139	156
Green	283	229	347	276	338	299	282	334	372	328	273	353
Green no harm	639	584	596	581	597	547	510	558	682	570	530	612
Total	1058	936	1094	991	1086	968	946	1047	1251	1110	981	1155
Percentage of total that are Red/Amber/Yellow *	12.9%	13.1%	13.8%	13.5%	13.9%	12.6%	16.3%	14.8%	15.7%	19.1%	18.1%	16.5%

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

Degree of harm analysis:

Degree of harm will be updated when more information emerges. The patient safety support team add a provisional degree of harm at the point of an incident being reported based on information recorded at that point, and what the harm could potentially be. This is checked and revised when an incident is finally approved, after the manager has reviewed and added the outcome. This can be delayed due to length of time to review incidents, and volumes. This is a constantly changing position and the data was accurate at the time of extraction (10/11/20).

Deaths: Of the 4 deaths recorded, there are 2 Deaths that are awaiting confirmation of cause of death for decision regarding level of review (these are 1 each at CAMHS (Barnsley) and Core Team (South - Kirklees). The other 2 deaths are categorised as, Suicide (incl apparent) - community team care - current episode. Theses are recorded one each at Assessment and Intensive Home-Based Treatment Team / Crisis Team (Calderdale) and Core Team (Barnsley).

Severe harm: There were 2 severe incidents recorded. These were Safeguarding Adults - Sexual abuse recorded at Walton PICU and Self harm (actual harm) with suicidal intent recorded at single point of access team Wakefield.

Moderate harm: There were in total 12 moderate harm incidents recorded for the month of Oct 2020. These were 11 pressure ulcers, all recorded across the neighbourhood teams. There was also 1 Self harm (actual harm) incident recorded at CAMHS Reach Team (Crisis Team), Wakefield. This figure is lower than previous months. No particular reason has been identified for this.

Safety First cont…

Summary of Serious Incidents (SI) by category

	20/21 Q1	20/21 Q2	20/21 Q3 (Oct)	19/20 Q4	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Administration/supply of medication from a clinical area	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Damage (deliberate - e.g Vandalism)	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	1	0	1	0	0	1	0	0	0	0	0	0	1	0	0
Death - confirmed from physical/natural causes	1	0	0	1	0	1	1	0	0	0	0	1	0	0	0	0
Death - confirmed related to substance misuse (drug and/or alcohol)	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Information disclosed in error	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Security - Other	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Self harm (actual harm) with suicidal intent	0	2	0	0	0	0	0	0	0	0	0	0	1	0	1	0
Slip, trip or fall - patient	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0
Substance Misuse	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0
Suicide (incl apparent) - community team care - current episode	3	2	2	8	1	1	4	2	2	0	2	1	0	2	0	2
Suicide (incl apparent) - community team care - discharged	1	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0
Suicide (incl apparent) - inpatient care - current episode	0	1	0	1	0	0	1	0	0	0	0	0	1	0	0	0
Unintended/Accidental injury	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Physical violence (contact made) against staff by patient	0	0	0	2	1	0	1	1	0	0	0	0	0	0	0	0
Physical violence (contact made) against other by patient	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Pressure Ulcer - Category 3	2	1	0	0	0	1	0	0	0	0	0	2	1	0	0	0
Total	9	12	2	15	2	4	9	4	2	0	4	5	3	7	2	2

Please Note: initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report

• Incident reporting levels have been checked and remain within the expected range.
• Degree of harm and severity are both subject to change as incidents are reviewed and outcomes are established.
• Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
• All serious incidents are investigated using Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
• Risk panel meets weekly and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report, the format and content is regularly reviewed.

Mortality

Learning: Thematic learning work will be completed during Q3 for sharing during Q4. Clinical mortality review group has been postponed during to Covid 19 pressures on services. Although learning continues to be shared through the production of SBAR's which are shared via the learning library.
Regional work: no updates
Reporting: Q2 2020/21 data for learning from deaths included in Q2 incident report. http://nww.swyt.nhs.uk/incident-reporting/Pages/Incident-management-annual-report.aspx . Reporting aligned to revised BDU structures.
Structured judgement reviews: Despite having additional SJR reviewers, clinical pressures are meaning staff report not having capacity to take on an SJR causing delays in allocation. There are 4 Incidents currently awaiting awaiting allocations for SJR. 1 SJR awaiting completion of 2nd review.

Safer Staffing Inpatients

In October 2020, as well as continuing to deliver our services, we are experiencing the next "wave" of the pandemic which is impacting on our services. We have had 6 inpatient outbreaks which the operational services, with the support of our internal mechanisms and services, have coped with extremely well. The new band 5 starters have, in the main, received their PIN numbers and are now recorded in the registered work force. BDU and team business continuity plans have remained resilient in the face of significant challenges and all staffing escalation plans for inpatient services have been, or will shortly be, reviewed. We continue to offer modified mandatory online training as well as online. We continue to utilise the temporary staffing workforce as well as overtime and time owing to cover our inpatient areas. We continue with the latest recruitment drive for bank as well as plans for a collaboration between 5 trusts looking at international recruitment continue at pace.

Another pressure has been the impact that track and trace has had as it is leading to staff having to self-isolate which wasn't the case in the first wave of the pandemic. Testing has proven to be quicker thus allowing staff to return to work sooner.

No wards have fallen below the 90% overall fill rate threshold in October. Of the 31 inpatient areas, 22 (70.4%), a decrease of one ward on the previous month, achieved greater than 100%. Indeed, of those 22 wards, eight (a decrease of three wards) achieved greater than 120% fill rate. The main reason for this being cited as acuity, observation and external escorts.

Registered on Days -Trust Total 85.1% (an increase of 7.4%). The number of wards that have failed to achieve 80% registered nurses decreased by four to 13 (41.6%). Eight wards were within the Forensic BDU, two in Wakefield and three in Calderdale and Kirklees. Although our overall fill rates remain high, all inpatient areas remain under pressure from a registered staffing perspective. This is often compensated by increasing the number of HCAs per shift. Contributory factors included high levels of acuity, high sickness/absence and existing vacancies. Tailored localised adverts are proving beneficial to recruitment of band 5 RNs with some success in both Calderdale and Kirklees as well as our ongoing centralised recruitment drives and attendance at recruitment fairs. This will continue going forward with bespoke adverts for hot spot areas.

Registered on Nights- Trust Total 95.0% (an increase of 1.4%). Five wards (16%), an increase of one on the previous month, fell below the 80% fill rate in the month of October. Four were within the forensic BDU and the other C&K. This was due to a number of reasons reflective of the reasons in the section above. The number of wards who are achieving 100% and above fill rate on nights increased by one to 16 (51.2%). Three wards utilised in excess of 120% and these were within the C&K, Barnsley and Forensic BDU.

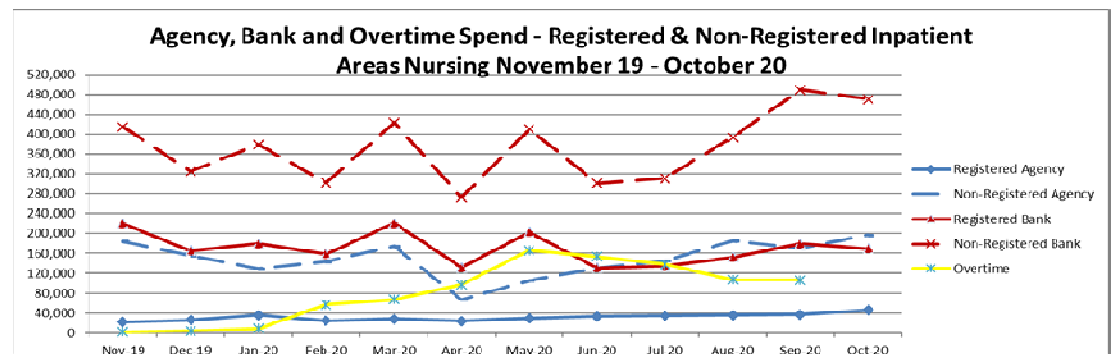Overall fill rate for registered staff increased by 4.45% to 90.05%.

Overall fill rate for all staff within inpatient areas reduced by 0.4% to 114.0%.

Ward Name	Aug-20 Average Fill Rate - All Staff (%)	Sep-20 Average Fill Rate - All Staff (%)	Oct-20 Average Fill Rate - All Staff (%)
Beamshaw	100.8%	100.6%	106.0%
Clark	122.7%	113.1%	111.1%
Melton Suite PICU	119.2%	122.5%	122.1%
Neuro Rehab Unit	148.3%	124.4%	136.4%
Stroke Rehab Unit	115.2%	103.9%	111.8%
Willow Ward	107.6%	101.6%	118.5%
Ashdale	101.1%	99.0%	94.0%
Beechdale	144.2%	131.7%	150.2%
Elmdale	97.5%	97.7%	93.8%
Enfield Down	97.7%	98.2%	94.6%
Lyndhurst	98.0%	98.8%	100.9%
Ward 18	102.5%	105.8%	106.4%
Ward 19 – Female	94.7%	101.1%	105.3%
Ward 19 – Male	101.1%	101.3%	105.5%
Appleton	93.2%	87.3%	92.2%
Bronte	129.0%	122.4%	126.6%
Chippendale	100.5%	93.2%	94.8%
Hepworth	162.6%	103.4%	103.2%
Gaskell	175.1%	156.7%	168.7%
Newhaven	91.9%	90.2%	97.0%
Priestley	92.2%	89.0%	94.3%
Ryburn	107.6%	100.8%	99.1%
Sandal	129.1%	128.4%	119.6%
Thornhill	123.3%	107.9%	98.0%
Waterton	121.8%	112.8%	114.5%
Crofton	105.5%	116.9%	107.4%
Horizon	128.1%	152.2%	140.0%
Nostell	124.1%	122.3%	111.0%
Poplars	131.8%	153.7%	143.3%
Stanley	136.5%	135.7%	136.5%
Walton PICU	136.5%	134.8%	120.0%
All Wards	**118.0%**	**114.4%**	**114.0%**

Fill Rate Key for All Staff:
- Less than 90% fill rate
- Greater than or equal to 120% fill rate

Agency, Bank and Overtime Spend – Registered & Non-Registered Inpatient Areas Nursing November 19 – October 20

Legend: Registered Agency, Non-Registered Agency, Registered Bank, Non-Registered Bank, Overtime

Total Fill Rate by BDU

Legend: Aug-20, Sep-20, Oct-20 — Barnsley, C & K, Forensic, Wakefield

Forensic and LD BDU decreased from 116% to 115% (this is often affected by the bespoke care packages that are offered through Horizon). Barnsley increased from 111% to 117%. Calderdale and Kirklees BDU increased from 103% to 105%. Wakefield BDU decreased from 132% to 123%.
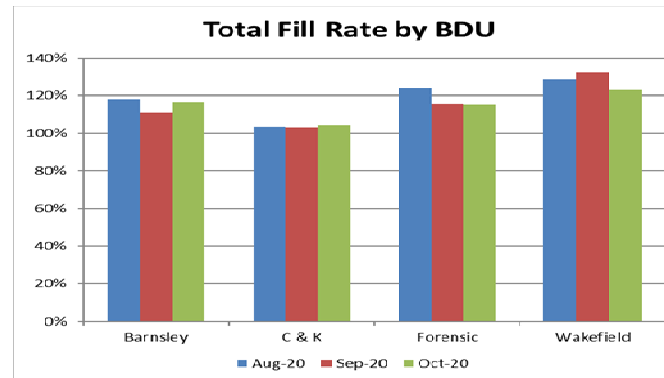
Throughout the last month the main wards where staffing was a raised concern were Poplars, Ward 19, Crofton and Newton Lodge. Shifts were picked up quickly and the fill rate of requested flexible staffing shifts remained high as can be seen in the figures below.

Categories	No. Of Shifts	Total Hours	Unfill Percentage
Registered	319	3,493.50	31.55% (-4.14%)
Unregistered	439	4,775.83	12.87% (+1.82%)
Grand Total	758	8,269.33	17.16 (+0.44%)

We are continuing to target the areas above within our recruitment campaigns, block booking and prioritisation within bank booking. However, this does vary on a weekly basis dependent on acuity and clinical need.

In October the number of shifts that were requested of the flexible staffing rose compared to the month before to 4,278, (RNs requests increased from 988 to 1020 and HCA requests rose from 3186 to 3258), and this led to a slight overall increase in bank and agency spend of £5,0641. This was broken down into: Agency increased by approx. £35k and bank decreased by approx. £29k whilst we were unable to produce the overtime figure at this time.

Information Governance

October saw a decrease in the total number of incidents compared to the previous month. Information being disclosed in error continues to be the most reported category and breaches of this type were typically due to correspondence being sent to the wrong email or postal address, failure to blind copy personal email addresses which are visible to all recipients, incorrect attachments being sent by email and conversations being overheard by unauthorised parties.

An action plan to raise awareness of the consequences of incidents took effect from September. This includes refreshed communications, change improvement workshops and a programme of sending letters to teams where incidents occur, IG attending team meetings.

No incidents were reported to the Information Commissioner's Office (ICO) during October. An incident of information being disclosed in error that was previously reported to the ICO has now been closed: the ICO confirmed no further action would be taken but made some recommendations, including investigating the incident to determine the root cause. The internal investigation is almost complete and the report will be available soon.

Commissioning for Quality and Innovation (CQUIN)

Schemes for 20/21 have been suspended during the Covid-19 pandemic period.

Patient Experience

Friends and family test shows

• 97% of respondents would recommend community services.
• 84% would recommend mental health services.

Mental Health Services
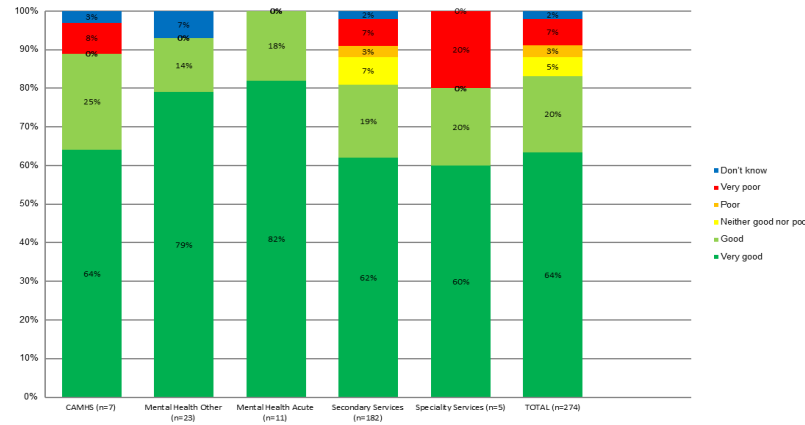
Community Services
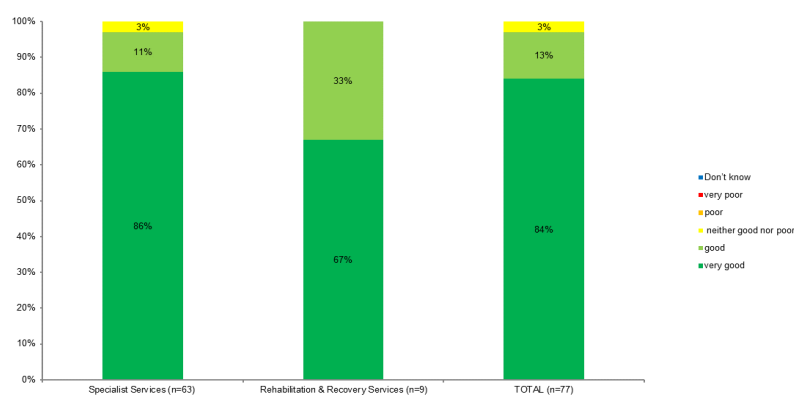
• 87% (351) of respondents felt that their experience of services had been very good or good across Trust services.
• 97% (n=77) of respondents felt that their experience of community services had been very good or good across community services.
• 84% (n=272) of respondents felt that their experience of mental health services had been very good or good across mental health services.
• Text messages provided 72% of the responses in October.

The new patient experience system is being piloted on electronic devices within the QIA Team over the next four weeks. The system will then be piloted within services across the Trust.

Thinking about the service we provide. Overall, how was your experience of our service?
Very good, good, neither good nor poor, poor and very poor.

Care Quality Commission (CQC)

CQC improvement plan

The monthly improvement plan updates show that we continue to increase in the number of completed actions. All of the 'must do' and 97% of the 'should do' actions are either completed or remain on track. One action has been rated red as it has not been completed within the given timescales. We are starting to plan and look at how we can monitor assurance against the actions to make sure we sustain and continue to make the necessary improvements.

		October 2020	
		MUST (n =12)	SHOULD (n=37)
Blue		5 (42%)	28 (76%)
Green		7 (58%)	8 (21%)
Green	Amber	0	0
Amber	Red	0	0
Red		0	1 (3%)
Total		12	37

Safeguarding

Safeguarding Children and Adults

Safeguarding remains a critical service, all statutory duties have been maintained, data flow (internally and externally) has continued in a timely manner and the team have continued to provide supervision. Level 3 Safeguarding adults and children training continues to be delivered virtually via MS Teams. This has been positively received although further work to support interaction is being undertaken. Levels 1 and 2 have been accessed via e-learning with all mandatory courses (including PREVENT) reported above the 80% mandatory training target.

The team continue to review Datix and clinical records as part of internal quality monitoring and in preparation for external CQC and Ofsted inspections. Additionally, members of the team continue to provide support to the covid19 staff testing and the flu vaccination programme.

Shadowing experiences have been offered to Social Work students to work alongside the safeguarding team. This has been positively received. The safeguarding team have received the FIRM risk assessment training and continue to work with the Barnsley General Community service to support development of an adaptation of the FIRM risk assessment.

External information gathering requests have been responded to and the team have continued to attend Child Safeguarding Practice Review panels, Safeguarding Adult Review panels and Domestic Abuse panels.

The team have supported clinical activity through attendance at multi-disciplinary meetings, professional meetings and Best Interest meetings. All members of the team have attended virtual webinar to ensure that their practice and the training material and advice provided is up to date and relevant. The West Yorkshire Quality Assurance Mark Domestic Abuse Training has been amended to a virtual presentation, it is being delivered on a monthly basis within SWYPFT.

Infection Prevention Control (IPC)

• Ongoing work for COVD19 pandemic
• Annual report 2020/21, completed and approved
• Surveillance: For September there has been zero cases of C difficile, MRSA Bacteraemia and MSSA bacteraemia. There has been one ecoli bacteraemia in on SRU in November 2020 which is deemed unavoidable
• Mandatory training figures are healthy:
• Hand Hygiene-Trust wide Total –98%
• Infection Prevention and Control- Trust wide Total –96%
• Policies and procedures are up to date.

Complaints

There were 24 new formal complaints in October 2020. Of these 4 have had timescales start, 1 has been closed as no consent/contact and 19 are awaiting consent/questions

4% of new formal complaints (n=1) had staff attitude as a primary subject

21 compliments were received

10 formal complaints were closed in October 2020. Of these, 60% of complaints (n=6) were closed within 40 working days. Of the 4 complaints that exceeded 40 working days, 2 complaints that were closed at 60 days and 2 complaints that were closed at 71 and 75 days. The reasons why complaints exceeded the 40 day target included delays in receiving the completed investigation from clinical services, issues with the quality of information received in the completed investigation and the volume of concerns to provide a response to.

Count of written complaints/count of whole time equivalent - 4.73WTE (including a band 6 and 7) – stays the same

Reducing Restrictive Physical Intervention (RRPI)

There were 165 reported incidents of Reducing Restrictive Physical Interventions used in October 2020 this is an increase of 40 incidents since September 2020.

Of the different restraint positions used in the 165 incidents, standing position was used most often 90 (39%) followed by both the seated and supine restraints at 45 (19%). The high level of supine restraints is attributed to mainly two service users within the learning disability service who were often seated and then placed in a supine position to manage risks.

Prone restraint was reported 8 (4%) times in October 2020, this has halved in total from last month.

Incidents where prone descent immediately turned into a supine position where recorded at 10 (4%) this is a separate entity to prone restraint.

Calderdale BDU recorded 4 Prone Restraints, forensic and specialist services recorded 2 each all other services reported no Prone Restraint.

The Trust target of 90% of prone restraints lasting under 3 minutes and the importance of striving to maintain this is strongly emphasised.

In October the percentage of prone restraints lasting under 3 minutes was 87.5% which is a reduction of 6.5% from September, it must be noted that out of 8 prone restraints only one was above 3 minutes.

Total restraints
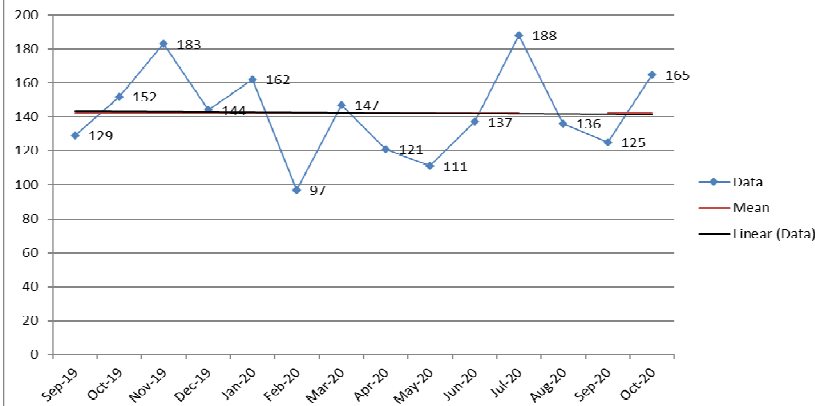
Incidents by team October 2020

Restraint positions

Legend:
- Kneeling
- Prone - chest down position, regardless of on what surface
- Prone then rolled into other position Side/Back
- Safety Pod
- Seated
- Side
- Standing
- Supine held on their back, regardless of surface
- Restricted escort
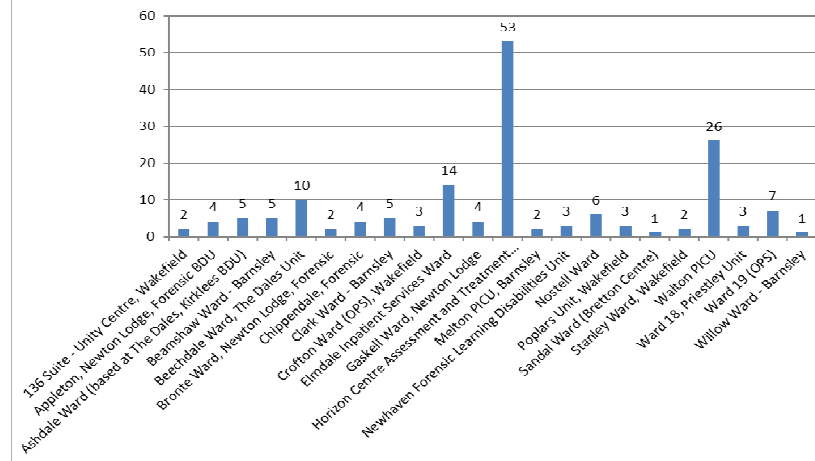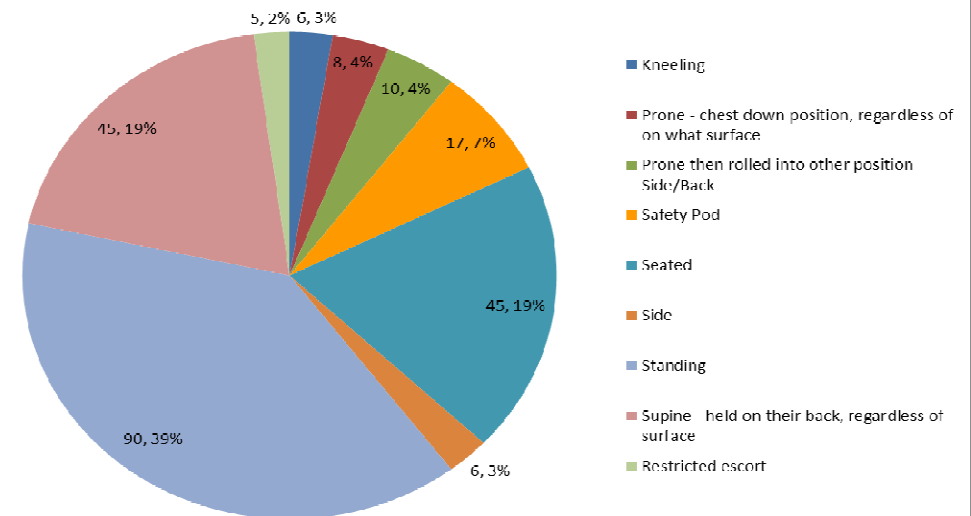
Self Harm

Actual self-harm incidents reported on Datix occurring between 05/01/2020 and 14/11/2020 at 16/11/2020, compared with incidents occurring in the same period in 2019

All actual self harm incidents reported Trustwide which occured during 2020 (by incident date 05/01/2020 - 14/11/2020) compared with the same weeks in 2019 (at 16/11/2020)
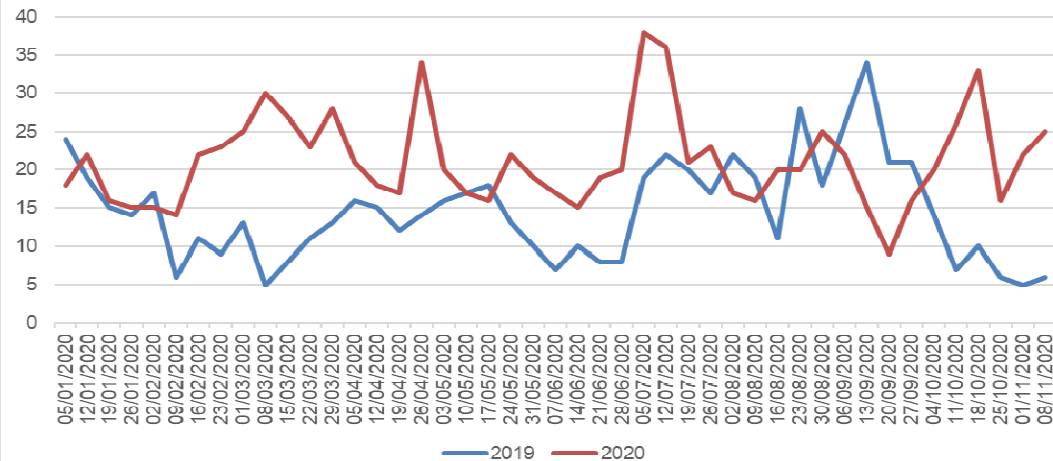
Actual Self Harm comparison

Week Commencing	2019	2020
05-Jan	24	18
12-Jan	19	22
19-Jan	15	16
26-Jan	14	15
02-Feb	17	15
09-Feb	6	14
16-Feb	11	22
23-Feb	9	23
01-Mar	13	25
08-Mar	5	30
15-Mar	8	27
22-Mar	11	23
29-Mar	13	28
05-Apr	16	21
12-Apr	15	18
19-Apr	12	17
26-Apr	14	34
03-May	16	20
10-May	17	17
17-May	18	16
24-May	13	22
31-May	10	19
07-Jun	7	17
14-Jun	10	15
21-Jun	8	19
28-Jun	8	20
05-Jul	19	38
12-Jul	22	36
19-Jul	20	21
26-Jul	17	23
02-Aug	22	17
09-Aug	19	16
16-Aug	11	20
23-Aug	28	20
30-Aug	18	25
06-Sep	26	22
13-Sep	34	15
20-Sep	21	9
27-Sep	21	16
04-Oct	14	20
11-Oct	7	26
18-Oct	10	33
25-Oct	6	16
01-Nov	5	22
08-Nov	6	25
Total	**655**	**953**

Please note:

To ensure this data is accurate as possible, it includes all actual self harm incidents even where the incident has not yet been approved by managers (22 in total pending review). Figures may change as incidents are reviewed and approved.

The peak in July 2020 has been explored further and analysis has shown that between 1/7/2020 - 1/8/2020 there was a total of 135 incidents of actual self-harm.

This involved 34 patients. 27 patients had 3 or less self harm incidents in the period. There were 6 patients who had more than 3 incidents. Of these, one patient had 30 incidents (28 on Clark, 2 on Beamshaw), Another patient had 30 incidents (Elmdale). The next highest total of self harm in the period was for a patient with 12 incidents (10 on Clark and 2 on Ward 18).

Of the 135 incidents between 1/7/2020-1/8/2020, it involved 20 different teams. 12 were assigned to inpatient wards, and 8 were incidents occurring in the community. Of the inpatient wards, Clark had the highest number (52), followed by Elmdale (47). The third highest wards were jointly Stanley ward and Horizon Centre both with 5 incidents.

Analysis of the data from 2020 shows that there are two subcategories of self harm that are higher than other methods. These are self strangulation, which is the highest subcategory of self harm incident (307 incidents). There was a peak in July where there were 63 incidents, this figure has now reduced August (9), September (11) and October (29).

Analysis of incidents shows that a small number of individual service users account for this higher number of incidents.

The next highest subcategory is by cutting (193 incidents). This varies across months ranging from 14 - 27 incidents. Following this, the third highest subcategory is 'headbanging' with 61 incidents. The headbanging incidents are across a range of units, but Ward 18 had the highest number (20).

The peak in incidents in October 2020 has been explored further. Analysis has shown that this is primarily due to an increase in incidents on Clark Ward, for one individual patient using self strangulation methods. Within the data overall, there were 3 incidents reported as moderate or severe harm in this reporting period (October 2020), which occurred in 3 different teams - CAMHS ReACH Team (Crisis Team) Wakefield, Single Point of Access (Wakefield) and Wakefield CAMHS West Team involving prescription medication - self poisoning, jumping from height and headbanging. Self-strangulation, cutting, hanging and scratching/biting are the highest reported self harm incidents in October 2020.

Apparent Suicide

Apparent suicides reported on Datix occurring between 05/01/2020 and 14/11/2020 at 16/11/2020, compared with incidents occurring in the same period in 2019

All apparent suicides reported Trustwide which occurred during 2020 (by incident date 05/01/2020 - 14/11/2020) compared with same weeks in 2019
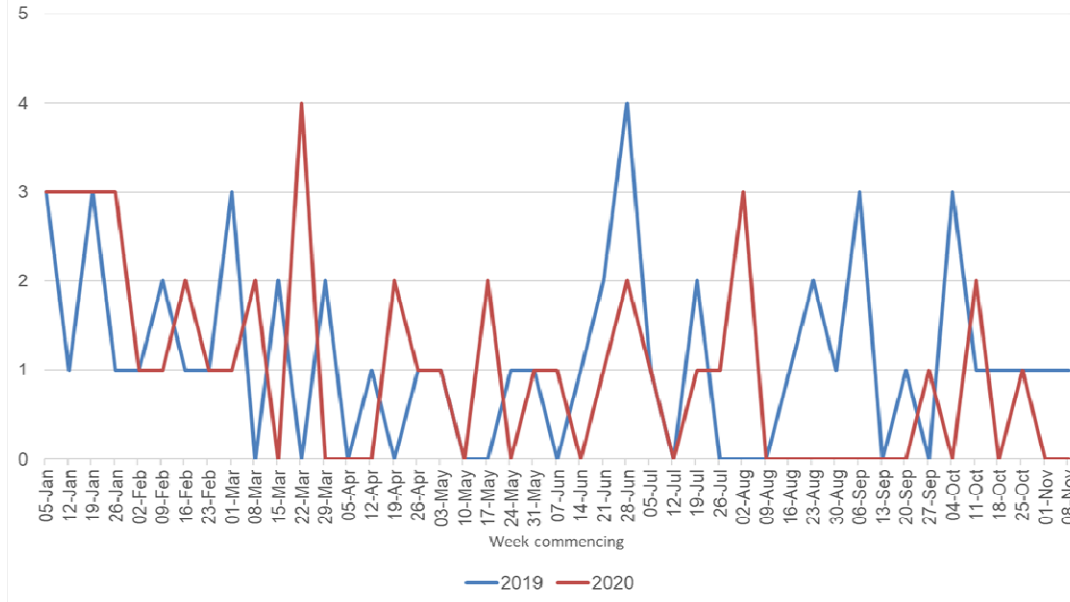
Apparent suicide comparison

Week Commencing	2019	2020
05-Jan	3	3
12-Jan	1	3
19-Jan	3	3
26-Jan	1	3
02-Feb	1	1
09-Feb	2	1
16-Feb	1	2
23-Feb	1	1
01-Mar	3	1
08-Mar	0	2
15-Mar	2	0
22-Mar	0	4
29-Mar	2	0
05-Apr	0	0
12-Apr	1	0
19-Apr	0	2
26-Apr	1	1
03-May	1	1
10-May	0	0
17-May	0	2
24-May	1	0
31-May	1	1
07-Jun	0	1
14-Jun	1	0
21-Jun	2	1
28-Jun	4	2
05-Jul	1	1
12-Jul	0	0
19-Jul	2	1
26-Jul	0	1
02-Aug	0	3
09-Aug	0	0
16-Aug	1	0
23-Aug	2	0
30-Aug	1	0
06-Sep	3	0
13-Sep	0	0
20-Sep	1	0
27-Sep	0	1
04-Oct	3	0
11-Oct	1	2
18-Oct	1	0
25-Oct	1	1
01-Nov	1	0
08-Nov	1	0
Total	**51***	**45****

Please note:

Data refreshed and verified on 16 November 20 from Datix for both 2019 and 2020 data.
Some inaccuracies in the data previously submitted has been identified due to the manual nature of the data extract process. Checks have now been built into the report production.

*In comparison, the 2019 figure includes 6 apparent suicides of people who were not under SWYPFT care.
**2020 figure includes 5 apparent suicides reported but which after initial review were not SWYPFT incidents.

Examples of 2020 cases are someone who had a contact with Liaison and Diversion Team, and died several months later, and death of someone who had had presented at a community team base, but was not under SWYPFT care, death of person who police liaison practitioner was asked to speak to as part of role, person did not engage, not under Mental Health Services.

Covid-19 related incident reporting

203 incidents reported between 1/3/20-16/11/20 where 'Covid' or 'Corona' was used in the description or action taken fields. These incidents have been themed as below. One incident may have more than one theme.

163 Incidents	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
Coronavirus or Covid 19 used in threat against patient	1	1	0	0	0	0	0	0	0	2
Coronavirus or Covid 19 used in threat against staff	3	2	1	0	0	0	1	1	0	8
Death of patient from suspected Covid 19 - no underlying health	0	0	1	0	0	0	0	0	0	1
Death of patient from suspected Covid 19 - underlying health	2	16	3	1	0	0	0	0	1	23
Death of patient from suspected Covid 19 related death - pending	0	7	5	3	1	0	0	0	1	17
Impact of coronavirus/Covid 19 on patient and staff safety	4	5	9	3	0	2	12	10	5	50
Impact of Covid 19 on community patient, changes to care	2	2	2	1	2	3	0	0	0	12
Impact of Covid 19 on patients mental health	2	2	1	0	2	0	1	0	0	8
Issues relating to PPE equipment	1	1	1	0	0	2	0	1	0	6
Non compliance with social distancing - inpatient area	1	7	4	8	3	3	3	4	2	35
Patient being nursed in isolation	5	4	3	4	2	4	3	3	0	28
Patient in contact with symptomatic person	0	0	2	0	0	0	2	0	0	4
Staff in contact with colleague displaying Covid-19 symptoms	0	0	0	0	1	0	3	1	1	6
Staff in contact with other person displaying Covid-19 symptoms	1	0	2	0	0	0	2	1	1	7
Staff in contact with patient displaying Covid-19 symptoms	2	8	5	3	2	2	3	1	1	27
Staff member on swabbing team exposed to Covid 19	0	1	0	0	0	0	0	0	0	1
Staff presenting with Covid 19 symptoms	1	1	1	0	2	0	7	2	1	15
Total	25	57	40	23	15	16	37	24	13	250

Mental Health Act

This section provides some key metrics related to performance against the Mental Health Act (MHA) requirements. Development of these has been taking place over the last few months. Monthly reporting of performance against Section 17 leave is now available. Future developments will include reporting relating to Section 132 patients rights. Progress to date on this is as follows:
• The Trust section 132 policy and additional document amendments have been completed and agreed with the practice governance coach and the matrons.
• The Mental Health Act administrators have started attending the wards and meeting with registered staff to show them the new process, where to record on SystmOne and where to access The SystmOne white board (dashboard) so that the registered staff can at a glance and in real-time see what the activity is and what needs addressing / where the hotspots are.
• The MHA administrators will be developing a process to keep this under review and send reminders where needed to registered staff alerting that a patients' rights are due. Further update regarding this can be seen below.

Section 17 leave

The Care Quality Commission have regularly raised an issue with the non completion of page 2 of the Section 17 leave forms. The recording of who has been informed of the leave and the involvement of the service users is a requirement of the MHA code of practice 2015.
The process of reviewing and proactive action has been in place since September 2019. Over the last 12 months there has been good progress in getting this practice embedded at ward level however as the data shows a number of services continue to show as red.
This data indicates that the forms are being reviewed by the MHA administrators and where required are returned to the clinical team for action and completion.
It is important to note that this report is monitoring the amount of s17 leave forms that require MHA administration intervention. With the intervention of the MHA office staff we should be achieving 100% compliance.
The monitoring of these forms is showing that the clinical staff are completing some parts of the forms but they need to be fully completed hence these being returned to the clinical staff.
The Ward Managers within the Forensic service have now been tasked with undertaking weekly checks of the forms. This is also the case within in patient services across the Trust.
The practice governance coaches and Matrons will continue to dip sample records and have oversight of the process.
All services are reporting that they can see an improvement over the past 2 weeks and this can be partially borne out by the figures reported for October 2020.
Training on the completion of the S17 forms by the MHA admin team has been offered to the clinical services.
Inclusion of the purpose, use and completion of the S17 leave forms is included in staff induction and the mandatory training provided within the Trust.

Service	May-20 Section 17 form			Jun-20 Section 17 form			Jul-20 Section 17 form			Aug-20 Section 17 form			Sep-20 Section 17 form			Oct-20 Section 17 form		
	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete
Older people services Trustwide	58	49	84.5%	77	58	75.3%	33	30	90.9%	74	68	91.9%	82	68	82.9%	48	43	89.6%
Working age adult - Trustwide	247	210	85.0%	292	192	65.8%	203	169	83.3%	269	195	72.5%	295	246	83.4%	163	137	84.0%
Specialist Forensic services	6	5	n/a	18	16	88.9%	11	11	100%	135	107	79.3%	248	193	77.8%	118	87	73.7%
Rehabilitation services - trustwide	24	24	100%	15	15	100%	20	20	100%	13	13	100%	13	13	100%	7	7	100%

Patients rights

Work is progressing on reporting for the adherence to reading of patients' rights. This data is now being recorded on SystmOne. We are now in the process of writing a report to flow this data. We were anticipating this data to be available in last months integrated performance report but due to Covid-19 this has been delayed. A further update will be provided in next months report.
There is currently a manual process in place monitoring the reading of patients' rights which is being undertaken by the mental health act administrators in conjunction with the wards.

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

NHS Improvement - Oversight Framework Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Data quality rating 8	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	98.2%	97.8%	90.0%	98.7%	97.0%	95.6%	90.0%	94.9%	96.8%	98.7%	98.5%		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100.0%	100.0%	28.5%	43.8%	55.2%	31.4%	28.5%	26.2%	33.9%	43.8%	42.9%		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	99.7%	97.9%	100%	96.1%	99.0%	99.2%	100%	96.8%	96.4%	95.2%	100%		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	319/327 97.6%	269/279 =96.4%	297/299 = 99.3%	300/302 =99.3%	90/92 =97.8%	102/102 = 100%	105/105 = 100%	110/110 = 100%	84/85 =98.8%	106/107 =99.1%	97/98 =98.9%		
Data Quality Maturity Index 4	Improving Health	Responsive	CH	95%	98.3%	98.5%	98.5%	98.5%	98.5%	98.5%	98.6%	98.7%	98.7%	98.0%	98.9%		
Out of area bed days 5	Improving Care	Responsive	CH	20/21 - Q1 247, Q2 165, Q3 82, Q4 0	335	958	415	737	167	108	140	336	224	177	106		
IAPT - proportion of people completing treatment who move to recovery 1	Improving Health	Responsive	CH	50%	53.6%	54.3%	46.6%	52.7%	51.4%	49.1%	42.8%	50.1%	54.3%	54.1%	55.4%		
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	CH	75%	79.3%	85.3%	88.3%	92.8%	86.3%	88.1%	89.7%	91.1%	92.8%	94.5%	95.2%		
IAPT - Treatment within 18 weeks of referral 1	Improving Care	Responsive	CH	95%	97.6%	98.9%	98.9%	99.1%	99.3%	98.5%	98.9%	98.5%	99.2%	99.6%	99.8%		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	60%	82.6%	85.6%	84.6%	87.0%	70.7%	95.8%	92.3%	87.8%	79.5%	94.3%	97.0%		
% clients in settled accommodation	Improving Health	Responsive	CH	60%	90.5%	91.3%	91.3%	91.1%	91.3%	91.2%	91.2%	91.1%	91.1%	91.1%	91.3%	⚠️	
% clients in employment 6	Improving Health	Responsive	CH	10%	11.8%	12.1%	12.5%	12.6%	12.3%	12.3%	12.7%	12.6%	12.6%	12.6%	12.6%	⚠️	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Data quality rating 8	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	TBC	27	17	10	34	2	5	3	0	8	26	10		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	TBC	3	3	4	6	1	2	1	0	3	3	2		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	Trend Monitor	206	180	258	205		258			205		Due January 2021		
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	CH	Trend Monitor	11.2%	10.0%	14.7%	13.7%		14.7%			13.7%				

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Data quality rating 8	Trend
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance 1	Improving Health	Responsive	CH	90%	98.8%	99.3%	99.1%	99.8%	99.5%	98.7%	99.0%	99.3%	100%	100%	100%		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	99%	99..9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	100%	99.9%	99.9%		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	98.7%	98.8%	98.7%	98.4%	98.8%	98.7%	98.6%	97.8%	97.9%	98.2%	98.2%		

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

Headlines:

• The Trust continues to perform well against most NHS Improvement metrics
• The percentage of service users waiting less than 18 weeks decreased to 98.5% in October, remaining above the target threshold.
• The percentage of service users seen for a diagnostic appointment within 6 weeks remains well below target at 42.9% . This is a consequence of the impact of Covid-19. This is an improvement against the previous month and a recovery plan is in place.
• Inappropriate out of area bed placements amounted to 106 days in in October. This is a decrease from 177 in September. Following communication with NHS Digital we have reassessed the reporting of inappropriate bed days and adjusted to reflect the inclusion of gender specific placements.
• During October 2020, there were 2 service users aged under 18 years placed in an adult inpatient ward for a total of 10 days. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. We routinely notify the Care Quality Commission (CQC) of these admissions and discuss the detail in our liaison meetings, actioning any points that the CQC request. This issue does have an impact on total Trust bed availability and therefore the use of out of area bed placements. In addition, the Trust's operational management group have recently signed off a new standard operating procedure for admitting young people to adult wards which has now been put into operation.
•% clients in employment- the Trust is involved in a West Yorkshire and Harrogate Health & Care Partnership wave 1 three-year funding initiative, led by Bradford District Care, to promote, establish and implement an Individual Placement Support (IPS) scheme. IPS is evidence based vocational scheme to support people with mental health problems to gain and keep paid employment. Work is currently ongoing in Calderdale to expand the opportunities we can offer people under this scheme. A South Yorkshire & Bassetlaw partnership bid for individual placement support wave 2 funding has been successful which will see the creation of additional employment workers to support secondary care mental health services in Barnsley. There are some data completeness issues that may be impacting on the reported position of this indicator.
• The scope of the data quality maturity index changed in July 2019 as part of a national CQUIN, though the target has remained the same. The Trust has been consistently achieving this target.
• IAPT treatment within 6 weeks of referral has achieved the 75% target although there are continuing challenges in meeting this particularly in regard to staffing numbers.

Data quality:

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

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

• The reporting for employment and accommodation for October shows 12.8% of records have an unknown or missing employment and/or accommodation status, this is a slight increase compared to September which showed 12.6% of records have an unknown or missing employment and/or accommodation status. This has therefore been flagged as a data quality issue and work takes place within business delivery units to review this data and improve completeness.

This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU).

Barnsley general community services

Key Issues
• Bed and staffing crisis at Barnsley hospital impacting on community services and particularly crisis response and discharge to assess (D2A) team.
• Crisis response out of hours at capacity in relation to four visits per day and support to patients in last days of life. We are bolstering twilight shifts.
• Dietetics - lack of specialist staff, due to maternity leave.
• Significant increase on Covid-19 positive in care homes, increasing the wrap around from our teams for quite poorly residents.
• Daily safety huddles with critical staff groups.
• Daily tactical calls with Barnsley hospital and wider partners
• Daily system Bronze now in place.
• Urban House (Wakefield) client number continue to increase daily, with more complex needs. The health integration team continue to support clients in the current alternative hotel accommodation in Wakefield. Lead Nurse is clinically extremely vulnerable (CEV) and working from home. Commissioner discussions continue.

Strengths
• Community therapy teams consistently reviewing patients requiring rehabilitation support workers (RSW) which has enabled a consistent daily capacity of available RSW to keep the flow of patients being discharged from the hospital into community services.
• All services flexing across the system to enable services to manage the increased number of staff isolating due to symptoms of Covid-19.
• Constant communication with our hospital and social care partners to keep the flow of patients through the system and to the best place of care for their needs.
• New referrals increased by 300 into neighbourhood nursing compared to the previous month.
• Beds in community setting - we are supporting approximately 7,300 patients.
• Week commencing 26.10.2020 - 9,200 contacts with over 7,000 being face to face and a significant amount of these requiring home visits.
• The Yorkshire smoke free (YSF) Calderdale commissioner has indicated they intend to extend our current contract to March 2022.
• The YSF Wakefield Commissioner has extended the contract to December 2021 and seeking professional advice to possibly extend the contract for an additional 12 months.
• The live Well Wakefield commissioner has confirmed they intend to extend the contract until March 2023 (via Nova)
• Live Well Wakefield continues to be the service of choice for additional community support with regard to Covid-19.
• The vaccination and immunisation team continues to deliver sessions for school aged children in a variety of venues /days/times and have had good uptake and positive feedback.
• Health and Wellbeing services (HWB) - client feedback across all services remains consistently positive.
• Health and Wellbeing services - staff feedback from our staff wellbeing survey is extremely positive overall.
• Health and Wellbeing services - the majority of staff are working from home with no significant issues of note.
• All HWB services remain very busy and are delivering a "blended service" of face to face, telephone and video conferencing and are not currently experiencing any notable disruption due to Covid-19
• Breathe tender submitted (note now extended to Feb 2021)

Challenges
• Patients discharged to community services from the hospital, that are medically stable to leave hospital but higher than normal acuity; community therapists have to manage these patients in a different way.
• Significant staffing challenges in relation to sickness, self-isolation, shielding.
• Covid 19 vaccine mobilisation

Areas of Focus
• Keeping the flow of patients to the most appropriate place of care within the whole health care system.
• Continue to support health integration team to deliver safe services in Urban House and the hotel.
• Work has commenced on developing an integrated service pathway for neuro rehabilitation in Barnsley. This is in line with a request from CCG to streamline current pathways which include inpatients, brain injury rehab and domiciliary neuro.
• Clinical Supervision – the BDU have a service wide action plan and we are taking steps to ensure that the process of recording supervision is tightened up.

Barnsley mental health services and child and adolescent mental health services:

Mental Health:
Strengths
• All-age liaison model now operational
• Community contacts significantly above target with majority provided via telephone/video-link. Face to face contact increasing and offered where clinically required.

Areas of focus
• Work progressing to improve approach regarding access to out of area locked rehabilitation beds (including associated financial pressures)
• Reduced IAPT access during Covid-19. Face to face re-commenced in line with Trust guidance.
• Memory service diagnostic clinics re-instated with increased capacity to address backlog by the end of December.
• Recording of care programme approach (CPA) reviews and supervision being addressed through management supervision and in coordination with P&I colleagues
• Early intervention in psychosis (EIP) performance against cardio metabolic assessment compromised by Covid-19 restrictions. Working to improve data quality and address the backlog by December.

Child and adolescent mental health services (CAMHs):
Strengths
• All-age liaison model operational across all areas. Complemented by 7 days per week CAMHS crisis provision
• Agreed joint governance approach with Barnsley CCG to develop service specification. Intention to present a costed model in December.
• Trend in waiting numbers from referral to treatment in Barnsley and Wakefield remains positive.

Areas of focus
• Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have significantly increased – with escalating demand outstripping commissioned capacity. Now a focus of the CAMHS Improvement Board with a business case submitted to secure resources in Calderdale.
• Referral numbers across all services increasing – but not exceeding previous levels. Work continues with partners in local systems to manage emotional/mental health needs at lowest level possible.

This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU).

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Inpatient:

Key issues
• High demand for inpatient beds continues. Maintaining patient flow and facilitating sufficient ward capacity has been extremely challenging although no patients have been placed out of area in acute beds since September, and usage of PICU (psychiatric intensive care unit) out of area beds has remained stable and attributable to gender specific and safeguarding clinical reasons rather than shortage of beds. Concerted work on optimising patient flow is continuing and the service is now fully recruited and is moving towards 7 day working, with formal consultation about to commence.
• Cohorting standard operating procedures that support the separation of people with symptoms or a positive Covid-19 diagnosis are in place for acute and older people's services. An inpatient clinical pathway is in place for Covid-19 positive patients. This has now been reviewed to take into account the latest guidance and testing. The position is reviewed daily by the matrons to determine how care can be delivered and services managed in the event of an outbreak. Outbreaks across wards and the requirement for isolation and quarantine have been managed effectively using the procedure.
• Acute wards continue to see high levels of acuity and service user distress, with further challenges in managing shielded and cohorted patients. Staffing levels have generally been able to be maintained without growth in bank and agency usage. Weekly meetings with mental health partners across the integrated care system have enabled the strengthening of collaborative approaches, shared learning and innovative practice developments.
• The 'inpatient admissions and discharges summary' providing a daily report of the current position for each ward in terms of discharges over the last 7 days compared to the average number of weekly admissions to that ward continues to add value to the service and is complementing the work around criteria led discharge. The average length of stay remains in excess of target and has been identified as part of the trust wide programme of improvement in addressing demand and capacity in acute services.
• Significant pressures in the wider system have led to intensive work on improving pathways with acute hospitals. Focused inter-agency improvement projects are underway and include 'deep dives' into frequent attenders and waits in ED.
• Progress on improvement in clinical supervision rates is being tracked weekly across services and has shown significant improvement across the board. The Quarter 2 performance for the inpatient service line in the BDU was 89.5%. The essential importance of supervision in terms of safe practice and individual well-being has been emphasised. Work has been underway to address any recording issues and to ensure all colleagues receive supervision in line with policy requirements. Hotspot teams and wards have been identified and have action plans in place, where variations and particular challenges exist.

Strengths
• Ward 19 has gone 365 days without a medicines omission, a great achievement and are sharing their excellent practice with other wards across the service.
• Sustained improvements in patient flow and discharge pathways in each area following intensive work across acute and community pathways are being sustained.
• Criteria led discharge is progressing well across all units and is underpinning the approach to patient flow.
• Work continues to improve patient flow generally and to engage with partners in the wider system, including acute hospitals, to improve patient experience and pathways.
• With support and investment from the estates team the service is developing its first break out space on Crofton - a bespoke rest area away from adjacent to wards which will offer genuine 'downtime' opportunities for staff relaxation and recuperation facilities. This proto-type is now being scoped in Dewsbury and Halifax.

Challenges
• Adult acute occupancy remains at full capacity and acuity levels remain high, together with Covid-19 requirements, leading to sustained challenges on the wards.
• Demand for older people's beds has risen
• Pathways from acute hospitals and emergency departments
• Staffing difficulties remain in medical posts in acute wards in Wakefield – this is being addressed through a local task and finish group.

Areas of focus
• Continued improvement in supervision levels.
• Emergency department waits.
• Working effectively to improve timely discharge from wards.
• Patient flow in acute adults with an emphasis on alternatives to admission and collaborative inter-agency planning.
• Improvements to staffing levels and support for staff wellbeing in all services.
• Staffing challenges in acute medical teams.

This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU).

Wakefield, Kirklees and Calderdale Community:

Key issues
• Intensive input continues in front line services to adopt collaborative approaches to care planning, to build community resilience; and to explore all possible alternatives to hospital admission for people who need acute care. This has included developments in the trauma informed personality disorder pathway (TIPD). Work is underway in the intensive home based treatment teams (IHBT) to look at building up early discharge, alternatives to admission and to ensure robust gatekeeping, including progress on accompanying approved mental health practitioners (AMHPs) on mental health act assessments. The care closer to home programme is focusing on patient flow and IHBT and community team interfaces.
• Demand and levels of activity in IHBT and the mental health liaison teams leading to pressures for inpatient beds.
• The action plan and training around care programme approach (CPA) reviews, data quality and activity and improvement in how we use SystmOne is leading to some positive impact but requires more work. It is being closely monitored and supported at trio level. Performance reporting issues have been identified and performance and operational services are working closely together to address these. Wakefield has achieved 99.6% performance in Q2 following these plans.
• Community services continue to provide assessment, care management and interventions with service users utilising a range of innovative means of communication and ensuring face to face contacts are made wherever these are clinically indicated. Work is underway to optimise the use of our building spaces so that group work and more face to face therapies can be delivered.
• Building risk assessments are in place for all community bases and are being fully reviewed against phased recovery plans. Services are working collaboratively across all areas to optimise safety along with patient and staff access and usage.
• The IAPT teams continue to implement digital solutions and have robust plans in place to manage wait times and increase access. They have been participating in workshops with NHS England around service provision during and post Covid-19. Following the introduction of online e-referral forms, increased social media presence and increased offer of digital provided therapies to improve the ease of access to the service and choice, access rates are growing. Face to face work is building alongside, although accessing space in primary care remains a challenge. Work has also been successful on Covid-19 pathways out of acute hospitals and the long-term conditions linked pathways.
• All-age liaison services are now in place and fully operational in Calderdale, Kirklees and Wakefield.
• Progress on improvement in clinical supervision rates is being tracked weekly across services and has shown significant improvement across the board. The Quarter 2 performance for the community service lines in the BDU was 91.6% for Calderdale and Kirklees and 93.4% for Wakefield. The essential importance of supervision in terms of safe practice and individual well-being has been emphasised. Work is underway to address any recording issues and to ensure all colleagues receive supervision in line with policy requirements. Hotspot teams and wards have been identified and have action plans in place.

Strengths
• Community teams have continued to optimise the use of technology. Team business and supervision is carried out on Microsoft Teams and AccuRx for appointments with service users. Telephone appointments and WhatsApp have also been utilised. Work has now commenced in services around the implications of digital exclusion and a local evidence base is building around how we can best support all service users and carers in terms of future access and best use of our services.
• Kirklees IAPT continue work on their comprehensive action plan to address waiting times and recovery standards. Waiting times have been eliminated for access to computerised cognitive behavioural therapy due to improved systems and processes to increase capacity. This has allowed IAPT to divert additional resource to treatment and there has been significant reduction in waiting times for both low intensity and counselling, meaning that service users will receive timely access to these treatment pathways. Exploration of a digital offer is now underway for more courses to manage the predicted increase in demand across the board for mental health services.
• The single point of access (SPA) has continued work on service improvement and is implementing the UK triage tool, working with local GPs to develop electronic paperwork and referral systems.
• Supervision levels are high throughout the service.
• Training and development for all staff has continued for the trauma informed personality disorder pathway
• Performance remains good for 72 hour follow up from discharge from hospital.
• Action planning continues in all community teams building on the outcomes of the virtual 'we want to be outstanding' workshop for team managers and trios.

Challenges
• Supervision levels need to be sustained to enable staff to optimise their wellbeing and practice.
• There are still areas for improvement with CPA reviews in Calderdale and Kirklees, although progress has been noted.
• Demand and patient flow issues remain and further work is required to optimise community solutions.
• Pathways from acute hospitals and emergency departments are challenging.
• Maintaining service delivery in community settings in ways that keep pace with changes in how society functions and service user needs.
• Data quality issues remain in single point of access (SPA) regarding accuracy of access and assessment rates for Calderdale, this is being worked on by the service and Performance and Information.
• IAPT access and recovery rates require constant focus.

Areas of Focus
• Contributing to patient flow and effective use of inpatient resources and alternatives to admission.
• Building groups and face to face therapy interventions and the safe utilisation of estates.
• Support for staff wellbeing in community teams.
• Continuing and developing service delivery, innovation and recovery.
• Continue to improve performance in service area hotspots through focused action planning tracked team by team by general managers.
• Continue our contribution to the primary care networks in local areas and the partnership working in the provider alliances.
• Develop and strengthen the creative community offer lead by Recovery Colleges and our wider partners.
• Continuing and developing service delivery, innovation and recovery.
• Recruitment and mobilisation of new investment including the community rehabilitation service in Calderdale.
• Continue to improve performance and concordance in service area hotspots including data quality in SPA.
• Continue with developments at ICS and CCG level around community transformation, rehabilitation and recovery modelling.
• Continue focus on improvement in SPA and IHBT models in conjunction with work in partnership with primary care networks and provider alliances.

This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU).

Forensic business delivery unit and Learning Disability services:
Key Issues
Forensics
• Development of the forensics lead provider collaborative continues to progress. Panel date with NHSE now in diary for the end of November.
• Occupancy levels for Newton Lodge and Newhaven have dipped slightly. The Newhaven position is attributed to the 'Transforming Care' agenda.
• Mobilisation of the specialist community forensic team (SCFT) continues.
• Awaiting final report from Sancus into the domestic homicide.
• Organisation development work, leadership restructure and forensic development plan all continue despite internal service pressures.
• OPEL level increased to level 3. This is predominantly because of staffing issues which is a combination of vacancies, and Covid-19 related absence.
Learning Disabilities
• Increased pressure within community services with an increase in referrals for hospital treatment following the breakdown of community placements.
• Restoration & recovery work remains a priority. A surge in community cases has resulted in higher levels of anxiety in carers/providers. Refusals of face to face contacts has risen.
• Acuity on Horizon ward is very high.
• Two key roles recruited to and in post - operational manager and ward manager.
• Work on the assessment and treatment unit reconfiguration across West Yorkshire continues. Internal steering group formed with executive director support.
• OPEL level increased to level 3.
ADHD/ASD
• Operational activity is on track to meet commissioned activity.
• Business plans have been submitted for service expansion across the footprint and ICS.
• Recruitment to key posts continues and is now making improved progress.

Strengths
Forensics
• Services maintained throughout the pandemic both in in-patient wards and community services.
• Mandatory training figures remain at a consistently good level.
• Flu campaign across the forensic BDU is progressing very well.
• Appointments to staff vacancies in all disciplines except nursing is positive.
• Supervision levels strong in Newhaven (100%), Bretton Centre (90.2%) and Newton Lodge (91.2%)
Learning Disabilities
• Staff continue to work in an innovative and creative way to support service users and carers in challenging circumstances.
• KPI data has improved further for October – we are now meeting the majority of targets across all localities
• SWYPFT has been approached to support the delivery of annual health checks in Calderdale. This will last 4 months and support the national agenda re engagement of GPs with people a learning disability.
ADHD/ASD
• All KPIs deliverable despite pandemic.
• Referral rates remain good.
• Mandatory training levels excellent.
• Supervision level 93.5%

Challenges
Forensics
• Absence levels remain higher than the Trust average.
• High levels of staff vacancies in registered nursing
• Retention of registered nurses.
• Clinical acuity remains high across the BDU.
Learning Disabilities
• Staff absence levels have increased and contribute to pressure within Horizon and community services.
• High levels of acuity on Horizon and in community settings.
• Increase in referrals from Leeds now there are only 2 operational assessment & treatment units (ATUs) in West Yorkshire. SWYPFT currently has the only unit with seclusion facilities so the potential for levels of acuity to rise is high.
• Supervision levels are lower than expected 58.4%.
ADHD/ASD
• Maintaining performance in line with key KPIs and aspirations of expansion during a pandemic.
• Maintaining required level of contact and competing for clinical space to do that.

Areas of Focus
Forensic
• Preparation for role as lead provider of the West Yorkshire provider collaborative.
• Forensic development plan, work continues and is progressing.
• Recruitment and retention of staff supported by HR.
• Staff wellbeing.
Learning Disabilities
• Restoration and recovery remains a priority.
• West Yorkshire collaboration regarding development of an ATU model.
• Improving supervision is a key priority - action plan in progress including weekly monitoring by the quality and governance lead and targeted actions to improve recording. This will now also be a standing agenda item on both the governance and BDU meetings and weekly reports will be provided to the deputy director.
• Horizon have an action plan in place to ensure we are fully managing the increase in incidents, putting measures in place to mitigate wherever possible.
ADHD/ASD
• Staff wellbeing a key focus.
• Positive use of digital technology to support service delivery.
• Phased plan for the reintroduction of face to face contact commenced in June and remains ongoing.

This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU).

Communications, Engagement and Involvement

Communications, Engagement and Involvement
• Bronze command meeting taking place internally for communication and engagement. Participation in Trustwide Silver.
• Coronavirus updates sent out to all staff and governors.
• Coronavirus sections on the intranet and website maintained and updated, with proactive comms around coronavirus e.g. back to school support from CAMHS
• Sharing of staff and service user good news stories internally, externally and through social media channels.
• Community mental health survey support
• Staff wellbeing initiatives promoted
• Flu campaign. Ongoing promotion of the 'Have a vaccine, give a vaccine' campaign.
• 'Choose well for mental health' campaign in development. To be launched in the next month.
• Wakefield CAMHS, continued support for transformation work (ReACH team and eating disorders)
• Awareness days and weeks supported on social media and in internal communication channels
• Information governance campaign.
• Partner Bronze command meetings continue to taking place in all areas. Support provided re. outbreak management.
• Support provided to EyUp Charity (e.g. case studies, charity challenge), Creative Minds (e.g. website, socials) and Spirit in Mind (website, and event support).
• Support provided to SystmOne programme – FIRM roll-out and sharing of service user records
• New intranet development project supported – spec produced for procurement.
• Promotion of West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICS' initiatives and campaigns

Engagement, Equality and volunteering update
• Work continues to support Phase 3 planning
• Business proposal to mainstream the offer for 'Virtual Visitor' shared at silver and gold command to identify funding. Talks will take place with IM&T regarding digital support required
• Reviewing the Covid-19 equality impact assessment (EIA) and research tool this quarter with emerging intelligence
• Progressing the work to involve Wakefield in a conversation on mental health; developed and shared with the Alliance.
• Work to support the involvement of stakeholders in the ethics committee
• Work to support involvement in the digital strategy
• Work to support involvement in a 'Smoke Free' site
• Identified a process to support SEQUIN submission for secure services
• A 'Passport for Carers' online event has now led to the development of the passport, a number of actions to support a future action plan are in place to take the work forward including a partnership group.
• Trust wide strategy – still in draft and shared with Equality & Inclusion Committee and Trust Board for additional comments and updates. The strategy will be signed off in December. The associated action plans for equality, engagement and carers will follow once the objectives are agreed
• Trust wide strategy EIA in development, short film and image, easy read and summary all being progressed
• Payment for involvement policy now being looked at and a draft will be circulated in Autumn for comment
• Linking into wider volunteering approaches and supporting partners such as Barnsley council to mobilise volunteer opportunities
• Worked in partnership with Barnsley community and voluntary services (CVS), council and SWYPFT colleagues to mobilise a preventative mental health support network along the lines of Virtual visitor
• The team have now appointed an engagement, equality and inclusion project officer.
• Successful bid to charities commission and staff recruited and in post – our involvement has secured 2 posts focussed on BAME staff and BAME communities
• Peer support worker report, action plan now been developed, promoting the opportunities for BDUs to host a peer worker post in any vacant posts going forward. A number of presentations are planned.
• Draft strategy for volunteering developed and a framework to support volunteers is in place, further work to develop the strategy in ongoing.
• All volunteers are being risk assessed using the staff risk assessment tool prior to reintroduction back into Trust services
• Use of ESR to support volunteer training and DBS is now ready to use
• Boundary training has been co-designed with HR and Safeguarding times to support both volunteer and staff roles
• Work ongoing to address diversity in volunteering
• Currently we have 176 volunteers, 7 are active and a further 47 are waiting to be processed or have been placed on hold

This is the November 2020 priority programme progress update for the integrated performance report. It is a summary of the activity conducted in the period for October 2020. The priority programme areas of work providing an update in this report have been refocused in response to the covid19 pandemic. The following programmes of work reported in the IPR this month are:
1. CAMHS improvement
2. Forensic improvement
3. Advance our wellbeing and recovery approach
4. Work with partners in Barnsley, South Yorkshire, Kirklees, Calderdale, Wakefield, West Yorkshire
5. Accelerating use of digital technology
6. Providing care as close to home as possible
The framework for this update is based on the revised Trust priority programmes agreed in March 2020, and provides details of the scope, aims, delivery and governance arrangements, and progress to date including risk management. The proposed delivery is in line with the Trust's Integrated Change Framework.

Priority	Scope	SRO	Change Manager	Governance Route	Narrative Update	Progress RAG rating
IMPROVE HEALTH						
Advance our wellbeing and recovery approach	Focus on how we change the offer to support community wellbeing and recovery in light of Covid19 working with Creative Minds, Recovery Colleges, SIM, and Volunteer services to develop and deliver innovative offers to help people in their own homes.	Salma Yasmeen	Sue Barton & Matt Ellis	EMT	The Recovery College websites continue to be well received. A variety of different approaches are being used to engage with learners and to make sure that people remain connected and can access the courses they need. Creative Minds continue to oversee the delivery of a variety of interventions with performance reported into the Charitable Funds Committee. In the last 6 months 6990 people have been directly impacted through this work. The Arts and Health Programme Manager for Calderdale has commenced delivery of the agreed plan which aims to ensure that arts, creativity and culture is used across Calderdale to support people's health and well-being. Work has commenced to embed physical activity into systems and processes of teams within Calderdale to ensure that the people they support are able to live a larger life and for longer through physical activity. This role is linking with the physical activity offers already in place including through the Recovery College and Creative Minds. Plans are in place to recruit to a peer support co-Ordinator role to further develop the use of peer support across Trust services	
Work with partners in Barnsley, South Yorkshire, Kirklees, Calderdale, Wakefield, West Yorkshire	Work with partners in Barnsley, Kirklees, Calderdale, Wakefield, South Yorkshire and West Yorkshire to develop a joint response to Covid-19 and placed based recovery plans.	Sean Rayner / Salma Yasmeen	Sharon Carter	EMT	West Yorkshire Mental Health, Learning Disability and Autism Programme Services continues working to deliver the precovid priority work programme, with current priorities also including delivering ongoing support during covid such as mutual aid and population support schemes, and new priorities such as improving collaboration and staff health and wellbeing. We are actively working as a partner in our local systems to manage and mitigate the impact of a rise in COVID cases, including our system-level surge/escalation approach, and manage the impact on the restoration of non-COVID health services in our Phase 3 plan submissions. Work has commenced on modelling changes to mental health demand with partners through our Mental Health Intelligence and Insight Group, as part of recovery and stabilisation. Work continues at ICS and Placed based level on planning and producing bids for both Community Mental Health Transformation funding and Crisis & Liaison Transformation funding for first submission for both funding streams to NHSE on 18th November 2020. We have worked with our colleagues in all localities to develop MH proposals to be put forward for allocation of winter funding aligned to winter planning in October.	
IMPROVE CARE						
Provide all care as close to home as possible	Focus on PICU, patient flow and Criteria Led Discharge (CLD) All other workstreams to maintain a momentum but at an appropriate pace	Carol Harris	Ryan Hunter	OMG	PICU - new standard operating procedure has now been developed and will go through internal governance. New processes set up for admissions to PICU beds and any required gender specific placement. Criteria led discharge - process now started of moving over to SystmOne, all wards to complete by December 2020. Implementation review feedback from SSG due in the next period. Patient flow – protocol at policy ratification group on 16 Nov; patient flow working across extended hours and still working toward formal process for extended service. Single point of access (SPA) – information being collated for interim triage scale review. Kirklees GP practices have been identified to further test e-referral and support primary care pathway work in advance of wider rollout of new e-referral process. Ongoing work with Healthwatch, including co-production from service users and carers to support staff training is being taken forward. Intensive home based treatment (IHBT) (Kirklees) – now delivering a model with fidelity to IHBT standards. Recruitment continues to be positive though recent Covid issues are leading to capacity challenges. Trauma informed personality disorder (TIPD) – working with stakeholders to integrate the TIPD pathway with third sector agencies. Initial discussions with women's centre have taken place. Working towards Kirklees pathway being operational from November 2020. Dialectic behavioural therapy (DBT) pathway will be starting in Wakefield shortly and utilising initial work from there to standardise across the pathway. Community- most activity is now being taken forward as business as usual and current focus on community mental health proposals. Initial review of achievement of objectives has taken place and found positive impact across in-scope caseloads but some challenges still persist, in particular HCP caseloads in some core services. Further consideration of actions on these required and how they feed into out of area (OOA) governance. Gatekeeping review – a review of gatekeeping across the Trust has been delayed due to recent operational priorities and is now likely to happen early 2021 which could identify further changes required to help make the system be more sustainable.	Progress Against Plan
					Failure to deliver timely improvement due to lack of resource, other work priorities and skills - the likelihood of this is increasing again due to the second wave of covid, though activity is still progressing.	
					Milestones include: Performance Management - inpatient report development - Summer 2020 Patient Flow Protocol through internal governance - now Nov 2020 PIU SOP through internal governance - Nov 2020 SPA Triage Scale live - Jul 2020; initial review Oct/Nov 2020, full review early 2021 CLD future system decision - Oct 2020, move to S1 from Nov. TIPD Kirklees pathway operational Nov 2020 IHBT joint AMHP assessment further review - early 2021 Gatekeeping Review - Jan 2021	

Camhs Improvement work	Rescoping based on project capacity and required support to implement changes to operational delivery. Will maintain a momentum but at a slower pace. This also includes improvement work to consolidate changes made in response to the pandemic that have had positive outcomes.	Carol Harris	Supported by Carmain Gibson-Holmes (Wakefield), Kate Jones /Maeve Boyle (Barnsley)	CAMHS Improvement Group with monthly report to OMG	All Age Liaison Service (MHLT) has been fully implemented in all districts with effect from as follows: Barnsley 1st October 2020, Wakefield – 19th October 2020 and Calderdale & Kirklees - 26th October 2020. Review of MHLT staff competencies using the competency framework has been completed in Barnsley and Wakefield and is well underway in Calderdale & Kirklees. The cessation of 1st on-call arrangements (from CAMHS Crisis and Home Based Treatment Team) has not resulted in any issues. Barnsley General Hospital colleagues have been positive about the service change. Ongoing background support being made available by CAMHS teams to all of the MHLT teams. Barnsley CAMHS Crisis and Home Based Treatment Team Standard Operating Procedure was approved by Operations Management Group on 7th October 2020. CAMHS Improvement Board (CIB) has reviewed, updated and approved its terms of reference and membership following Trust Board approval to continue with this work as part of its programme priorities. Programme support for Calderdale and Kirklees districts has been identified. Recruitment cycle is being repeated within Wakefield due to non-fulfilment of some posts after a successful recruitment process. The consequential impact is for the wider district such as ASD pathways. Waiting list (WL) numbers in Barnsley have not reduced as much as planned due to higher number of people being accepted for CAMHS input in October 2020 – 33 compared with monthly average of 18 cases (Nov 19 to Sept 20). Revised WL trajectory has been drafted for consideration at CIB meeting in November 2020. Work is ongoing with Barnsley CCG regarding the demand and capacity modelling for the new CAMHS Service Model and joint monthly steering meetings are continuing. A summary paper capturing all the changes made by all of the CAMHS services has been produced and shared with CAMHS Improvement Board.	Progress Against Plan
					Work is ongoing to consider the demand and capacity modelling of the new service model with Barnsley CCG via the monthly meetings. The pace of this work needs to accelerated to enable appropriate costings to be completed, signed off by the CCG and appropriate mobilisation by the Barnsley CAMHS service from April 2021 onwards. A high-level outline has been developed and a meeting is being progressed to agree timeframes and expectations with lead commissioner.	Management of Risk
					Implementation plan/Key milestones include: By 14/10/20 Review of Barnsley and Wakefield MHLT staff competencies using the competency framework to enable progression and transition to the All Age Liaison Services. By 31/10/20 Full implementation of the All Age Liaison Service in Barnsley with appropriate support from CAMHS services. By 14/10/20 Barnsley CAMHS C&HBTT SOP approved by Operations Management Group. By 31/10/20 Evaluation of 3 virtual groups within Barnsley completed based on PDSA model approach to assist with wider learning within all CAMHS services. By 31/10/20 CAMHS Improvement Board to complete its review of Terms of Reference and consider whether CAMHS improvement work is now appropriate to become 'business as usual' and stepped down as a priority programme of work.	
Forensics Improvement work	Improvement plan has been prioritised by steering group with clear focus on safety, learning lessons, staff engagement and staff wellbeing	Carol Harris	Sue Barton	Forensics Improvement Group with monthly report to OMG	The forensic improvement actions continue to be delivered in line with the plan. The group have recently reviewed all the actions on the plan which had been paused because of Covid 19 and have moved some of these into the active parts of the programme as a reflection of the work that is taking place. Organisational Development work is a key part of the plan going forward. Unfortunately the third workshop had to be postponed due to operational pressures caused by Covid 19. However the fourth leadership workshop date is still in place and will be used if at all possible. The comprehensive bespoke communication approach has been developed and initial feedback to the regular, systematic communication mechanisms is positive.	
IMPROVE RESOURCES						
Make better use of digital technology and introducing new ways of virtual working to help support staff and service users	Focus on testing, implementing and evaluating digital technology to help maintain services in light of Covid19 EPMA – electronic prescribing project AirMid & WhatsApp for E Consultations Virtual Visitors Continue to maintain I Hub to support staff wellbeing and facilitate conversations	Mark Brooks	Vicki Whyte	ISIG	EPMA (Electronic Prescribing and Medicines Administration) – It was agreed at the project board on 5th November that the go-live date be moved to January 2021 with a new target date for the first roll out to Poplars ward, Lyndhurst ward and Ward 18 at Dewsbury hospital of 18th January dependent upon the Covid-19 situation. It was agreed that the project must continue the momentum and the delivery of EPMA be prioritised across the Trust. Virtual Visitor Scheme - continues to be used across in-patient wards to ensure the people in our care do not become socially isolated and continue to have contact with their families during the pandemic.	
MAKE THIS A GREAT PLACE TO WORK				EMT	Focus on this in relation to Covid 19: Support the wellbeing of #allofus to help people cope & connect Support people to embrace new ways of working that have been beneficial . These programmes of work report at key milestones directly to EMT and thus no update is required via the IPR	

Glossary of terms:

AMHP Approved Mental Health Professional	MH Mental Health
ATU Assessment and Treatment Unit	MOU Memorandum of Understanding
Bassetlaw	NHS National Health Service
BDCFT Bradford District Care Trust	NHSE/I National Health Service England/ NHS Improvement
C&YP Children and Young People	NMOC New model of care
CCG Clinical Commissioning Group	OMG Organisational Management Group
CSDG Clinical Safety Design Group	OPS Older Peoples Services
DBT Dialectic Behavioural Therapy	P&I Performance and Information
EMT Executive Management Team	PCH Primary Car Hub (also referred to as Primary Care Network)
ESD Early Supported Discharge	PCN Primary Care network (also referred to as Primary Care Hub)
FIRM Formulation Informed Risk Assessment	QI Quality Improvement
GP General Practitioner	QSIR Quality, Service Improvement and Re-design
HASU Hyper Acute Stroke Unit	RACI Roles and responsibilities indicator
HCP Healthcare Partnership	SBAR Situation - Background - Assessment - Recommendation quality improvement tool
IAPT Improving access to Psychological Therapies	SPA Single Point of Access
ICS Integrated Care System	SPC Statistical Process Control
ICT Integrated Change Team	SRU Stroke Rehabilitation Unit
IHBT Intensive Home Based Treatment	SSG an external consultant agency
IHI Institute for Health Improvement	SWYPFT South West Yorkshire Partnership Foundation Trust
IM&T Information management and technology	TIPD Trauma Informed Personality Disorder
IPS Individual Placement Support	UEC Urgent and Emergency Care
LD Learning Disabilities	VCS Voluntary and Community Sector
LTC Long Term Conditions	WY West Yorkshire

Overall Financial Performance 2020/21

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to date	Forecast August 20	Narrative
1	**Surplus / Deficit**	£0.1m	(£2.1m)	For April to September the Trust received retrospective funding to ensure a breakeven position. This included reasonable additional covid costs. For October to March the Trust has a revised operational plan based on block and system allocated income. In October a surplus of £0.1m has been reported, which was favourable to plan.
2	**Agency Cap**	£3.9m	£7m	Whilst there is currently no NHS Improvement agency cap set for 2020/21 the Trust continues to monitor agency spend and action plans remain to ensure agency staffing usage and costs is appropriate. Spend in October was £0.6m, which is similar to the recent trend.
3	**Cash**	£64m	£41m	Cash in the bank continues to be above planned levels. The main reason is the timing of block income payments (which are a month in advance). This is partly offset by the earlier timing of invoice payments as demonstrated by the better payment figures.
5	**Capital**	£1.2m	£5.6m	A revised capital forecast for 2020/21 has been produced taking account of current capital priorities and the impact of covid-19 on accessibility and costs. This has reduced the overall forecast by £1m.
6	**Better Payment**			This performance is based upon a combined NHS / Non NHS value and demonstrates that 80% of invoices have been paid within 7 days. The impact of the new finance and procurement system continues to be monitored.
	30 days	97%		
	7 days	80%		

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

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	5.0%	5.0%	5.0%	5.0%	4.9%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	5.0%	5.30%	5.0%	4.6%	4.2%	3.9%	3.9%	4.0%	3.8%	3.8%	3.8%	3.9%
Aggression Management	Improving Care	Well Led	AD	>=80%	81.3%	80.5%	80.9%	81.6%	85.5%	85.5%	85.5%	85.5%	85.5%	86.5%	86.0%	86.3%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	83.6%	81.9%	81.2%	80.9%	89.4%	89.4%	89.4%	89.4%	89.4%	90.3%	89.4%	88.7%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	88.5%	88.6%	89.2%	89.0%	93.7%	93.7%	93.7%	93.7%	93.7%	93.8%	93.6%	93.3%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	92.3%	92.1%	92.6%	92.4%	95.2%	95.2%	95.2%	95.2%	95.2%	95.7%	95.7%	96.0%
Fire Safety	Improving Care	Well Led	AD	>=80%	87.4%	87.9%	88.3%	88.3%	93.7%	93.7%	93.7%	93.7%	93.7%	93.9%	93.4%	92.8%
Food Safety	Improving Care	Well Led	AD	>=80%	82.5%	83.0%	82.3%	81.6%	76.9%	76.9%	76.9%	76.9%	76.9%	78.3%	76.7%	76.8%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	91.3%	91.0%	90.4%	89.1%	95.8%	95.8%	95.8%	95.8%	95.8%	96.2%	96.0%	96.1%
Information Governance	Improving Care	Well Led	AD	>=95%	92.8%	94.1%	90.4%	98.0%	98.2%	98.2%	98.2%	98.2%	98.2%	98.8%	98.8%	98.9%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	91.9%	92.0%	92.1%	92.2%	95.0%	95.0%	95.0%	95.0%	95.0%	95.5%	95.6%	95.5%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	93.5%	92.5%	92.3%	90.5%	93.3%	93.3%	93.3%	93.3%	93.3%	94.6%	94.3%	94.8%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	90.8%	89.8%	90.1%	87.2%	89.5%	89.5%	89.5%	89.5%	89.5%	91.2%	90.8%	91.4%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	76.1%			73.3%			73.4%			74.9%		Due Jan 2020
Prevent	Improving Care	Well Led	AD	>=80%	87.1%	88.8%	90.8%	91.1%	93.2%	93.2%	93.2%	93.2%	93.2%	94.6%	94.6%	94.4%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	94.1%	94.1%	94.0%	94.3%	96.2%	96.2%	96.2%	96.2%	96.2%	92.8%	92.8%	93.0%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	89.8%	89.0%	89.8%	90.7%	92.4%	92.4%	92.4%	92.4%	92.4%	93.6%	93.6%	93.3%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	96.0%	96.5%	97.3%	97.1%	96.9%	96.9%	96.9%	96.9%	96.9%	96.8%	96.8%	
Bank Cost	Improving Resources	Well Led	AD	-	£887k	£705k	£769k	£685k	£1,241k	£727k	£866k	£721k	£687k	£778k	£907k	£915k
Agency Cost	Improving Resources	Effective	AD	-	£572k	£559k	£537k	£581k	£613k	£469k	£507k	£518k	£558k	£606k	£588k	£604k
Overtime Costs	Improving Resources	Effective	AD	-	£6k	£11k	£15k	£69k	£191k	£196k	£382k	£342k	£257k	£276k	£213k	
Additional Hours Costs	Improving Resources	Effective	AD	-	£36k	£39k	£37k	£42k	£58k	£58k	£61k	£66k	£71k	£59k	£53k	
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£510k	£547k	£510k	£429k	£435k	£374k	£388k	£399k	£408k	£411k	£387k	
Vacancies (Non-Medical) (WTE)	Improving Resources	Well Led	AD	-	473.4	466.1	467.2	511.2	528.0	222.1	222.1	192.3	208.9	205.9	234.0	
Business Miles	Improving Resources	Effective	AD	-	317k	272k	273k	302k	312k	193k	149k	138k	164k	166k	147k	

Health & Safety

Month	Objective	CQC Domain	Owner	Threshold												
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	15						7					

1 - this does not include data for medical staffing.

- As at November 24th, 161 staff off work Covid-19 related, not working which compares to 108 one month earlier. This is the highest number of staff absent due to Covid-19 since mid-May.
- 2917 staff tested as at November 24th.
- 398 staff have tested positive for Covid-19, 181 of which tested positive within the last month.
- Staff turnover increased to 9.3% from 8.9 % in September.
- Non-Covid sickness absence was 3.9% in October 20 and cumulatively is 3.9%. This compares favourably to previous years.
- Compliance with training requirements is positive.
- Focus being applied to food safety training of which staff require this training and how it is provided.
- Little change overall in staff recieving supervision although improvements have been noted in some BDUs, particularly Wakefield, Kirklees and Calderdale.
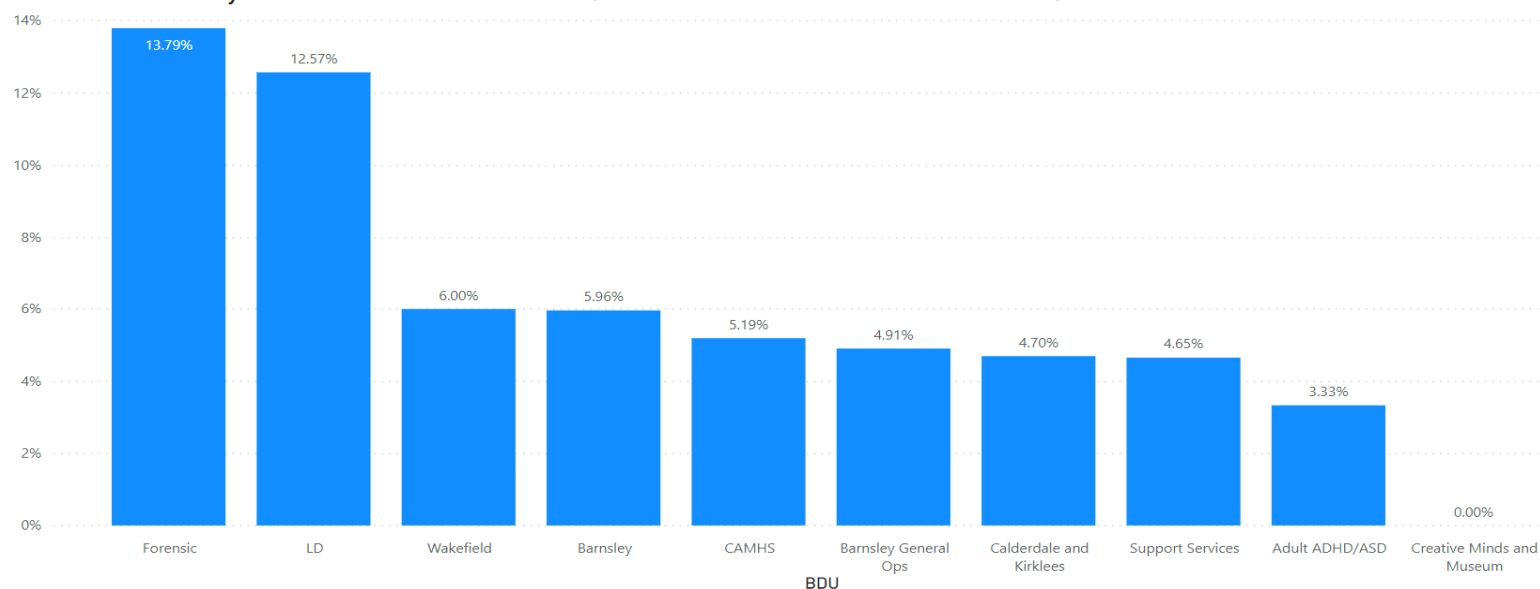
Sickness reporting

As at 24th November, the Trust has 308 staff absent or working from home due to Covid-19. This makes up 5.9% of the workforce. Of those absent, 21.8% are symptomatic and 18.8% have household symptoms. The business delivery unit (BDU) with the biggest impact is Forensic with 13.8% of staff impacted (56/406). This is obviously having a significant impact on operational services and resources are being deployed accordingly to ensure patient and staff safety during this challenging period.
• The Trust continues to use a Gold, Silver and Bronze command structure.
• Bank and agency availability is being reviewed to assist with resource availability.
• Critical functions for corporate support services are typically working from home to adhere to the government's social distancing guidelines.
• Communications team is ensuring guidance is distributed and keeping staff up to date.
• Average length of absence (days) for those not working due to covid symptoms (based on absence start date) (November is a to date figure)
Mar 10.3 days, Apr 10.7 days, May 9.7 days, Jun 7.4 days, Jul 6.1, Aug 7.6, Sep 6.9, Oct 9.6, Nov 6.6

The following graph show the percentage of staff absences attributed to Covid-19 as a proportion of the BDU headcount.

Sick/Absent % by BDU/Service/Cost Centre (excludes Trust Bank/Pastoral Care)

BDU	Percentage
Forensic	13.79%
LD	12.57%
Wakefield	6.00%
Barnsley	5.96%
CAMHS	5.19%
Barnsley General Ops	4.91%
Calderdale and Kirklees	4.70%
Support Services	4.65%
Adult ADHD/ASD	3.33%
Creative Minds and Museum	0.00%

The following graph shows the reasons for Covid-19 absence by BDU.

Absence by BDU and Reason for absence

Reason for absence ● Elective surgery is... ● Holiday isolatio... ● Household sy... ● OH advised is... ● Other COVID r... ● Positive lateral ... ● Shielding (hi... ● Symptomatic ... ● Test & Trace l... ● Test & Trace .
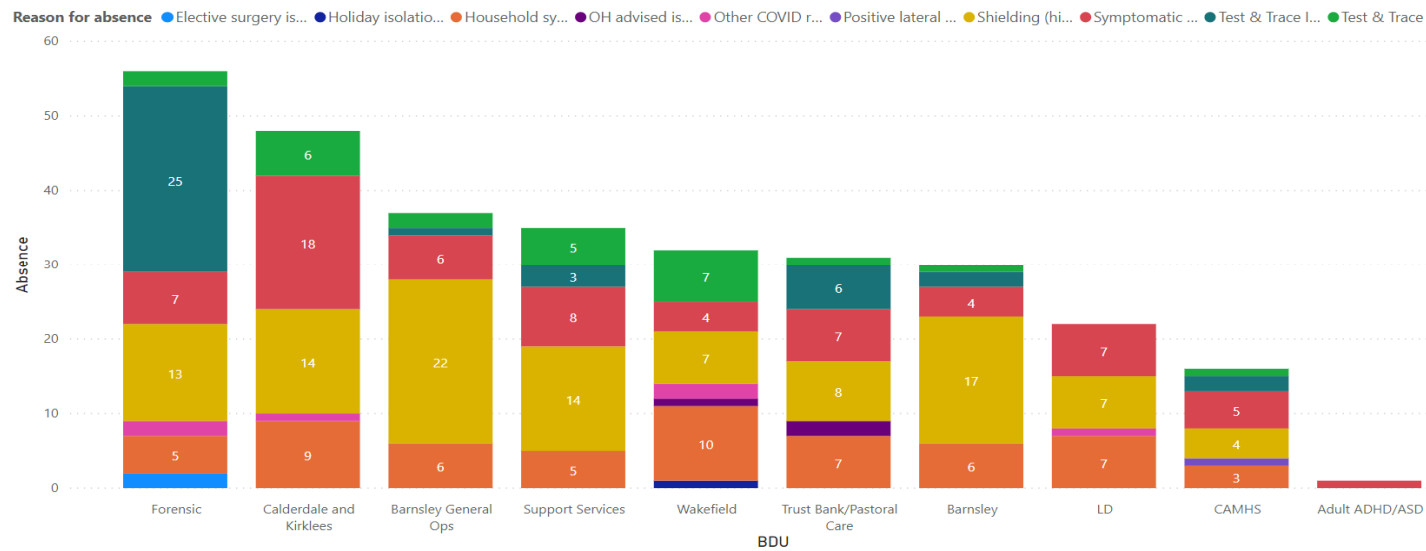
The following chart shows Covid-19 staff absences over the period 16th March - 24th November:

Numbers of absent staff who are working from home due to COVID-19

● Working from home ● Not Working
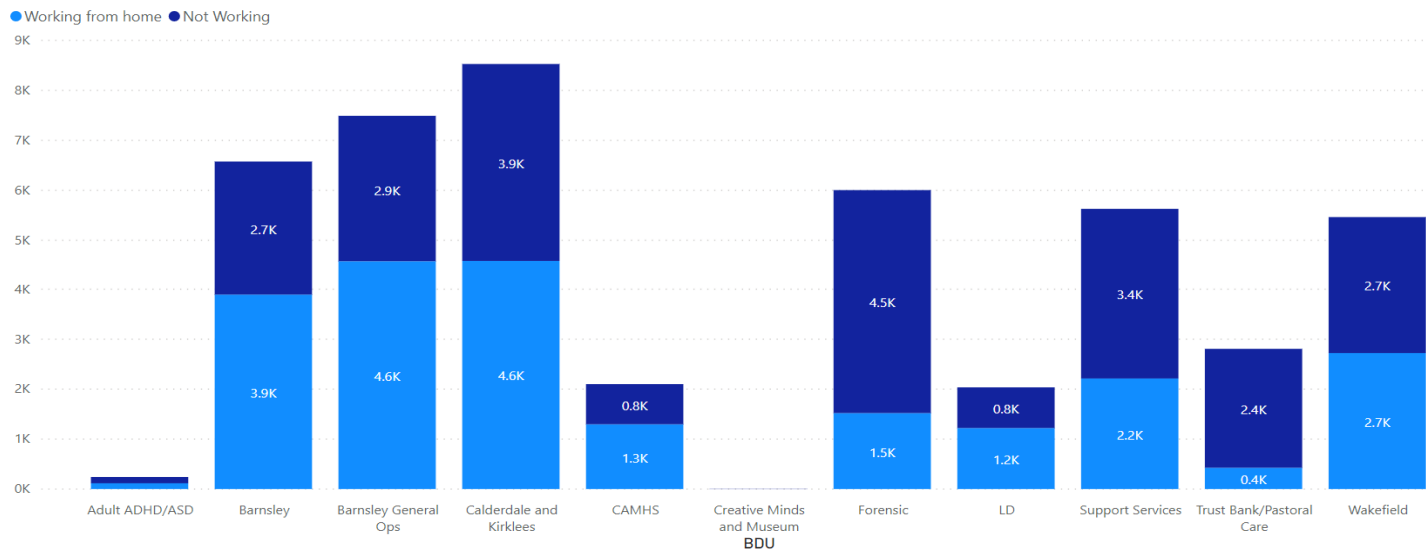
Guardian of Safe Working Report - Q2 (July - September 2020)

Impact of the Pandemic
The impact of COVID-19 has been wide-ranging and there has been a significant impact on the rotas for doctors in training. There was a 75% increase in the number of gaps on the various rotas in April-June, compared with the previous quarter. However, there was a significant reduction in the number of gaps in Wakefield, Calderdale and Kirklees in August and September, leading to a 20% drop in gaps overall for the most recent quarter. In Barnsley, this quarter was still affected by doctors shielding for a prolonged period. Other issues affecting rotas include doctors having to self-isolate for shorter periods, pregnant trainees having to come off the on-call rota sooner than planned and a small number of Foundation Year 2 doctors requested to be redeployed to support their colleagues in the acute trust. These issues were added to the more usual ones of vacancies, sickness and Less than full-time trainees in full-time training placements. It is a testament to the fantastic work of rota coordinators and the trainees themselves that all the vacant slots were filled by the trust bank. The Medical Directorate Business Manager, the AMD for Medical Education, the Guardian of Safe Working and the College Tutors met frequently, at the height of the pandemic, on the Medical Education Bronze Call, to coordinate the trust's response and these meetings continue.

Distribution of Trainee Doctors within SWYPFT
Recruitment to core training posts in Psychiatry has been much better recently and with the amalgamation of core training schemes across W. Yorkshire from August 2020, it is hoped that we will see a reduction in vacancies in Calderdale and Kirklees. Currently we have one core trainee vacancy in Barnsley and another in Calderdale.

Exception reports (with regard to working hours)
There have only been a few ERs completed in SWYT since the introduction of the new contract and there have been none during this period.

Fines
There have been none within this reporting period.

Work schedule reviews
There were no reviews required.

Rota gaps and cover arrangements
The tables below detail rota gaps by area and how these have been covered. The Medical Bank has been working well. Following the large increase in gaps at the start of the pandemic, trainees were offered higher rates of pay to cover some hard-to-fill shifts. The costs that were directly attributable to COVID-19, where trainees were shielding or self-isolating, are shown separately.

Gaps by rota July/Aug/Sept '20

Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	72 (39%)	72 (100%)	0	0	0
Calderdale 1st	21 (11%)	21 (100%)	0	0	0
Kirklees 1st	19 (21%)	19 (100%)	0	0	0
Wakefield 1st	23 (13%)	23 (100%)	0	0	0
Total 1st	135(21%)	135 (100%)	0	0	0

Costs of Rota Cover July/Aug/Sept '20

1st On-Call Rotas	Shifts (Hours) Covered by Medical Bank	Cost of Medical Bank Shifts	Cost directly attributed to COVID-19
Barnsley	72 (672)	£23,520	£5,040
Calderdale	21 (201)	£7,043	£0
Kirklees	19 (392)	£13,720	£1,960
Wakefield	23 (212)	£9,420	£2,880
Total	135 (1742.5)	£53,703	£9,880

Issues and Actions
Recruitment – There are a number of initiatives that the trust has been involved with, through The Royal College (MTI - Medical Training Initiative) and Health Education England (WAST - Widening Access to Specialist Training). We no longer have any MTI doctors after the last resigned recently and we do not anticipate taking further MTI doctors as we hope to have few if any Core Training Vacancies. We currently have 6 WAST doctors in the Trust, with HEE paying the full salary and there is evidence that this scheme is encouraging more doctors to apply for Psychiatry training.

Junior Doctors' Forum (JDF) – This continues to meet quarterly, offering a forum for trainees to raise concerns about their working lives and to consider options to improve the training experience. The last JDF met by Microsoft Teams and was very well attended with 35 people present, including 30 trainees. Issues discussed included rotas, completion of exception reports and understandably also trainees' experience related to COVID-19. For example, this included PPE and Fit Testing, the impact of COVID on study leave, training experiences and ARCP progression. However, there were also brief updates on topics discussed previously such as Seclusion reviews. Where concerns do not relate directly to the contract, issues are raised with the relevant Clinical Lead or the AMD for Postgraduate Medical Education

Education and support – The Guardian will continue to work closely with the AMD for Postgraduate Medical Education to improve trainees experience and to support clinical supervisors. The Guardian will continue to encourage trainees to use Exception Reporting, both at induction sessions and through the Junior Doctors' Forum.

Publication Summary

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

Learning disability services monthly statistics (assuring transformation: September 2020, mental health statistics data set: July 2020 final)

NHS workforce statistics: July 2020

NHS sickness absence rates: April 2020 to June 2020, provisional statistics

Mental Health Act statistics, annual figures: 2019-20

Diagnostic imaging dataset: June 2020

Diagnostic imaging dataset: July 2020

Psychological therapies: reports on the use of IAPT services, England, August 2020, final including reports on the IAPT pilots

Mental health services monthly statistics performance: August, provisional September 2020

Community services statistics: July 2020

Out of area placements in mental health services: August 2020

Finance Report

Month 7
(2020 / 21)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

	Performance Indicator	Year to Date	Forecast 2020 / 21	Narrative
1	Surplus / (Deficit)	£0.1m	(£2.1m)	For April to September the Trust received retrospective funding to ensure a breakeven position. This included reasonable additional covid costs. For October to March the Trust has a revised operational plan based on block and system allocated income. In October a surplus of £0.1m has been reported, which was favourable to plan.
2	Agency Spend	£3.9m	£7m	Whilst there is currently no NHS Improvement agency cap set for 2020/21 the Trust continues to monitor agency spend and action plans remain to ensure agency staffing usage and costs is appropriate. Spend in October was £0.6m, which is similar to the recent trend.
3	Cash	£64m	£41m	Cash in the bank continues to be above planned levels. The main reason is the timing of block income payments (which are a month in advance). This is partly offset by the earlier timing of invoice payments as demonstrated by the better payment figures.
4	Capital	£1.2m	£5.6m	A revised capital forecast for 2020/21 has been produced taking account of current capital priorities and the impact of covid-19 on accessibility and costs. This has reduced the overall forecast by £1m.
5	Better Payment			
	30 days	97%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 80% of invoices have been paid within 7 days. The impact of the new finance and procurement system continues to be monitored.
	7 days	80%		

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

Income & Expenditure Position 2020 / 2021

| Budget Staff WTE	Actual worked WTE	Variance WTE	Variance %	Month Budget £k	Month Actual £k	Month Variance £k	Description	Year to Date Draft Budget £k	Year to Date Actual £k	Year to Date Variance £k	Annual Budget £k	Forecast Outturn £k	Forecast Variance £k
				18,394	20,108	1,714	Clinical Revenue	131,367	131,194	(173)	232,446	232,290	(155)
				18,394	**20,108**	**1,714**	**Total Clinical Revenue**	**131,367**	**131,194**	**(173)**	**232,446**	**232,290**	**(155)**
				4,372	1,237	(3,134)	Other Operating Revenue	12,038	11,372	(667)	20,319	17,641	(2,677)
				22,766	**21,346**	**(1,420)**	**Total Revenue**	**143,406**	**142,566**	**(840)**	**252,764**	**249,932**	**(2,833)**
4,324	4,377	53	1.2%	(15,797)	(15,969)	(171)	Pay Costs	(110,541)	(110,457)	84	(192,642)	(192,123)	519
				(4,203)	(4,090)	113	Non Pay Costs	(25,780)	(25,621)	159	(45,912)	(46,432)	(520)
				(2,840)	(500)	2,341	Provisions	(1,945)	(1,106)	839	(7,246)	(4,397)	2,849
				0	0	0	Gain / (loss) on disposal	0	(23)	(23)	0	(23)	(23)
4,324	**4,377**	**53**	**-1.2%**	**(22,841)**	**(20,559)**	**2,282**	**Total Operating Expenses**	**(138,267)**	**(137,208)**	**1,059**	**(245,800)**	**(242,975)**	**2,825**
4,324	**4,377**	**53**	**-1.2%**	**(75)**	**787**	**862**	**EBITDA**	**5,139**	**5,358**	**219**	**6,964**	**6,957**	**(8)**
				(521)	(523)	(3)	Depreciation	(3,615)	(3,622)	(7)	(6,168)	(6,211)	(43)
				(197)	(195)	3	PDC Paid	(1,718)	(1,667)	51	(2,945)	(2,894)	51
				(50)	0	50	Interest Received	0	0	0	0	0	0
4,324	**4,377**	**53**	**-1.2%**	**(843)**	**69**	**912**	**Surplus / (Deficit)**	**(194)**	**69**	**263**	**(2,148)**	**(2,148)**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,324	**4,377**	**53**	**-1.2%**	**(843)**	**69**	**912**	**Surplus / (Deficit)**	**(194)**	**69**	**263**	**(2,148)**	**(2,148)**	**0**

The Trust budgets have been updated in October 2020 to reflect the new operational plan. As this realigned budgets for April to September (in line with actual expenditure levels) there is a movement in the in-month budget which means that variances are not representative of in month performance.

Trust Monthly I & E Profile
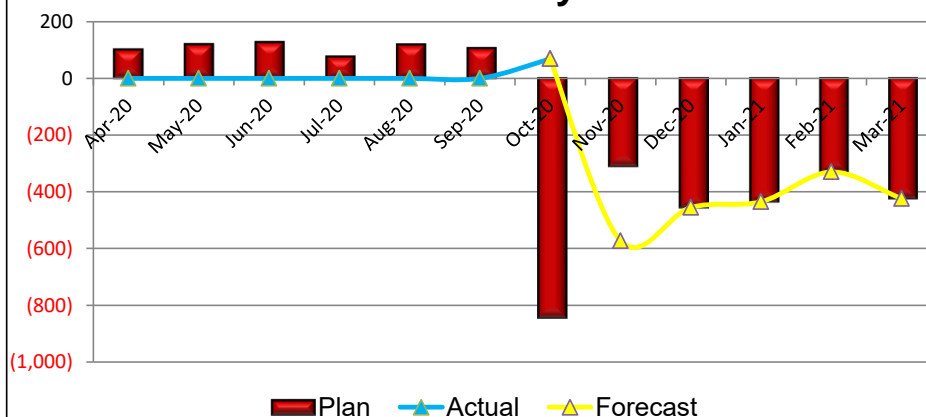
Trust Cumulative I & E Profile
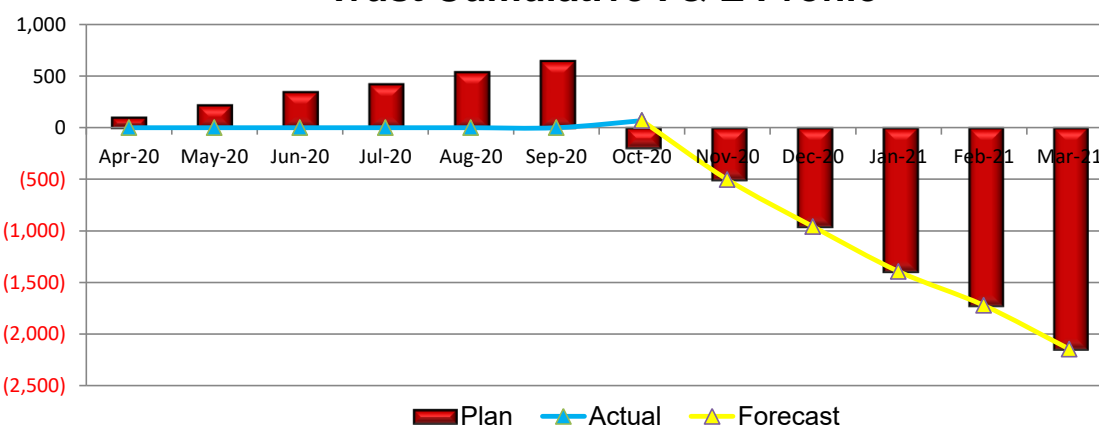
Income & Expenditure Position 2019 / 20

The Trust reported a breakeven position for April to September 2020 enabled by national funding. For October 2020 to March 2021 we have an operational plan for a £2.1m deficit.

For October 2020 to March 2021 the Trust has an operational plan which is to deliver a deficit of £2.1m. This is based on expenditure run rates and updated funding available.

Income

Income arrangements have been updated, and whilst block arrangements remain in place, these have been updated to reflect planned Mental Health Investment Standard (MHIS) funding and additional Integrated Care System (ICS) funding allocations.

Income is in line with this revised plan and is forecast to deliver in year. There is a process for agreeing funding changes in year with commissioners and these will be reflected as and when agreed.

Pay

Pay spend in October was £16.0m which is in line with previous months noting that it was higher in September primarily due to the payment of 6 months of medical pay award. Staffing continues to be reviewed to ensure safer staffing models are maintained givem volatile levels of staff absence.

Non Pay

Non Pay spend continues to experience both cost pressures and savings within the overall position. Healthcare subcontracts (out of area placements) continue to have financial pressure. This covers both acute and PICU out of area bed placements (explained further on page 11) and the purchase of locked rehab services in Barnsley.

Savings generated in categories such as travel, general office costs and training are helping to reduce the overall non-pay spend. These are arising from agile ways of working and use of digital technology.

Covid-19 Financial Impact

Covid-19 is a key contributor to the financial position and the table below highlights the areas where the Trust has incurred incremental costs as part of its response. These costs have been identified as additional and reasonable in line with national guidance.

Costs identified for April to September 2020 (H1) have been reimbursed from nationally funding. Costs incurred for October 2020 to March 2021 must be contained within the overall Trust operational plan. No additional top ups will be possible.

October costs have reduced although it is expected that backfill costs will increase again in future months. One off non-pay costs were incurred in H1 and any further cost commitments are subject to Operational Management Group approval.

| Heading	Description	H1 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k
Staffing	Backfill of shifts due to covid (sickness, isolation, shielding)	780	211						991
Staffing – community	Community additional shifts	249	0						249
Staffing – cohort	Dedicated ward within Forensics required due to positive covid cases	77	0						77
Staffing - students	Costs of student nurses and medics over and above previous	480	0						480
Staffing – out of area	Costs of out of area placement providers to provide additional staff due to potential covid cases	53	0						53
Total – Pay		**1,639**	**211**	**0**	**0**	**0**	**0**	**0**	**1,850**
IM & T	Equipment to support new ways of working, from home, video conferencing, increased telecommunications	441	161						602
Laundry	In house laundry service including scrubs	331	4						335
Infection Control	Central store of additional infection control supplies (wipes, cleaning products)	249	1						250
Catering	Staff meals - those working on inpatient wards and in the community. Supply of refreshments	69	0						69
Discharge Equipment	Purchase of additional equipment to support hospital discharges	71	0						71
Communications	Consent to share letter	40	0						40
Misc / other	Other general non pay not captured in the headings above	158	5						163
Total – Non Pay		**1,359**	**171**	**0**	**0**	**0**	**0**	**0**	**1,530**
Total cost recovery		**2,998**	**382**	**0**	**0**	**0**	**0**	**0**	**3,380**

As part of the reset for the Trust operational plan the contracting arrangements for October 2020 to March 2021 have also been updated. The nationally calculated block income (based upon 2019/20 plus 2.8% uplift) remains and has been supplemented by additional funding for the Mental Health Investment Standard (MHIS). This whas been agreed with commissioners. There is a process for amending these values for changes in investment.

Further funding has flowed through the Integrated Care System (ICS) on an allocations basis. This included funding to cover all covid related additional expenditure and this now shows as CCG income as it flows through a lead local CCG.

The block payments covered income from NHS commissioners. This therefore included payment for services, staff recharges, recharge for projects etc. Income expected for these additional services has been allocated to BDUs but the overall value to the Trust remains unchanged.

|	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k	Total 19/20 £k
CCG	14,530	13,924	14,321	14,361	14,000	14,278	16,696	16,866	16,750	16,750	16,635	16,635	185,746	171,720
Specialist Commissioner	2,322	2,322	2,322	2,322	2,322	2,322	2,322	2,453	2,387	2,387	2,387	2,387	28,259	27,895
Local Authority	335	473	409	439	419	417	430	417	417	417	417	417	5,006	7,755
Partnerships	619	637	597	628	639	625	625	631	631	631	631	631	7,527	7,673
Top Up	550	550	702	658	1,254	1,537	0	(0)	0	0	0	0	5,252	0
Other	35	35	35	35	76	35	35	35	35	35	35	76	501	418
Total	18,391	17,940	18,386	18,443	18,711	19,214	20,108	20,402	20,221	20,221	20,105	20,147	232,290	215,461
19/20	17,509	17,502	17,373	17,646	17,765	17,628	17,906	17,572	18,061	19,031	18,334	19,134	215,461	

Trust Income Profile
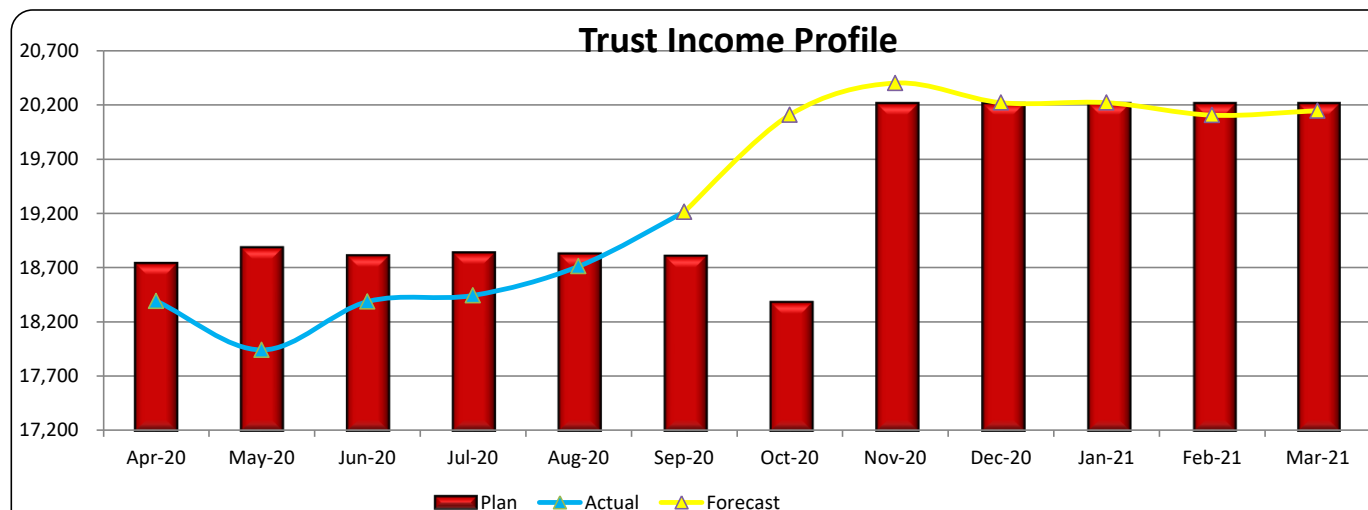
Budgets, for the year to date, have been reset in month 7 hence the variance in the graph to the left. This highlights the increase in income received and that the forecast is in line with the new plan for the remainder of the year.

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

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k
Substantive	13,947	14,646	14,470	14,256	14,462	14,647	14,450						100,877
Bank & Locum	727	866	721	687	844	971	915						5,731
Agency	469	507	518	558	606	588	604						3,850
Total	15,142	16,019	15,709	15,501	15,912	16,205	15,969	0	0	0	0	0	110,457
19/20	14,923	14,629	14,145	14,288	14,522	14,463	14,531	14,656	14,568	14,815	14,896	15,490	168,476

Bank as %	4.8%	5.4%	4.6%	4.4%	5.3%	6.0%	5.7%						5.2%
Agency as %	3.1%	3.2%	3.3%	3.6%	3.8%	3.6%	3.8%						3.5%

	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Current
Substantive	3,900	4,004	4,026	4,026	4,006	3,965	3,980						4,026
Bank & Locum	203	253	193	197	244	225	277						193
Agency	68	75	83	90	108	93	121						83
Total	4,171	4,332	4,302	4,312	4,357	4,283	4,377	0	0	0	0	0	4,302
19/20	3,989	4,013	4,002	4,002	4,057	4,069	4,119	4,191	4,138	4,152	4,160	4,285	4,098

Pay Expenditure Profile
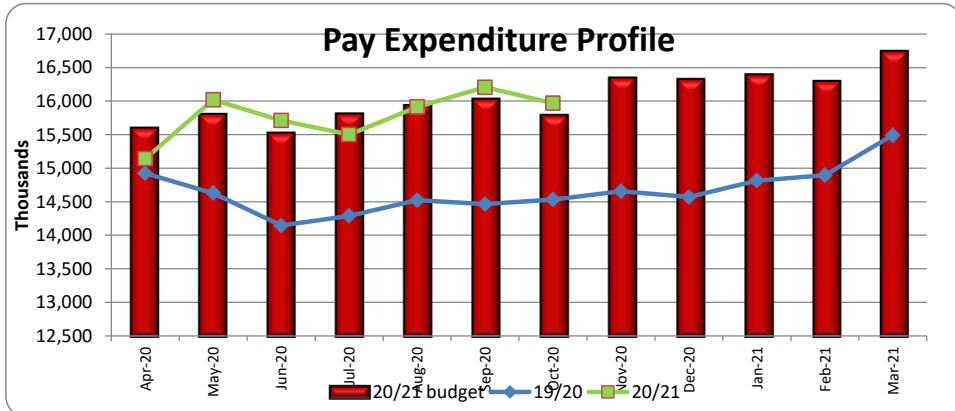
As shown in the table and graph pay costs overall have increased from 2019/20 (average run rate £14.7m per month). Of this annual pay awards and increments are estimated at £500k per month. This has increased due to the medical pay awards received in September 2020.

There has been an overall increase in WTE in month across all categories. Recruitment of substantive staff continues for new services and services receiving additional Mental Health Investment Standard (MHIS) funding. There has also been further additional temporary staff due to rising staff absenses due to covid-19 with the largest increase in bank WTE. This covers all areas but primarily forensics and adult acute inpatient

Agency spend is £604k in October.

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

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

NHS E & I introduced a set of rules in April 2016 to support trusts to reduce agency spend and move towards a sustainable model of temporary staffing. Part of this support has been through the introduction of agency spend caps and suggested maximum pay rates.

Due to covid 19 there is currently no agency cap for 2020/21, however controls remain the same. The Trust continue to submit the same detailed agency information to NHSI on a weekly basis. This information monitors both the volume of agency shifts utilised and performance against suggested maximum agency rates (caps). Shifts exceeding these caps continue to require appropriate prior approval including by the chief executive as previous.

October 2020 spend is £604k and is in line with the trend for the last 2 months. This is slightly less than the 2019/20 agency run rate. (2019/20 average was £617k per month).

Of this value £281k related to medical agency spend with a further £258k on nursing staff (registered and unregistered). In terms of medical staff we currently have 18 agency in post; 4 relate to CAMHS and 4 relate to Learning Disability services. This has increased from 16 in July.

The triangulation continues to compare agency spend with substantive staff and bank staff payments as part of the overall workforce strategy.

Agency Expenditure Trends (£m)
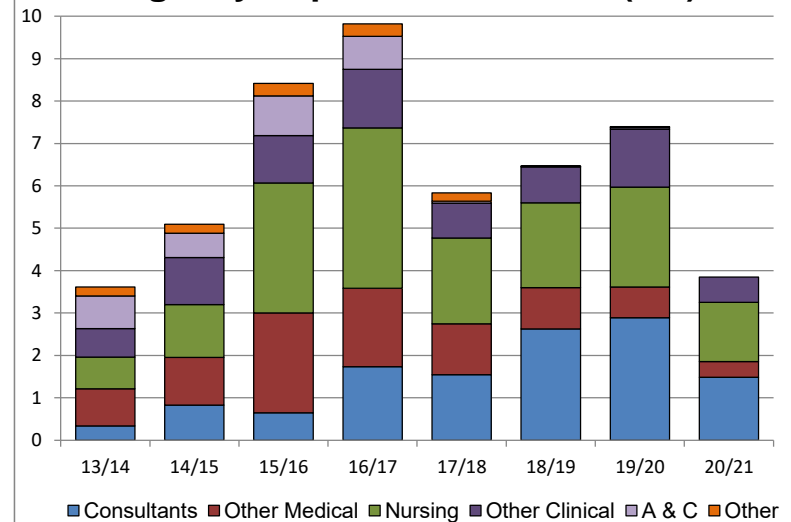
Agency and bank expenditure trend
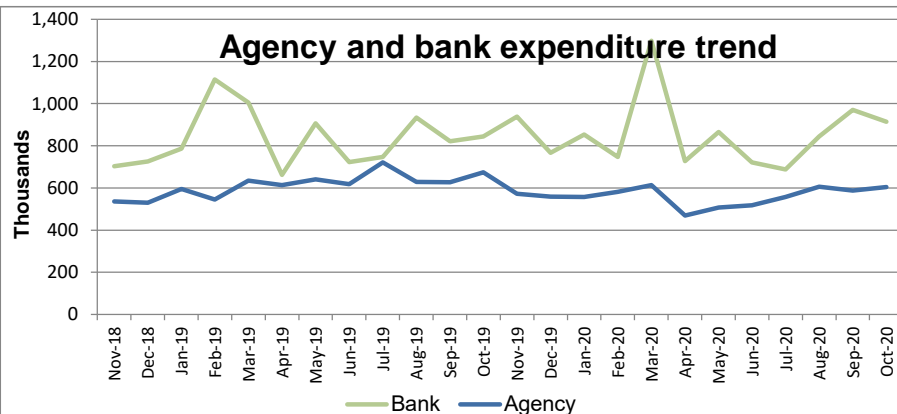
Agency Spend By Month

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

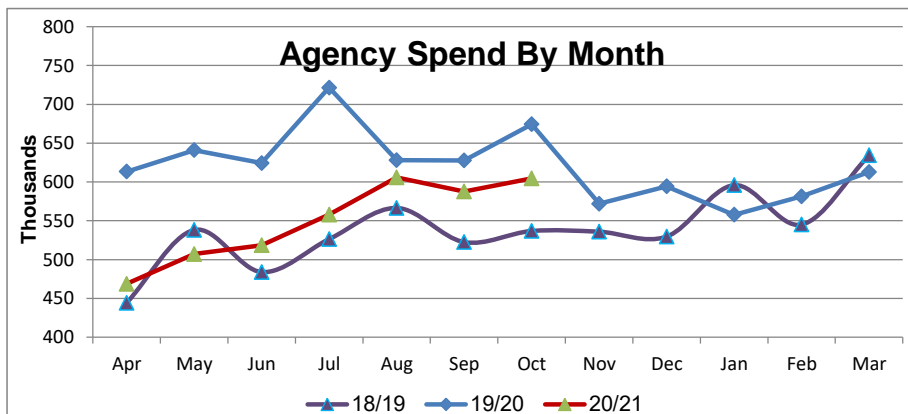|	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k
2020/21	3,900	2,811	3,236	3,906	3,821	3,857	4,090						25,621
2019/20	3,333	3,391	3,276	3,400	3,295	3,554	3,547	3,458	3,762	4,073	4,954	6,200	46,244

Non Pay Category	Budget Year to date £k	Actual Year to date £k	Variance £k
Clinical Supplies	1,810	2,034	(224)
Drugs	1,985	1,923	62
Healthcare subcontracting	4,209	3,822	387
Hotel Services	1,151	1,258	(107)
Office Supplies	3,501	3,876	(375)
Other Costs	2,658	3,364	(706)
Property Costs	3,935	6,088	(2,153)
Service Level Agreements	3,608	0	3,608
Training & Education	304	521	(218)
Travel & Subsistence	1,293	1,418	(126)
Utilities	698	703	(5)
Vehicle Costs	629	614	16
Total	25,780	25,621	159
Total Excl OOA and Drugs	19,586	19,876	(290)
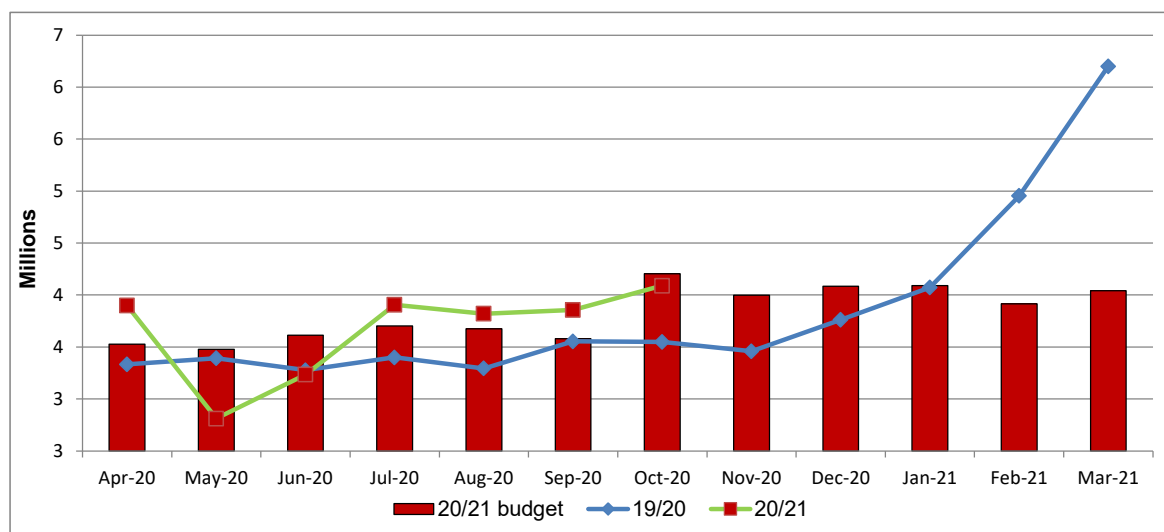
Key Messages

The national and Trust response to covid-19 is having a notable impact on non-pay costs. Additional PPE and cleaning material costs have been largely mitigated in part by national supply of key product lines. These have been at nil cost to the Trust although there have been occasions where the Trust has needed to purchase additional supplies directly. The non pay impact identified directly as a result of covid (in-house laundry, scrubs, infection control measures, provision of staff meals and refreshments) totals £1.7m for the year to date as highlighted earlier in this report. This is included within each of the individual non pay categories above.

Due to the update in Trust finance and procurement system the chart of accounts used to categorise non-pay spend has changed. The mapping and alignment of this continues to ensure that we have the level of breakdown previously provided. The main example of this is service level agreements which have been split depending on what the agreement covered and is therefore included in other headings (primarily property and other costs).

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

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

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

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

Out of Area Expenditure Trend (£)

	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
17/18	212	255	178	246	245	359	365	277	286	208	373	729	3,733
18/19	376	363	349	357	392	314	232	417	268	317	191	355	3,929
19/20	289	222	158	93	76	17	48	82	158	191	230	359	1,924
20/21	141	55	88	342	253	164	135						1,177

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
17/18	282	367	253	351	373	427	479	434	414	276	626	762	5,044
18/19	607	374	412	501	680	473	245	508	329	358	197	220	4,904
19/20	282	354	238	206	156	28	53	129	166	216	305	275	2,408
20/21	110	54	120	305	147	76	33						845

Bed Day Information 2020 / 2021 (by category)

PICU	92	45	34	113	102	53	31						470
Acute	18	9	86	192	45	23	2						375
Total	110	54	120	305	147	76	33	0	0	0	0	0	845
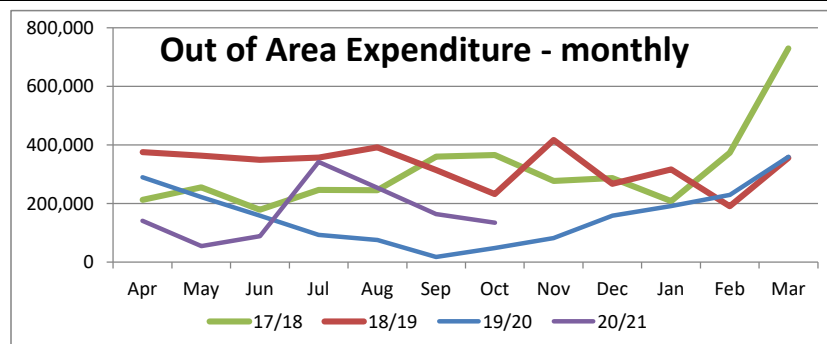
Delivery of service demands remains a challenge for the Trust, and whilst the focus remains on ensuring that costs are minimised and care is provided in the most appropriate environment and location, some out of area placements are being utilised.

Activity and costs have continued to reduce since July 2020 with reductions in both PICU and acute out of area activity. As at 31st October there were 3 placements (3 PICU, 0 acute). This continues to be monitored as activity can fluctuate.

	2019 / 2020 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	108,146	105,616	1
Current Assets			
Inventories & Work in Progress	238	238	
NHS Trade Receivables (Debtors)	6,048	1,803	2
Non NHS Trade Receivables (Debtors)	953	1,418	3
Prepayments, Bad Debt, VAT	2,219	2,902	
Accrued Income	1,904	3,516	4
Cash and Cash Equivalents	36,417	63,951	5
Total Current Assets	**47,778**	**73,827**	
Current Liabilities			
Trade Payables (Creditors)	(4,102)	(6,060)	6
Capital Payables (Creditors)	(272)	(712)	
Tax, NI, Pension Payables, PDC	(6,311)	(5,573)	
Accruals	(10,869)	(14,452)	7
Deferred Income	(1,462)	(19,902)	
Total Current Liabilities	**(23,016)**	**(46,698)**	
Net Current Assets/Liabilities	**24,763**	**27,129**	
Total Assets less Current Liabilities	**132,909**	**132,745**	
Provisions for Liabilities	(8,724)	(8,491)	
Total Net Assets/(Liabilities)	**124,185**	**124,254**	
Taxpayers' Equity			
Public Dividend Capital	44,971	44,971	
Revaluation Reserve	12,763	12,397	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	61,231	61,666	8
Total Taxpayers' Equity	**124,185**	**124,254**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2020.

1. Capital expenditure is detailed on page 13. The asset value is reducing due to depreciation charges and limited capital spend year-to-date.

2. NHS Debtors are predominately 1 invoice which has been agreed as payable in March 2021 (£1.6m). Due to the block nature there is very little outstanding.

3. Non NHS debtors continue to be low and well managed.

4. Accrued income mainly consists of settlement of the covid-19 cost reimbursement and top up payments for September 2020 (£1.8m).

5. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 15.

6. The impact of the system change on the Better Payment Practice Code (page 17) continues to be assessed.
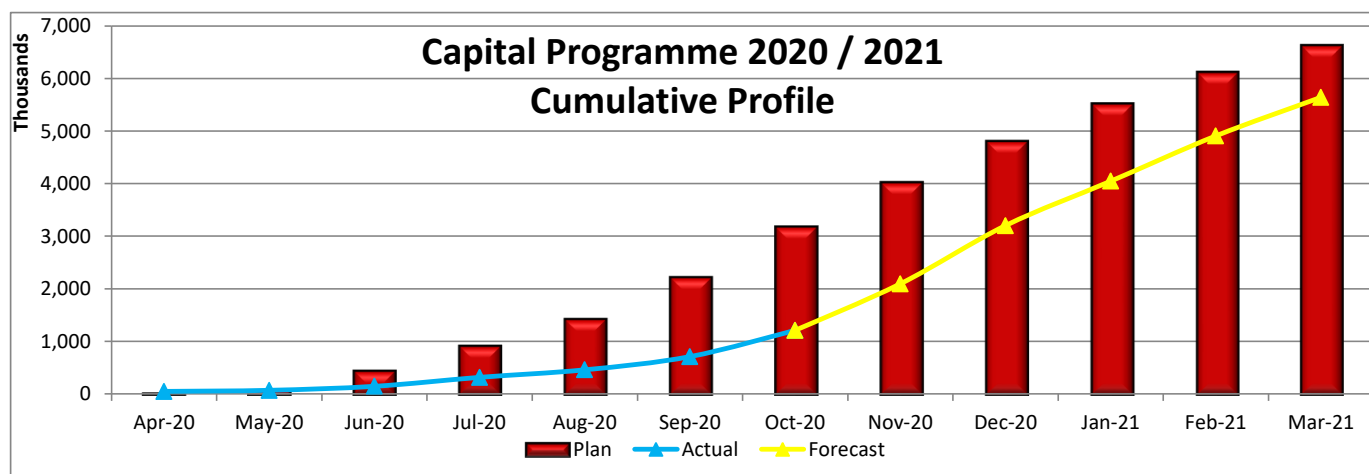
7. Accruals are higher than year end as the Trust awaits invoices for goods and services received.

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

3.1 Capital Programme 2020 / 2021

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	3,479	1,506	611	(894)	3,423	(56)	
Equipment Replacement	100	50	92	42	178	78	
IM&T	2,455	1,653	504	(1,149)	2,043	(412)	
Major Capital Schemes							
Hub Development	600	0	0	0	0	(600)	
						0	
						0	
VAT Refunds			0			0	
TOTALS	**6,634**	**3,209**	**1,207**	**(2,001)**	**5,644**	**(990)**	

Spend in October is £0.5m

Capital Programme 2020 / 2021 Cumulative Profile

Legend: Plan, Actual, Forecast

Capital Expenditure 2020 / 21

The Trust submitted a revised capital plan in May 2020 of £6.6m. This represents a 15% reduction from the original £7.8m. A further £4k has been added from the national backlog maintenance programme.

A further detailed review has been undertaken in September 2020. This provides an updated forecast of realistic spend up to 31st March 2021 bearing in mind the current implications of covid-19, accessibility, impact on pricing etc.

As a result there is a reduction of c. £1m with the majority of the change the hub development and IT schemes.
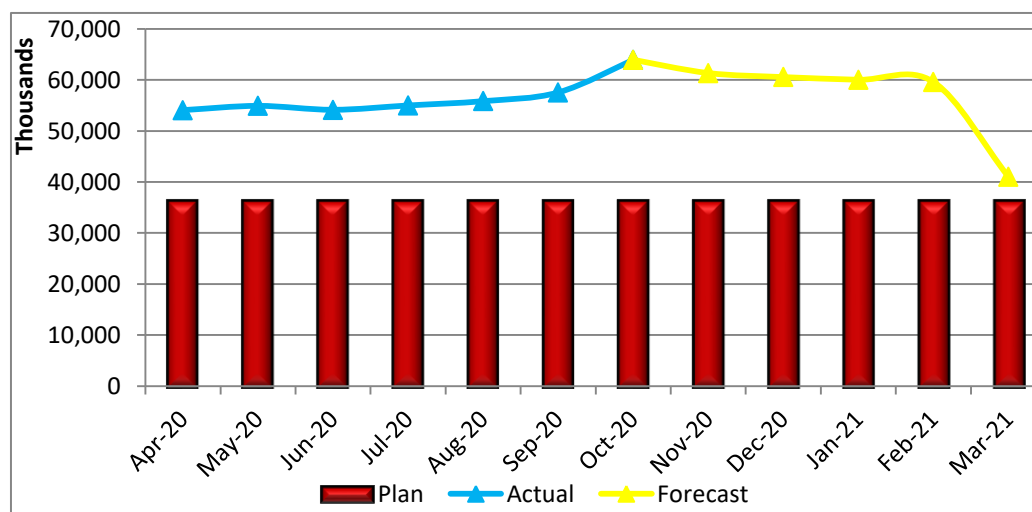
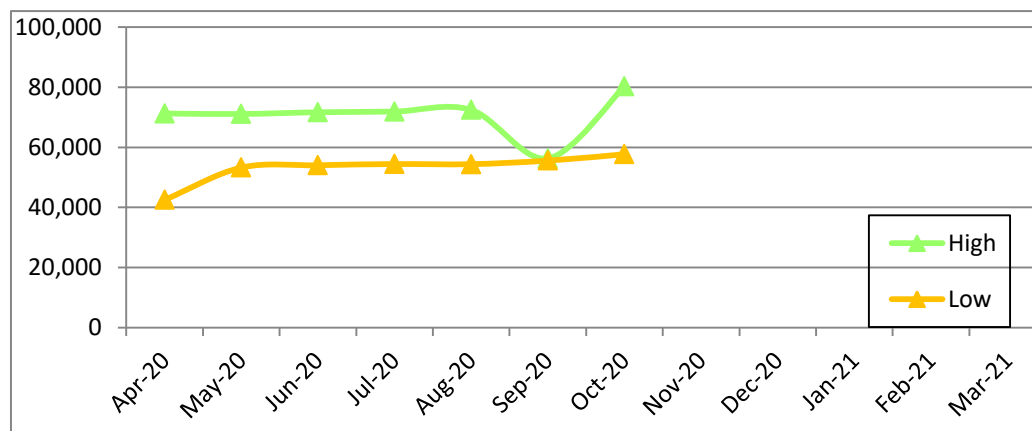|	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	36,417	
Closing Balance	36,417	63,951	27,534

Cash remains higher than 2019/20. The main factor is the timing of block payments which are a month in advance.

Even though block contract payments are being received a month in advance, which has a positive impact on the cash position, the Trust continues to look to maximise cash.

A detailed reconciliation of working capital compared to plan is presented on page 15.

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

The highest balance is: £80.3m
The lowest balance is: £57.7m

This reflects cash balances built up from historical surpluses.

	Actual £k	Note
Opening Balances	**36,417**	
Surplus / Deficit (Exc. non-cash items & revaluation)	5,382	
Movement in working capital:		
Inventories & Work in Progress	0	
Receivables (Debtors)	3,780	
Accrued Income / Prepayments	(2,295)	
Trade Payables (Creditors)	290	
Other Payables (Creditors)	(738)	
Accruals & Deferred income	22,023	
Provisions & Liabilities	(232)	
Movement in LT Receivables:		
Capital expenditure & capital creditors	(767)	
Cash receipts from asset sales	91	
PDC Dividends paid		
PDC Dividends received		
Interest (paid)/ received		
Closing Balances	**63,950**	

Cash Bridge 2020 / 2021
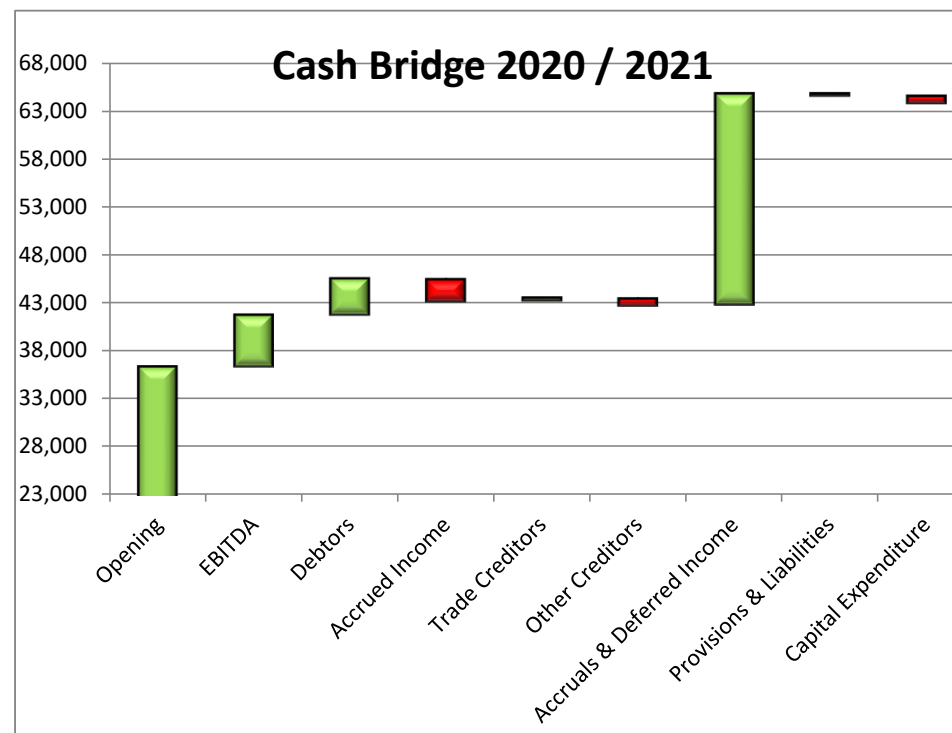
The table above summarises the reasons for the movement in the Trust cash position during 2020 / 2021. This is also presented graphically within the cash bridge.

The surplus / deficit movement is the Trust I & E position adjusted for depreciation which is non cash and adding back in PDC as this only generates a cash impact on a 6 monthly basis and is shown separately. The PDC payment expected in September has been deferred(until November 2020), this again improves the Trust's current cash position.

This highlights the largest positive cash impact is within accruals and deferred income. Of this £21.2m relates to the receipt of November 2020 block invoices during October in line with national guidance. This is higher than previous months as it includes ICS prospective funding.

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

The team continue to review reasons for non delivery of the 95% target and identify solutions to problems and bottlenecks in the process. A further focus has been provided following the implimentation of the new finance and procurement ledger system.

As part of the national response to the impact of COVID-19 all NHS Trusts were asked to pay suppliers within 7 days. Processes were reviewed to ensure that this could be supported and monitoring commenced immediately (20th April 2020).

To date, by value, we have paid 60% of NHS invoices and 84% of non NHS invoices within this 7 day target. It is expected this performance will continue to reduce as invoices within SBS, which have already failed this target, are paid in November. This is a symptom of the new system and will continue to be reviewed.

NHS	Number %	Value %
30 days		
Year to September 2020	92%	88%
Year to October 2020	92%	88%
7 days		
Year to September 2020	61%	62%
Year to October 2020	60%	60%
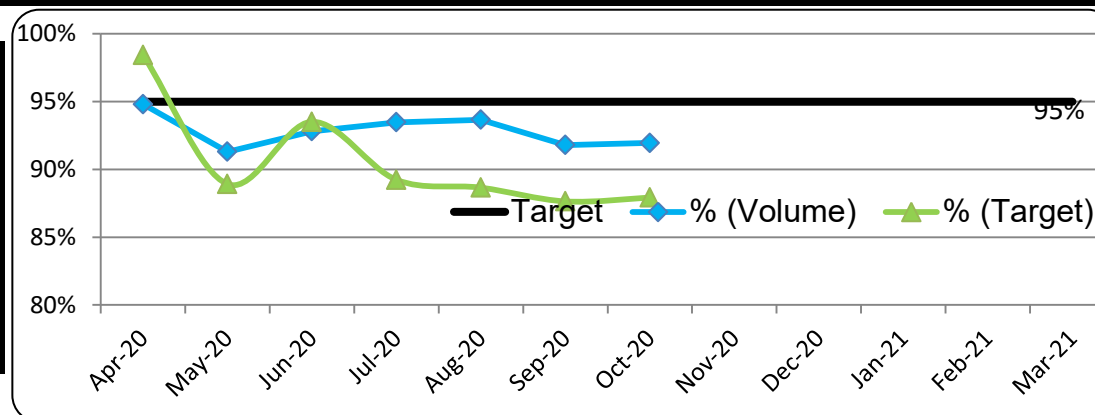
Non NHS	Number %	Value %
30 days		
Year to September 2020	98%	98%
Year to October 2020	97%	98%
7 days		
Year to September 2020	76%	86%
Year to October 2020	71%	84%
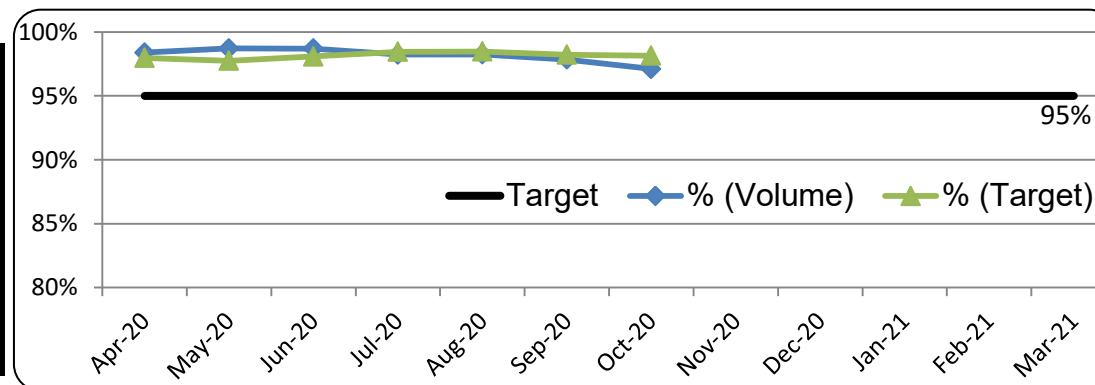
4.1 Transparency Disclosure

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

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

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

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

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
19-Oct-20	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	4710164224	364,058
10-Oct-20	Property Rental	Wakefield	Mid Yorkshire Hospitals NHS Trust	1600015124	182,622
26-Oct-20	Drugs	Trustwide	Bradford Hospitals NHS Trust	317346	120,204
12-Oct-20	Property Rental	Kirklees	Bradbury Investments Ltd	1503	118,518
23-Oct-20	Drugs	Trustwide	Bradford Hospitals NHS Trust	317521	83,225
28-Oct-20	Drugs	Trustwide	Lloyds Pharmacy Ltd	94390	64,729
16-Oct-20	Drugs	Trustwide	NHS Business Services Authority	1000066578	35,705
22-Oct-20	IT Services	Trustwide	Daisy Corporate Services	3I460376	34,579
19-Oct-20	Staff Recharge	Barnsley	Touchstone	SINV2018878	32,161
27-Oct-20	Purchase of Healthcare	Trustwide	Priory Middleton St George	3900011082	31,278
26-Oct-20	Computer Hardware	Trustwide	Dell Corporation Ltd	7402648261	30,706
13-Oct-20	Property Rental	Kirklees	Bradbury Investments Ltd	1504	27,758
27-Oct-20	Staff Uniforms	Trustwide	Grahame Gardner Ltd	840503	25,755

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

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

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

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

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

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

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

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.2%	4.3%	4.2%	4.1%	4.0%	4.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.0%	4.4%	3.8%	3.8%	3.6%	4.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.0%	86.0%	86.0%	86.0%	86.8%	86.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	91.7%	91.7%	91.7%	92.1%	91.7%	91.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.4%	91.4%	91.4%	90.8%	92.1%	92.9%
Equality and Diversity	Resources	Well Led	AD	>=80%	97.3%	97.3%	97.3%	97.4%	98.0%	98.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	94.6%	94.6%	94.6%	94.1%	93.9%	93.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.7%	79.7%	79.7%	79.9%	78.5%	79.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	97.9%	97.9%	97.9%	97.9%	98.2%	98.4%
Information Governance	Resources	Well Led	AD	>=95%	98.9%	98.9%	98.9%	99.1%	99.0%	99.1%
Moving and Handling	Resources	Well Led	AD	>=80%	92.6%	92.6%	92.6%	92.2%	91.8%	91.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.2%	94.2%	94.2%	94.7%	94.4%	94.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	91.6%	91.6%	91.6%	92.0%	91.8%	93.0%
Prevent	Improving Care	Well Led	AD	>=80%	94.5%	94.5%	94.5%	95.3%	95.3%	95.7%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.1%	97.1%	97.1%	92.9%	92.9%	93.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.4%	94.4%	94.4%	95.5%	95.5%	95.1%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	98.7%	98.7%	98.7%	98.4%	98.4%	
Bank Cost	Resources	Well Led	AD		£89k	£62k	£79k	£102k	£87k	
Agency Cost	Resources	Effective	AD		£35k	£39k	£58k	£56k	£60k	
Overtime Costs	Resources	Effective	AD		£73k	£48k	£43k	£48k	£18k	
Additional Hours Costs	Resources	Effective	AD		£27k	£28k	£27k	£24k	£18k	
Sickness Cost (Monthly)	Resources	Effective	AD		£101k	£112k	£98k	£99k	£89k	
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		3.30	4.35	0.51	3.59	-1.37	
Business Miles	Resources	Effective	AD		79k	69k	84k	85k	74k	

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	3.7%	3.3%	3.1%	3.1%	3.1%	3.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.7%	2.5%	2.7%	3.0%	3.2%	3.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.2%	86.2%	86.2%	86.6%	85.5%	85.6%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	89.6%	89.6%	89.6%	89.8%	89.0%	87.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	96.2%	96.2%	96.2%	95.7%	94.9%	94.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	96.0%	96.0%	96.0%	96.8%	96.7%	97.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	95.3%	95.3%	95.3%	95.0%	95.0%	95.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.5%	78.5%	78.5%	78.2%	77.2%	76.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.5%	95.5%	95.5%	96.2%	95.6%	96.5%
Information Governance	Resources	Well Led	AD	>=95%	98.5%	98.5%	98.5%	99.4%	99.3%	99.4%
Moving and Handling	Resources	Well Led	AD	>=80%	95.1%	95.1%	95.1%	95.6%	95.4%	95.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.0%	94.0%	94.0%	95.6%	94.8%	95.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	92.1%	92.1%	92.1%	93.5%	93.6%	94.4%
Prevent	Improving Care	Well Led	AD	>=80%	93.1%	93.1%	93.1%	95.2%	95.2%	95.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	96.2%	96.2%	96.2%	89.7%	89.7%	91.0%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	92.6%	92.6%	92.6%	94.2%	94.2%	94.1%
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	96.6%	96.6%	96.6%	96.9%	96.9%	
Bank Cost	Resources	Well Led	AD		£125k	£100k	£90k	£130k	£141k	
Agency Cost	Resources	Effective	AD		£62k	£27k	£40k	£67k	£50k	
Overtime Costs	Resources	Effective	AD		£21k	£47k	£26k	£25k	£26k	
Additional Hours Costs	Resources	Effective	AD		£2k	£2k	£2k	£1k	£1k	
Sickness Cost (Monthly)	Resources	Effective	AD		£93k	£63k	£71k	£83k	£75k	
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		40.12	40.77	37.74	36.11	39.69	
Business Miles	Resources	Effective	AD		25k	24k	32k	27k	26k	

Appendix - 2 - Workforce - Performance Wall cont….

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	5.0%	5.3%	5.4%	5.4%	5.4%	5.3%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	5.0%	6.1%	5.5%	5.4%	5.4%	5.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.9%	83.9%	83.9%	86.9%	85.5%	87.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	89.4%	89.4%	89.4%	92.3%	90.9%	91.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.0%	95.0%	95.0%	95.1%	93.8%	95.1%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.3%	94.3%	94.3%	95.6%	94.5%	95.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	92.9%	92.9%	92.9%	94.3%	93.0%	93.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	69.2%	69.2%	69.2%	72.3%	70.4%	69.7%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	94.9%	94.9%	94.9%	96.0%	95.6%	95.8%
Information Governance	Resources	Well Led	AD	>=95%	97.1%	97.1%	97.1%	98.5%	98.2%	98.4%
Moving and Handling	Resources	Well Led	AD	>=80%	95.4%	95.4%	95.4%	96.9%	96.4%	96.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.1%	90.1%	90.1%	93.0%	92.1%	92.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.0%	86.0%	86.0%	89.8%	88.0%	87.5%
Prevent	Improving Care	Well Led	AD	>=80%	90.2%	90.2%	90.2%	92.5%	92.5%	92.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.9%	94.9%	94.9%	91.9%	91.9%	91.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	88.2%	88.2%	88.2%	89.0%	89.0%	88.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	98.6%	98.6%	98.6%	98.6%	98.6%	
Bank Cost	Resources	Well Led	AD		£258k	£191k	£204k	£239k	£291k	
Agency Cost	Resources	Effective	AD		£137k	£172k	£183k	£190k	£207k	
Overtime Costs	Resources	Effective	AD		£112k	£105k	£86k	£74k	£79k	
Additional Hours Costs	Resources	Effective	AD		£5k	£6k	£8k	£5k	£5k	
Sickness Cost (Monthly)	Resources	Effective	AD		£68k	£82k	£83k	£84k	£78k	
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		97.40	125.15	114.49	107.62	106.84	
Business Miles	Resources	Effective	AD		8k	8k	9k	12k	11k	

CAMHS

Month	Objective	CQC Domain	Owner	Threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	2.1%	2.4%	2.4%	2.5%	2.6%	2.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	2.2%	3.0%	2.3%	2.8%	3.5%	2.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.1%	76.1%	76.1%	75.6%	76.6%	75.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.8%	84.8%	84.8%	83.3%	81.1%	79.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	89.6%	89.6%	89.6%	91.2%	92.7%	94.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.2%	93.2%	93.2%	93.7%	93.7%	94.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	90.4%	90.4%	90.4%	89.5%	91.3%	91.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	25.0%	25.0%	25.0%	25.0%	0.0%	0.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.9%	92.9%	92.9%	92.3%	93.4%	93.5%
Information Governance	Resources	Well Led	AD	>=95%	96.6%	96.6%	96.6%	96.8%	96.9%	96.9%
Moving and Handling	Resources	Well Led	AD	>=80%	96.8%	96.8%	96.8%	96.5%	97.6%	97.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.1%	91.1%	91.1%	91.2%	91.9%	92.4%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.8%	87.8%	87.8%	88.4%	88.9%	89.0%
Prevent	Improving Care	Well Led	AD	>=80%	92.4%	92.4%	92.4%	93.3%	93.3%	92.4%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.6%	93.6%	93.6%	90.6%	90.6%	90.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.4%	90.4%	90.4%	92.0%	92.0%	92.1%
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	95.6%	95.6%	95.6%	95.0%	95.0%	
Bank Cost	Resources	Well Led	AD		£10k	£11k	£16k	£13k	£16k	
Agency Cost	Resources	Effective	AD		£120k	£134k	£153k	£154k	£144k	
Overtime Costs	Resources	Effective	AD		£56k	£42k	£23k	£36k	£26k	
Additional Hours Costs	Resources	Effective	AD		£2k	£5k	£5k	£4k	£5k	
Sickness Cost (Monthly)	Resources	Effective	AD		£16k	£24k	£19k	£23k	£30k	
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		45.55	43.55	49.63	46.44	2923.0%	
Business Miles	Resources	Effective	AD		7k	5k	7k	6k	5k	

Support Services

Month	Objective	CQC Domain	Owner	Threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	2.9%	3.1%	3.1%	3.1%	3.3%	3.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	2.9%	3.5%	3.2%	3.3%	3.8%	3.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	92.1%	92.1%	92.1%	92.9%	92.3%	93.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.7%	86.7%	86.7%	89.7%	87.1%	87.5%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	66.7%	66.7%	66.7%	100.0%	100.0%	80.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.3%	92.3%	92.3%	92.3%	92.0%	91.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	93.8%	93.8%	93.8%	93.9%	92.8%	90.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	93.7%	93.7%	93.7%	97.2%	97.8%	97.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.4%	94.8%	94.2%
Information Governance	Resources	Well Led	AD	>=95%	98.1%	98.1%	98.1%	98.4%	99.0%	99.3%
Moving and Handling	Resources	Well Led	AD	>=80%	96.4%	96.4%	96.4%	97.0%	98.6%	98.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.0%	99.0%	99.0%	99.0%	98.8%	98.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.0%	87.0%	87.0%	90.5%	81.8%	86.4%
Prevent	Improving Care	Well Led	AD	>=80%	96.7%	96.7%	96.7%	97.9%	97.9%	98.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.3%	97.3%	97.3%	98.5%	98.5%	98.4%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	96.6%	96.6%	96.6%	98.2%	98.2%	98.1%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	60.0%	60.0%	60.0%	100.0%	100.0%	
Bank Cost	Resources	Well Led	AD		£-16k	£53k	£45k	£32k	£47k	
Agency Cost	Resources	Effective	AD		£51k	£19k	£23k	£10k	£12k	
Overtime Costs	Resources	Effective	AD		£33k	£24k	£8k	£13k	£9k	
Additional Hours Costs	Resources	Effective	AD		£16k	£18k	£22k	£20k	£19k	
Sickness Cost (Monthly)	Resources	Effective	AD		£40k	£48k	£49k	£48k	£55k	
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		15.79	-70.62	-53.95	-42.87	11.15	
Business Miles	Resources	Effective	AD		11k	10k	8k	12k	8k	

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	1.9%	2.3%	2.7%	2.8%	2.8%	2.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	2.2%	3.1%	4.1%	3.2%	2.7%	2.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	88.2%	88.2%	88.2%	88.3%	88.0%	87.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	88.9%	88.9%	88.9%	90.4%	88.8%	88.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.6%	91.6%	91.6%	92.1%	91.4%	91.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	95.5%	95.5%	95.5%	96.8%	96.1%	96.1%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	92.1%	92.1%	92.1%	92.8%	93.5%	90.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	80.6%	80.6%	80.6%	81.9%	73.2%	76.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.5%	95.5%	95.5%	96.8%	95.5%	95.3%
Information Governance	Resources	Well Led	AD	>=95%	99.2%	99.2%	99.2%	99.7%	99.2%	99.0%
Moving and Handling	Resources	Well Led	AD	>=80%	96.3%	96.3%	96.3%	97.3%	96.6%	96.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.6%	93.6%	93.6%	94.9%	94.8%	94.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	93.4%	93.4%	93.4%	94.6%	93.5%	94.1%
Prevent	Improving Care	Well Led	AD	>=80%	90.7%	90.7%	90.7%	91.6%	91.6%	93.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	96.3%	96.3%	96.3%	91.6%	91.6%	93.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	93.4%	93.4%	93.4%	92.1%	92.1%	92.7%
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	96.6%	96.6%	96.6%	95.0%	95.0%	
Bank Cost	Resources	Well Led	AD		£86k	£56k	£58k	£63k	£57k	
Agency Cost	Resources	Effective	AD		£38k	£54k	£38k	£32k	£45k	
Overtime Costs	Resources	Effective	AD		£31k	£13k	£15k	£30k	£21k	
Additional Hours Costs	Resources	Effective	AD		£3k	£2k	£3k	£2k	£2k	
Sickness Cost (Monthly)	Resources	Effective	AD		£18k	£26k	£37k	£29k	£22k	
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		5.14	16.44	16.10	11.31	0.59	
Business Miles	Resources	Effective	AD		18k	21k	22k	24k	25k	

Appendix 2 - Workforce - Performance Wall cont….

Inpatient Service										
Month	Objective	CQC Domain	Owner	Threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	6.1%	5.8%	5.7%	5.6%	5.4%	5.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.1%	5.1%	5.5%	5.1%	4.7%	5.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.6%	85.6%	85.6%	87.2%	87.1%	86.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.7%	86.7%	86.7%	88.2%	87.8%	87.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.0%	95.0%	95.0%	94.3%	95.3%	88.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	95.3%	95.3%	95.3%	96.3%	96.5%	97.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	92.5%	92.5%	92.5%	94.9%	92.1%	91.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.6%	73.6%	73.6%	73.5%	73.3%	73.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.3%	95.3%	95.3%	96.1%	95.9%	95.7%
Information Governance	Resources	Well Led	AD	>=95%	97.4%	97.4%	97.4%	98.0%	98.8%	98.6%
Moving and Handling	Resources	Well Led	AD	>=80%	96.3%	96.3%	96.3%	97.5%	97.7%	97.2%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	84.6%	84.6%	84.6%	87.6%	89.2%	90.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	85.2%	85.2%	85.2%	86.5%	87.3%	88.1%
Prevent				>=80%	90.9%	90.9%	90.9%	92.2%	92.2%	92.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.5%	95.5%	95.5%	93.3%	93.3%	91.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	86.3%	86.3%	86.3%	87.5%	87.5%	86.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	96.9%	96.9%	96.9%	96.6%	96.6%	
Bank Cost	Resources	Well Led	AD		£230k	£164k	£164k	£200k	£268k	
Agency Cost	Resources	Effective	AD		£65k	£73k	£63k	£96k	£69k	
Overtime Costs	Resources	Effective	AD		£56k	£62k	£57k	£51k	£32k	
Additional Hours Costs	Resources	Effective	AD		£5k	£5k	£4k	£4k	£3k	
Sickness Cost (Monthly)	Resources	Effective	AD		£52k	£44k	£50k	£46k	£37k	
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		14.75	32.62	44.33	43.74	47.83	
Business Miles	Resources	Effective	AD		0k	1k	0k	0k	0k	

Glossary

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

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

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

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

Trust Board 1 December 2020
Agenda item 8.1

Title:	**Integrated Performance Report**
Paper prepared by:	Director of Finance & Resources
Purpose:	To provide the Trust Board with an update on the development of metrics to be reported in the integrated performance report (IPR) to demonstrate progress against the Trust's strategic objectives
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	- IPR is reviewed at Trust Board each month - Regular updates on the development of strategic objectives and priority programmes to the Trust Board - Detailed review of options at Board working group meeting
Executive summary:	- A working group of the Trust Board with governor and staff expertise representation formed to review the integrated performance report and key metrics to monitor progress made against the Trust's strategic objectives - The group has met once to date and focused on identifying key metrics to be reported in respect of understanding performance against the strategic objectives - A number of principles were identified and agreed by the group which are highlighted in the main report - For each strategic risk potential objective metrics have been identified for each priority programme which are again outlined in detail in appendix 2 - Focus in the immediate and short term is to be clear on what it is possible to report against, recognising that further development may be required to record information and report against it if the information is not recorded or reported on currently - Limited focus has been applied to longer term outcomes at this stage and for the improving health objective in particular. It is recognised there will be many factors that impact on the health outcomes of a community including our own services and performance - A draft reporting format has been developed and is attached to the paper - To identify the true impact of the priority relating to digital technology more understanding of clinical and operational needs is required and this section will need to develop in the coming months. There is a similar situation with our creative offers and the updated sustainability strategy - The next phase of the process is to review the full IPR to identify any further changes
Recommendation:	**Trust Board is asked to NOTE the progress made to date by the working group and APPROVE the recommended metrics for measuring performance against the Trust's strategic objectives subject to any changes agreed in the meeting**
Private session:	Not applicable

With **all of us** in mind.

Strategic Objectives – IPR Metrics

Introduction

Following agreement of the updated strategic objectives by the Trust Board, focus is now being applied to how progress against them is to be reported in the integrated performance report (IPR). A working group of the Trust Board with governor and staff expertise has therefore been formed. The aim of this group is to review the overall content and format of the IPR to ensure it remains meaningful and to recommend what metrics are used to monitor progress against strategic objectives. The purpose of this report is to provide an update of the work that has taken place to date and make a recommendation regarding metrics to be used to track progress against our strategic objectives.

Process

The working group consists of:

Tim Breedon	Director of Nursing & Quality
Mark Brooks	Director of Finance & Resources
Mike Ford	Non-Executive Director
Chris Jones	Non-Executive Director
John Laville	Lead Governor
Kate Quail	Non-Executive Director
Mel Wood	Head of Performance
Salma Yasmeen	Director of Strategy

To date the group has met once with the initial aim of identifying appropriate metrics to support understanding of performance against each of the Trust's strategic objectives. This report therefore focuses on that point with a follow up meeting planned to review the full IPR in terms of content and appearance.

In order to facilitate an effective process the executive directors on the working group plus the Director of Operations and Head of Performance met to identify some potential metrics. It was made clear the purpose of this exercise was to facilitate discussion and stimulate ideas as opposed to presenting a fait accompli.

At the outset of the meeting a number of general points were raised which served to act as a steer of the direction to be taken. These are summarised below.

- We agreed to focus on the measures as opposed to targets
- We need to be clear on the definition of each of the metrics so we fully understand what we are looking at
- In terms of the target audience whilst the IPR is primarily used in full at Trust Board we need to ensure alignment with reporting to other audiences
- There was general agreement that we need to be clear on the level of control and influence we have on the metric and report where we have direct contribution towards its achievement

- There was also recognition there are some metrics we have little control of ourselves e.g. GPs carrying out annual health checks for people with learning disabilities, that we may wish to have visibility of and influence other partners to improve
- We need to ensure there is alignment with other individual strategies and reporting of progress against them
- We need to be mindful of how often progress can be updated e.g. surveys tend to be annually
- RAG rating of progress against milestones against each priority would be helpful
- Any measures used should be done so to help improve Trust performance

There was also recognition that some of the ultimate outcomes particularly for the improving health objective are longer term in nature and whilst the Trust may contribute towards an improvement on long term health outcomes, there will be many more factors that influence and contribute. As such at this stage focus has primarily been applied to the regular metrics that can be reported against.

The preferred approach is to have a dashboard for each strategic objective. This dashboard will comprise of performance against each metric, provide a RAG rating against key milestones and narrative in bullet point form for any key comments to be made. An example of this format is attached as appendix 1.

Appendix 2 summarises the priorities associated with each objective and the recommended metrics.

The recommended metrics for each priority are summarised and explained in the following sections. It is emphasised that other metrics not included in the dashboard can continue to be reported in the appropriate section of the IPR e.g. quality or workforce sections.

Improving Health

Play a full role in our integrated care systems and associated places to contribute to outcomes in their 5 year plans

The initial metrics recommended for this priority are:

- Number of suicides (people on our caseload) – the aim clearly to see a reduction in numbers
- Number of people who stop smoking – this will be measured by people in our stop smoking services. It is currently not possible to report on the number of our service users across all of our services who stop smoking as this information is not captured
- Proportion of people from BAME communities accessing IAPT – there are a number of indicators that could be used in this section with this one felt to be helpful in the first instance given the benefits of accessing services at an early stage

Over time we would expect to add in a metric relating to benefits associated with becoming the lead provider for forensic services once clearly identified.

Improve outcomes through our wellbeing services, physical health and services for people with mental health illnesses and learning disabilities

The initial metrics recommended for this priority are:

- Cardio-metabolic assessment & treatment for people with psychosis*
- IAPT recovery rates
- 7 day follow up
- 12 month follow up
- Learning disability first face to face contact within 18 weeks*

*Ideally we would like to understand completion of physical health checks for people with mental health illness and annual health checks for people with learning disabilities. The responsibility for conducting these health checks and reporting against them sits with other bodies e.g. primary care and commissioners. As such other metrics have been identified initially. With regard to learning disabilities further work will be done with that team to ensure the metric that is able to best identify key performance is used.

There was a consensus that there should also be a metric in this section specifically relating to community health services in Barnsley. Given the wide range of services provided an appropriate measure will be discussed with the senior teams for those services.

During our discussions the possibility of identifying system-wide metrics was raised with potentially a separate dashboard of these metrics provided such that we can understand system performance and exert influence where we can, if we feel performance needs to improve.

Other options considered included identifying a way to measure physical activity. Whilst there is potential to begin to record physical activity in care plans this does not take place currently.

Enhance creative, cultural and digital offers through Creative Minds and our recovery colleges

Currently an exercise is taking place of baseline performance against the Creative Minds performance framework. This is expected to be completed by March 2021, which will enable metrics to be identified and targets set for 2021/22. One metric that could be developed is the number of people accessing creative cultural learning activities.

Improving Care

Within this section the group considered the potential metrics to be more clearly identifiable and directly aligned to the priorities.

Continually improve patient safety

The initial metrics recommended for this priority are:

- Incidents involving moderate or severe harm or death – reduction year on year is already identified within our quality priorities
- C-diff avoidable cases
- Numbers of pressure ulcers
- Safer staffing fill rates
- Children & young people in adult wards
- Staff absence due to Covid-19

- Number of nosocomial incidences of Covid-19 in our inpatient units

Potential outcomes would be sustained reductions in patient safety incidents and healthcare associated illnesses

Provide care as close to home as possible

The key metric for this priority would be:

- Out of area bed placements (days)

The ultimate outcome is for the elimination of out of area bed placements

Deliver improvements particularly in CAMHS and forensic services

Given the recognised issues that have led to this becoming a priority the recommended metrics are as follows:

- Numbers waiting over 4 weeks for assessment (CAMHS)
- Numbers waiting over 18 weeks for treatment (CAMHS)
- Friends & family test
- Forensic staff sickness
- Forensics staff turnover
- Race related incidents in forensics

In addition to the above there are a number of national metrics being developed for CAMHS. These will be assessed when available. Staff survey results are also considered a key metric, but as they are only available once a year will be reported on separately.

Expected outcomes would be improved access into CAMHS, sustained improvement in staff morale in forensics and a consistent reduction in incidents in forensics.

Safely deliver and restore inclusive services locking in innovation

Initial metrics for this priority would be:

- Waiting lists (services to be agreed)
- Access representative of the community population – this would need to be a consolidated number in the dashboard with detail taken through other fora.

Ultimately, we would expect to see equal access to services for all people who need to use them

Improve Resources

Spend money wisely and reduce waste

Key metrics are recommended as being:

- Surplus/(deficit) vs target
- Underlying surplus/(deficit)
- Cash
- Performance against efficiency targets (assuming these will be reinstated for 21/22)

The outcomes over time for this priority are identified as being consistent achievement of financial targets ensuring the Trust remains financially sustainable, an ability to fund our capital expenditure requirements and having income in line with nationally recognised benchmarks

Integrate digital approaches to the way we work

The group is keen to ensure that any metrics associated with the use of digital are backed up clinically e.g. quality of face to face may be more appropriate than the use of video consultations for some services and/or service users. With this in mind initial metrics could be:

- Number of 'did not attends' – there are some data quality concerns currently which are recognised
- Number of video consultations compared to phone and face to face – this is useful in terms of monitoring use of digital but not quality of service
- Prescribing errors – these are expected to reduce given the implementation of EPMA (electronic prescribing and medicines administration). The most appropriate metric to use is currently being considered by the Chief Pharmacist e.g. medicine omissions, medicines administered at the wrong time

Further work will take place via the reset and restoration group to ensure what is being recommended for use of digital technology is in line with clinical best practice and evidence.

Make SWYPFT a great place to work

Support the provision of a healthy, resilient & safe workforce

A number of metrics have been identified for this priority which cover:

- Sickness absence
- Staff turnover
- Clinical supervision and appraisal
- Incidents of violence and aggression against staff
- Cases of bullying & harassment
- Absence due to stress, anxiety and MSK
- Relative likelihood of appointment to roles band 5 and above for people with protected characteristics
- Access to training for people with protected characteristics

There are a number of outcomes we would expect to see as a result including having a motivated workforce, improved job satisfaction, ability to attract staff to the Trust and manage our own talent

Refresh and deliver our sustainability strategy and action plan

Metrics associated with this priority will be assessed following the update of the Trust's sustainability plan

Summary and Recommendation

In summary there are a number of metrics identified that can support the Trust Board's understanding of progress against our strategic objectives. These have been highlighted in this paper and appendix 2. There are a number that require further development and as such the dashboards will evolve between now and March 2021. It is currently envisaged that reporting in the new format and with the proposed metrics can commence from January 2021.

It is re-emphasised that metrics not included in the dashboard can continue to be reported in the appropriate section of the IPR and/or to Board committee.

It is recommended that Trust Board considers notes the progress to date made by the working group, its future plans and agrees the proposed metrics for evaluating progress against the strategic objectives.

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Proposed Metrics for Strategic Objectives & Priority Programmes

Objective	Priority	Regular Metrics	Outcome
Improve health	Play a full role in our integrated care systems and associated places to contribute to outcomes in their 5 year plans	1.Number of suicides 2.Number of people who stop smoking 3.Proportion of people from BAME communities accessing IAPT	Achievement of place-based outcome targets
Improve health	Improve outcomes through our wellbeing services, physical health and services for people with mental health illnesses and learning disabilities	1.Cardio-metabolic assessment & treatment 2.IAPT recovery rates 3.7 day follow up 4.12 month follow up 5.Learning disability first face to face contact within 18 weeks	Improvements in the health of the populations we serve
Improve health	Enhance creative, cultural and digital offers through Creative Minds and our recovery colleges	Full understanding of baseline of performance against the Creative Minds performance framework by March 2021 to enable targets to be set for 21/22 1.Number of people accessing creative cultural learning activities	
Improve care	Continually improve patient safety	1.Reduction in incidents involving moderate or severe harm or death 2.C-diff avoidable cases 3.Number of pressure ulcers 4.Safer staffing fill rates 5.Children & young people in adult wards 6.Staff absence due to Covid-19 7.Number of nosocomial incidences of Covid-19 in our inpatient units	1. Sustainable reduction in incidents over the longer term 2. Consistent reduction in healthcare associated illnesses
Improve care	Provide care as close to home as possible	1.Out of area bed placements (days)	1.Eliminate the use of out of area bed placements

Improve care	Deliver improvements particularly in CAMHS and forensic services	1. Numbers waiting over 4 weeks for assessment (CAMHS) 2. Numbers waiting over 18 weeks for treatment (CAMHS) 3. Friends & Family test 4. Forensics staff sickness 5. Forensics staff turnover 6. Race related incidents in forensics	1. Sustained Improvement in access to CAMHS 2. Sustained improvement in staff morale in forensics 3. Consistent reduction in incidents in forensics
Improve care	Safely deliver and restore inclusive services locking in innovation	1. Waiting lists 2. Access representative of community population	1. Patient outcomes 2. Access to services for all those who need them
Improve resources	Spend money wisely and reduce waste	1. Surplus/(deficit) vs target 2. Underlying surplus/(deficit) 3. Cash 4. Performance against efficiency targets	1. Ongoing achievement of financial targets 2. Ability to fund capital expenditure requirements 3. Income in line with nationally recognised benchmarks 4. Upper quartile in mental health benchmarking reports
Improve resources	Integrate digital approaches to the way we work	1. Number of 'did not attends' 2. Number of video consultations compared to phone and face to face 3. Prescribing errors (EPMA)	1. Access to services 2. Improved patient outcomes
Make SWYPFT a great place to work	Support the provision of a healthy, resilient & safe workforce	1. Sickness absence 2. Staff turnover 3. Clinical supervision and appraisal 4. Incidents of violence and aggression against staff 5. Staff survey results 6. Cases of bullying & harassment 7. Absence due to stress & anxiety and MSK 8. Relative likelihood of appointment to roles band 5 and above for people with protected characteristics 9. Access to training with protected characteristics	1. Motivated workforce 2. Improved job satisfaction 3. Recognised by service users, patients, and carers 4. Attract staff to the Trust 5. Managing our own talent
Make SWYPFT a great place to work	Refresh and deliver our sustainability strategy and action plan	Dependent on what is identified in the updated sustainability plan	

Priority Programmes

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Strategic objective	Priority programme	Metrics	A	M	J	Year end forecast
Improve health	Play a full role in our integrated care systems and associated places to contribute to outcomes in their 5 year plans.	1. Number of suicides for patients with an open referral to SWYPFT services.				
		2. Smoking quit rates for patients seen by SWYPFT stop smoking services (4 weeks).				
		3. Proportion of people from BAME communities accessing IAPT.				
	Improve outcomes through our wellbeing services, physical health and services for people with mental health illnesses and learning disabilities.	1. Cardio metabolic assessment & treatment.				
		2. IAPT – proportion of people completing treatment who move to recovery.				
		3. % of service users on CPA followed up within 7 days of discharge.				
		4. % of service users on CPA with a 12 month follow up recorded.				
		5. % of learning disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks.				
	Enhance creative, cultural and digital offers through Creative Minds and our recovery colleges.	Full understanding of baseline of performance against the Creative Minds performance framework by March 2021 to enable targets to be set for 2021/22. 1. Number of people accessing creative cultural learning activities.				

Key Metrics RAG Rating:

Key metric 1	🟩
Key metric 2	🟥
Key metric 3	🟩
Key metric 4	🟩
Key metric 5	🟩

Comments:

Priority Programmes

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Strategic objective	Priority programme	Metrics	A	M	J	Year end forecast
Improve care	Continually improve patient safety.	1. Reduction in incidents involving moderate or severe harm or death.				
		2. Number of c-diff avoidable cases.				
		3. Number of pressure ulcers.				
		4. Safer staffing fill rates. (%)				
		5. Number of children & young people in adult wards.				
		6. Staff absence due to Covid-19.				
		7. Number of nosocomial incidences of Covid-19 in our inpatient units.				
	Provide care as close to home as possible.	1. Out of area bed placements. (days)				
	Deliver improvements particularly in CAMHS and forensic services.	1. Numbers waiting over 4 weeks for assessment. (CAMHS)				
		2. Numbers waiting over 18 weeks for treatment. (CAMHS)				
		3. Friends & Family test				
		4. Forensics staff sickness				
		5. Forensics staff turnover.				
		6. Race related incidents in forensics.				
	Safely deliver and restore inclusive services locking in innovation	1. Waiting lists.				
		2. Access representative of community population.				

Key Metrics RAG Rating:

Key metric 1	🟩
Key metric 2	🟥
Key metric 3	🟩
Key metric 4	🟩
Key metric 5	🟩

Comments:

Priority Programmes

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Strategic objective	Priority programme	Metrics	A	M	J	Year end forecast
Improve resources	Spend money wisely and reduce waste.	1. Surplus / (deficit) vs target.				
		2. Underlying surplus / (deficit).				
		3. Cash				
		4. Performance against efficiency targets.				
	Integrate digital approaches to the way we work.	1. Number of 'did not attends'.				
		2. Number of video consultations compared to phone and face to face.				
		3. Prescribing errors (EPMA) (development required).				

Key Metrics RAG Rating:

Key metric 1	🟩
Key metric 2	🟥
Key metric 3	🟩
Key metric 4	🟩
Key metric 5	🟩

Comments:

Priority Programmes

NHS
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Strategic objective	Priority programme	Metrics	A	M	J	Year end forecast
Make SWYPFT a great place to work	Support the provision of a healthy, resilient & safe workforce.	1. Sickness absence.				
		2. Staff turnover.				
		3. Clinical supervision and appraisal.				
		4. Incidents of violence and aggression against staff.				
		5. Staff survey results.				
		6. Cases of bullying & harassment.				
		7. Absence due to stress & anxiety and MSK.				
		8. Relative likelihood of appointment to roles band 5 and above for people with protected characteristics.				
		9. Access to training with protected characteristics.				
	Refresh and deliver our sustainability strategy and action plan.	Dependent on what is identified in the updated sustainability plan.				

Key Metrics RAG Rating:

Key metric 1	🟩
Key metric 2	🟥
Key metric 3	🟩
Key metric 4	🟩
Key metric 5	🟩

Comments:

Trust Board 1 December 2020
Agenda item 8.2

Title:	**Serious Incident Report quarter 2 2020/21 (including learning from healthcare deaths quarter 2 2020/21)**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This report provides information in relation to incidents in quarter 2 and more detailed information in relation to serious incidents. Also, to provide assurance that learning from healthcare deaths arrangements are in place. The report provides cumulative data for 2020/21 deaths. The learning from healthcare deaths report requires publication on the Trust website.
Mission / values:	• We are respectful, honest, open and transparent. • We put the person first and, in the centre. • We are always improving.
Any background papers / previously considered by:	Previous quarterly reports which have been submitted to Clinical Governance and Clinical Safety Committee (CG&CS) and Trust Board, along with an annual incident report.
Executive summary:	• This report is produced by the patient safety support team and shows the data for incidents. Detailed quarterly reports will be produced and shared with each Business Delivery Unit. Data is also available at service line level. All managers have access to Datix dashboards to interrogate data further. • This report has overall figures for incident reporting. Q2 had 3342 incidents; higher than the previous quarter (2938). • 85% of incidents are graded as "low" or "no harm" showing a positive culture of risk management (the more 'green' incidents reported mean action taken proactively at an early stage before harm occurs). • We benchmark well based on National Reporting and Learning System (NRLS) report on patient safety incidents with consistent and timely reporting and no evidence of under reporting. • There has been no 'never events' reported in the Trust during Q2, the last 'never event' reported was in 2010/11. • The total number of serious incidents reported through Strategic Executive Information System (STEIS) in quarter 2 was 12; this is higher than what was reported in quarter 1 2020/21 (nine). • In quarter 2, the highest category of serious incident is 'death unknown, awaiting confirmation' (two) and 'suicide (including apparent suicide) community team care – current episode' (two). The latter is lower than quarter 1, which was four. • A recent 360 Assurance audit of incident processes resulted in significant assurance. An action plan has been developed to

- address areas for improvement. Our work on learning from experience was recognised as an area of excellent practice.
- 10 serious incident investigations have been submitted to the Commissioner during the quarter, and one previous serious incident has been closed by the Commissioners.
- A number of investigations are outside the 60 working day target. During the Covid-19 period and to present, the 60 working days timescale has been suspended by NHS Improvement. However, we have continued to aim to work towards this timescale during this time.
- We are starting the Royal College of Psychiatrists Serious Incident Review Accreditation process which will involve a period od self-review followed by peer review.

Learning from healthcare deaths

- The learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes.
- The Trust started reviewing all deaths reported on Datix using an incremental approach from April 2017.
- Total number of deaths reported on Datix by staff between 1 July 2020 – 30 September 2020 (by reported date, not date of death) was 74, all of which have been reviewed. This is lower than Q1 (132) which saw an increase because of Covid-19. The average figure for 2019/20 was 89 deaths per quarter (ranging from 74 – 108), the Q2 figure is within this range.
- Total in scope as described in the report is 68.
- Following the Mortality Review Group meeting on 20 August 2020, a decision was made to reduce the frequency of that meeting from monthly to quarterly.

The Clinical Governance and Clinical Safety Committee (CG&CS) scrutinised the report at their meeting on 10 November 2020 and commented as follows:

- The report provides important assurance that the appropriate process and learning arrangements are in place.
- The apparent suicide numbers monitoring remains critical to ensuring that the impact of the suicide prevention work is having a positive effect.
- The ongoing monitoring of incidents and the impact of the pandemic is essential in two key areas: apparent suicide and self-harm.
- The possibility of theming Datix issues in relation to policy implementation to be examined, in order to distinguish between issue with the policy or non-compliance.

	Risk appetite
	• Risk identified – the Trust continues to have a good governance system of reporting and investigating incidents, including serious incidents, and of reporting, analysing and investigating healthcare deaths. • This report covers assurance for compliance risk for health and safety legislation and compliance with Care Quality Commission (CQC) standards for incident reporting. This meets the risk appetite – low and the risk target 1 – 6. • The clinical risk – risk to service user / public safety and risk to staff safety which is again low on risk appetite and a risk target of 1 – 6. • Financial or commercial risks – reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite – cautious / moderate (4 – 6).
Recommendation:	**Trust Board is asked to NOTE the quarterly report on incident management and the action identified by CG&CS and add any further comment.**
Private session:	Not applicable.

Trust wide Incident Management Report
Quarter 2 2020/21

Incorporating Serious Incidents and Learning from Healthcare Deaths reporting for the period 01/04/2020 – 30/09/2020

Report prepared by Patient Safety Support Team

October 2020

Contents

Executive Summary

This report provides information in relation to incidents reported in Quarter 2 2020/21 and more detailed information in relation to serious incidents. A brief analysis of actions arising from completed Serious Incident investigations submitted to commissioners for the period of 1 July 2020 to 30 September 2020 is included. The report also includes the Trust's report on Learning from Healthcare Deaths to provide assurance that arrangements are in place and to provide cumulative data for the period 01/04/2020 – 30/09/2020. The Learning from Healthcare Deaths report will be available separately on the Trust website.

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

Quarter 2 2020/21 Headlines

- **3342** incidents reported
- **82%** of incidents resulted in no/low harm
- **12** Serious incidents reported
- Serious Incidents account for **0.4%** of all incidents reported
- No homicides
- No Never Events
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

> This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each Business Delivery Unit. Data is also available at service line level. All managers have access to Datix dashboards to interrogate data further.
> This report has overall figures for incident reporting. Q2 had 3342 incidents; higher than the previous quarter (2961).
> 82% of incidents are graded as "low" or "no harm" showing a positive culture of risk management (the more 'green' incidents reported mean action taken proactively at an early stage before harm occurs).
> "Physical aggression/threat (no physical contact): by patient" 316 incidents (9%) remains as the most reported category.
> "Violence and Aggression" continues to be the highest reported incident type (27%) (914) of all incidents reported in the quarter, consistent with the previous quarter) [fig 1]. Staff have reported that this can be linked to individual service users but also say some incidents are linked to the trust's current smoking policy.
> There have been no 'Never Events' reported in the Trust during Q2: the last Never Event reported was in 2010/11.

- The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Quarter 2 was 12; this is higher than what was reported in Quarter 1 20/21 (9). The range of serious incidents reported this quarter has included deaths (5), pressure ulcers (1), security – other (1) self-harm (2), Violence and aggression (1), Medication (1) and Information governance (1).
- In quarter 2, the highest category of serious incident is Death unknown, awaiting confirmation (2), Self harm (actual harm) with suicidal intent (2) and Suicide (including apparent suicide) community team care – current episode (2). The latter is lower than quarter 1 which was 4.
- All incidents that are graded red or amber are extracted from Datix for inclusion in a report that is reviewed at the weekly risk panel.
- All deaths are reviewed in line with the learning from healthcare deaths policy.
- We are implementing our Trust wide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern.
- We have taken the lead on the West Yorkshire and Harrogate Health Care Partnership 5-year suicide prevention strategy, which has adopted an evidence-based approach to suicide prevention and zero suicide philosophy for targeted areas and hotspots.
- A recent 360 Assurance audit of incident processes resulted in significant assurance. An action plan has been developed to address areas for improvement. Our work on learning from experience was recognised as an area of excellent practice.
- 10 serious incident investigations have been submitted to the Commissioner during the quarter and 1 previous serious incident have been closed by Commissioners.
- The actions from incidents are managed at Business Delivery Unit level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational management group.
- A number of investigations are outside the 60 working day target; these have agreed extensions with Commissioners. The complexity of investigations has contributed to delays.
- We are starting the Royal College of Psychiatrists Serious Incident Review Accreditation process which will involve a period of self review following by peer review.

Learning from healthcare deaths

- The Learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes.
- The Trust started reviewing all deaths reported on Datix using an incremental approach from April 2017
- The Learning from healthcare deaths policy was reviewed in January 2020
- The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
  - Death Certification
  - Case record review, including Structured Judgment Record Reviews. The managers 48-hour review on Datix is also classed as a first stage case record review.
  - Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding.
- Total number of deaths reported on Datix by staff between 1/07/2020 – 30/09/2020 (by reported date, not date of death) = 74, all of which have been reviewed.
- Total in scope as described in report = 68

1. Introduction

This report has been prepared by the Patient Safety Support Team to bring together Trust wide information on incident activity during Quarter 2 2020/21 (1 July 2020 to 30 September 2020) including reported serious incidents and Learning from Healthcare Deaths for the period 1 April 2020 to 30 September 2020.

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

2. Updates from the Patient Safety Support Team

During Quarter 2, the Patient Safety Support Team priority areas have included:

- Datix reporting structure work.
- Horizon Incident reporting training.
- Reducing the back log of incidents awaiting final approval.
- Identifying and theming Covid 19 related incidents.
- Providing data on self harm and apparent suicides on a weekly basis.
- Continue to amend data flows for severe harm and death incidents to the CQC.
- Responding to 3 FOI requests (including information related to serious incident data).
- Data production and reporting for monthly reports.

3. Incident Reporting Analysis

This report has overall figures for incident reporting. Q2 had 3342 incidents which is higher than the levels in the previous two quarters.

82% of all incidents reported on Datix are graded as green severity rating meaning they had "low" or "no harm". This shows a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs).

Headlines

Quarter 2 2020/21 Headlines

- **3342** incidents reported

- Increase on reporting compared with Q1 (2961)

- **82%** of incidents remain **no/low harm**

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

Figure 1 below shows the pattern and number of incidents reported by quarter in the Trust from Q3 16/17 to Q2 20/21. The rate fluctuates as would be expected. Quarter 2 2020/21 was slightly higher than the expected the average for a quarter. However, with the Trust changing profile of services, direct comparisons should be viewed with caution.

Figure 1 Comparative number of incidents reported by financial quarter Q3 2016/17 to Q2 2020/21
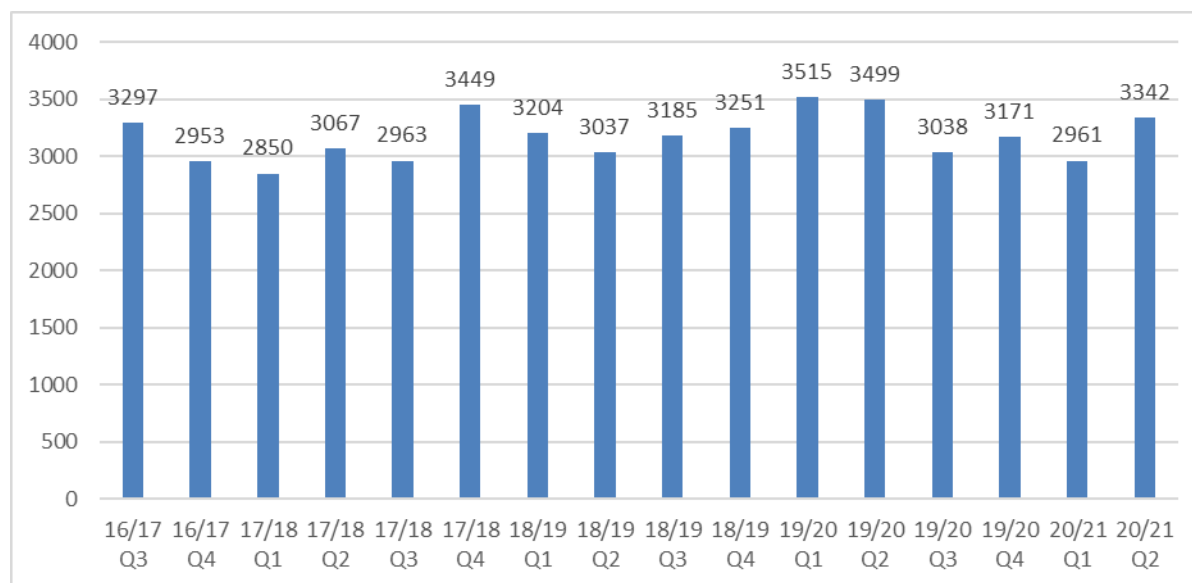
Severity

In Figure 2 there have been 28 red incidents reported in Q2 20/21. This data is live data at the point of producing the report. The incident may be initially graded red for a number of reasons. An example would be a death (for healthcare deaths we have been encouraging staff to report on Datix) but we later find out this is natural causes or where the individual has not been involved with Trust services for over six months so this may be re-graded and not reported on STEIS, this can take some time to get this information. Not all red incidents will meet the criteria for a serious incident (see page 20).

Figure 2 All incidents reported Trust wide between 01/07/2019 – 30/09/2020 by severity and financial quarter

	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2
Green (no harm)	1984	1839	1774	1615	1786
Green	1067	796	961	916	969
Yellow	317	270	283	279	449
Amber	106	98	118	124	110
Red	25	35	35	27	28
Total	3499	3038	3171	2961	3342

Figure 3 All incidents reported Trust wide between 1/07/2020 - 30/09/2020 by severity and BDU

	Green - No Harm	Green	Yellow	Amber	Red	Total
Barnsley General Community Services	213	116	11	44	1	385
Barnsley Community Mental Health Services	40	10	5	2	7	64
Calderdale Community Mental Health Services	34	19	9	0	2	64
Kirklees Community Mental Health Services	45	15	9	4	9	82
Wakefield Community Mental Health Services	60	24	9	4	1	98
Mental Health Inpatient Services	682	587	349	37	3	1658
Forensic Service	469	146	43	16	2	676
Learning Disability services	175	35	5	1	3	219
ADHD and Autism services	2	1	0	0	0	3
CAMHS Specialist Services	40	10	5	2	0	57
Trust wide (Corporate support services)	26	6	4	0	0	36
Total	1786	969	449	110	28	3342

Type and Category of incidents

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

Figure 4 Type of incident reported in Quarter 2 by BDU

	Barnsley General Community Services	Barnsley Community Mental Health Services	Calderdale Community Mental Health Services	Kirklees Community Mental Health Services	Wakefield Community Mental Health Services	Mental Health Inpatient Services	Forensic Service	Learning Disability services	ADHD and Autism services	CAMHS Specialist Services	Trust wide (Corporate support services)	Total
Violence and Aggression	9	9	6	7	4	480	269	123	0	6	1	914
Self Harm	7	7	13	13	21	389	25	21	0	2	0	498
Care Pathway, Clinical and Pressure Ulcer Incidents	228	1	2	0	5	71	2	14	0	6	0	329
Medication	46	13	9	7	11	142	54	3	1	1	2	289
All Other Incidents	12	8	4	4	5	145	60	4	0	4	6	252
Health and Safety (including fire)	14	1	3	1	3	102	79	10	0	3	6	222
Slips, Trips and Falls	20	2	0	1	1	104	15	9	0	1	1	154
Security Breaches	5	1	2	2	6	44	75	1	0	2	4	142
Legislation and Policy	0	0	0	0	1	52	44	3	0	0	0	100
Information Governance Incidents	15	5	2	11	11	10	5	9	2	13	7	90
Infection Prevention/Control	10	1	0	1	3	39	12	3	0	0	4	73
Death (including suspected suicide)	3	7	11	19	17	3	0	12	0	0	0	72
Safeguarding Adults	7	4	5	7	3	20	16	6	0	0	0	68
Missing/absent service users	0	0	1	0	0	45	13	0	0	1	0	60
Safeguarding Children	3	4	4	9	4	4	4	1	0	13	0	46
IT Related Issues	6	1	2	0	3	8	3	0	0	5	5	33
Total	**385**	**64**	**64**	**82**	**98**	**1658**	**676**	**219**	**3**	**57**	**36**	**3342**

Figure 5 Trust-wide Top 10 most frequently reported incident categories in rolling 5 quarters (1/07/2019 – 30/09/2020)
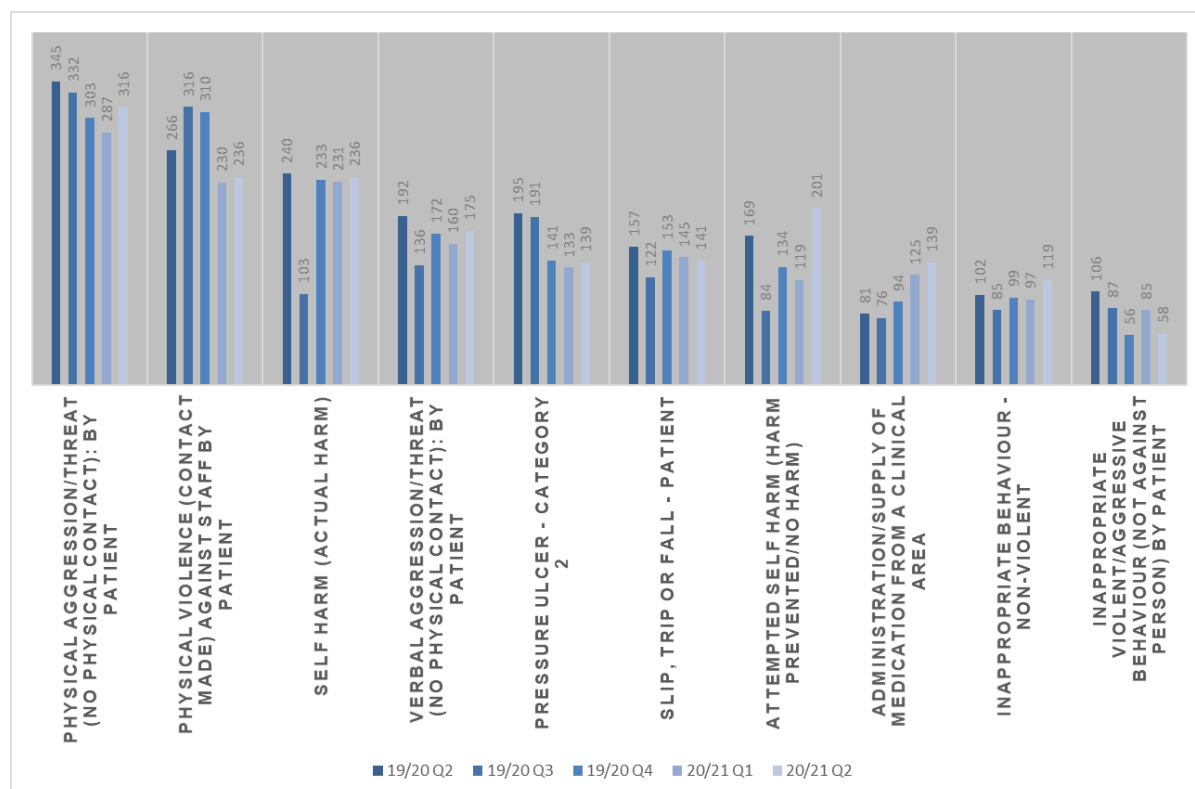
Figure 5 shows that in Quarter 2 2020/21 physical aggression/threat (no physical contact) by patient was the highest reported category of incident. Figures for previous quarters are included for comparison.

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

Reporting to National Reporting and Learning System

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

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

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

The NHS Patient Safety Strategy [2] published in July 2019 sets out plans for a new national reporting and learning system which will combine NRLS and the Strategic Executive Information System (for reporting serious incidents). 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 several reasons.

The published reports are added to the NRLS intranet page when released.

The latest NRLS Summary Report published in Sept 2020, covers the period 1 October 19 to 31 March 20, compares the Trust's data against the same period in 2018/19. 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 remained the same in October 2019 to March 2020, 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.

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

Have the care settings of your incidents changed?
- There are very small variations in comparative data by care setting, but this would be as expected.

4. Learning from incidents

Since March 2020 during the Covid 19 period we have drawn upon our existing improvement initiatives to support the Trust's work to learn from experience.

Learning Library

We have continued to use the #allofusimprove Learning library (our repository of information from a range of sources of learning from experience). Further details are available here http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx

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

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

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

Examples of recently added content include:

SBAR Acute hospital feeding against wishes.docx

SBAR-learning from SJR WEB109662.docx

Greenlight alerts

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

Greenlight alerts are available on the intranet:

There were no greenlight alerts reported in quarter 2.

Bluelight Alerts

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

The Bluelight alerts that have already been circulated in Quarter 2 are available on the intranet and below:

Bluelight alert 37 - 10 September 2020 - Covid-19 staff breaches
Bluelight alert 36 - 11 August 2020 - Visors
Bluelight alert 35 - 7 August 2020 - Bathroom (IPS) panel safety
Bluelight alert 34 - 23 July 2020 - Radiator grill safety
Bluelight alert 33 - 2 July 2020 - Cardinal Health Type IIR Surgical Masks to be quarantined and disposed of locally

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

We have continued to use **human factors** techniques in analysing incidents and serious incidents. Information on online training is available here. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

We have used our **Significant event analysis (SEA) tool** more during this period to enable incidents to be reviewed quickly to identify learning more quickly involving staff involved in the incident. Further guidance available here. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

Learning from Serious Incidents

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

Learning from Healthcare Deaths

Section 8 of this report contains our report on learning from healthcare deaths.

5. Incident reporting processes

The Datix team have continued to support managers with reviewing incidents when needed during Covid 19 period. Microsoft Teams has been used to facilitate this along with phone support. This method of training and support will continue.

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

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.

6. Trust wide Serious Incident (SI) Report[3] for Quarter 2 2020/21 (Data as at 8 October 2020)

Background context

Serious incidents are defined by NHS England as;

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

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

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

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;

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

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

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

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

National Update

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

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

There are two major changes anticipated arising from the NHS Patient Safety Strategy relating directly to Incident reporting and management. Both projects have been delayed during Covid 19. 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.
- New Patient Safety Incident Response Framework (PSIRF) which will replace the Serious Incident Framework. Full implementation is anticipated by July 2021.

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

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[5] NHS Improvement. Never Event policy and framework 2018
[6] https://improvement.nhs.uk/resources/patient-safety-strategy/

and later de-logged from StEIS following additional information. Conversely, some incidents are reported as Serious Incidents on StEIS after local investigation.

Headlines

During Quarter 2 2020/21, there were **12 Serious Incidents reported** to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS).

Quarter 2 2020/21 Headlines

- 12 Serious incidents reported

- Serious incidents account for 0.4% of all incidents

- No homicides
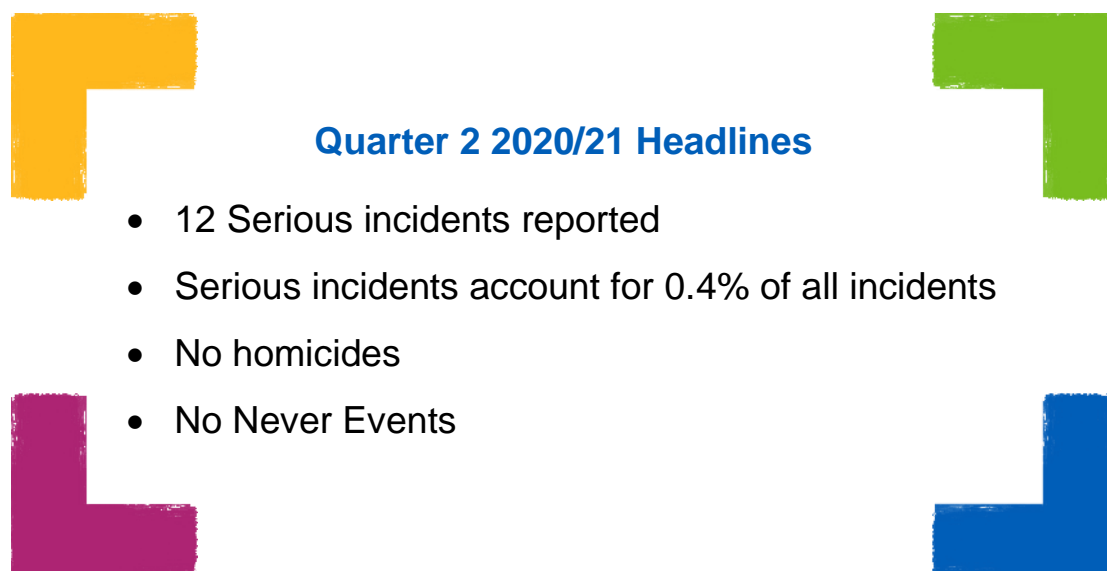
- No Never Events

Never Events[7] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were **no 'never event'** incidents reported by SWYPFT in Quarter 2 2020/21. 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.

Serious Incident Reporting Analysis

During Quarter 2 2020/21 there have been 12 serious incidents reported on STEIS, as shown in Figure 6 by financial quarter, with comparative data for previous years.

Figure 6 Serious Incidents (StEIS) reported to the Commissioner by financial year and quarter up to 30/09/2020 (2016/17 – 2020/21)

Financial Quarter	2016/17	2017/18	2018/19	2019/20	2020/21
Quarter 1	13	15	8	12	9
Quarter 2	13	18	9	12	12
Quarter 3	15	26	10	8	
Quarter 4	23	12	17	15	
Total	64	71	44	47	21

Figure 7 shows a breakdown of the 44 serious incidents in a rolling 12-month period (01/10/2019-30/09/2020) by the type of incident and the month reported. The number of SIs reported in any given period of time can vary, and given the relatively small numbers involved

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

and the broad definition of an SI, it can be difficult to identify and understand the reasons for this. However it is important that any underlying trends or concerns are identified through analysis.

Figure 7 Types of All Serious Incidents reported on STEIS in the 12-month period (01/10/2019 – 30/09/2020)

	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020
Violence and Aggression	0	1	0	1	1	0	0	0	0	0	1	0
Death (including suspected suicide)	2	1	3	7	2	2	0	2	3	1	4	0
Self Harm	0	0	0	0	0	0	0	0	0	1	0	1
Legislation and Policy	0	0	0	1	0	0	0	0	0	0	0	0
Medication	0	0	0	0	0	0	0	0	0	0	1	0
Information Governance Incidents	0	0	0	0	0	0	0	0	0	0	1	0
Care Pathway, Clinical and Pressure Ulcer Incidents	0	0	1	0	0	0	0	0	2	1	0	0
Slips, Trips and Falls	0	0	0	0	1	0	0	0	0	0	0	0
Health and Safety (including fire)	0	0	0	0	0	0	0	1	0	0	0	0
Security Breaches	0	0	0	0	0	0	0	1	0	0	0	1

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

Figures 8 and 9 show the SI reported in the quarter (12) by the team type and BDU and incident category.

Figure 8 Serious Incidents reported by team and BDU during Q2 2020/21

Team/BDU	Barnsley General Community Services	Barnsley Community Mental Health Services	Calderdale Community Mental Health Services	Kirklees Community Mental Health Services	Mental Health Inpatient Services	Forensic Service	Trust wide (Corporate support services)	Total
Ashdale Ward (based at The Dales, Kirklees BDU)	0	0	0	0	1	0	0	1

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Crofton Ward (OPS), Wakefield	0	0	0	0	1	0	0	1
Early Intervention Service (Insight) - Kirklees	0	0	0	2	0	0	0	2
Enhanced Lower Valley Team - Calderdale	0	0	1	0	0	0	0	1
Enhanced Team North 1 - Kirklees	0	0	0	1	0	0	0	1
Information Governance Team	0	0	0	0	0	0	1	1
Intensive Home Based Treatment Team (IHBTT) - Barnsley	0	1	0	0	0	0	0	1
Melton PICU, Barnsley	0	0	0	0	1	0	0	1
Neighbourhood Team - North East (Barnsley)	1	0	0	0	0	0	0	1
Stanley Ward, Wakefield	0	0	0	0	1	0	0	1
Thornhill Ward (The Bretton Centre)	0	0	0	0	0	1	0	1
Total	1	1	1	3	4	1	1	12

Figure 9 Serious Incidents reported by incident category and BDU during Q2 2020/21

Incidents by Category and BDU/ Directorate	Barnsley General Community Services	Barnsley Community Mental Health Services	Calderdale Community Mental Health Services	Kirklees Community Mental Health Services	Mental Health Inpatient Services	Forensic Service	Trust wide (Corporate support services)	Total
Administration/supply of medication from a clinical area	0	0	0	0	1	0	0	1
Damage (deliberate - e.g Vandalism)	0	0	0	0	0	1	0	1
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	0	1	1	0	0	0	2
Information disclosed in error	0	0	0	0	0	0	1	1
Self harm (actual harm) with suicidal intent	0	0	0	0	2	0	0	2
Suicide (incl apparent) - community team care - current episode	0	1	0	1	0	0	0	2

Suicide (incl apparent) - inpatient care - current episode	0	0	0	0	1	0	0	1
Physical violence (contact made) against other by patient	0	0	0	1	0	0	0	1
Pressure Ulcer - Category 3	1	0	0	0	0	0	0	1
Total	1	1	1	3	4	1	1	12

Apparent suicide - National and local demographic comparison

Trust-wide, there were a total of 45 apparent suicides that occurred during the rolling 12-month period between 1 October 2019 and 30 September 2020 (Figure 10). This compares with 48 during 2019/20 and 45 during 2018/19. We encourage reporting of apparent suicides for discharged patients where last contact was within the 6 months prior to death and where contact has been limited.

Figure 10 All Apparent Suicides reported in the last 12 months between 1/10/2019 – 30/9/2020 by Quarter (date reported) and geographical area

	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Total
Barnsley	1	4	2	4	11
Calderdale	2	3	3		8
Kirklees*	6	6	4	2	18
Wakefield**	2	5	1		8
Total	11	18	10	6	45

*includes one apparent suicide reported by Learning Disability Services, Kirklees
** includes one apparent suicide reported by Forensic services - death occurred in Wakefield.

The highest method of apparent suicide occurring in this period (Figure 11) related to death by hanging.

Figure 11 All Apparent Suicides reported in the last 12 months between 01/10/2019 – 30/9/2020 by Quarter (date reported) and method

	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	Total
Hanging - self injury	5	8	4	3	20
Other - self poisoning	1	1	2	0	4
Drowning - self injury	2	1	0	0	3
Method unknown - self injury	0	1	2	0	3
Prescription medication - self poisoning	1	2	0	0	3
Other self injury	2	0	0	0	2
Over the counter medication - self poisoning	0	1	0	1	2
Stabbing - self injury	0	0	1	1	2
Carbon monoxide - self poisoning	0	1	0	0	1
Contact with moving vehicle (car, train) - self injury	0	1	0	0	1

Cutting - self injury	0	1	0	0	1
Shooting - self injury	0	0	1	0	1
Suffocation - self injury	0	1	0	0	1
Swallowing objects - self injury	0	0	0	1	1
Total	11	18	10	6	45

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

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

Using this data, the NCI stated that the rate of suicide per 100,000 general population for our regions should be approximately 10.4 in the West Yorkshire STP footprint, and 10.3 within South Yorkshire and Bassetlaw. This is based on deaths up to 2017.

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

The NCI report states that on average during 2007-2017, patient suicides accounted for 27% of the general population suicide figures. The West Yorkshire and Harrogate average from 2017 is 35%.

Figure 12 provides an indication of the number of patient suicides by district against estimated levels.

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

Area (Not BDU)	Population ONS[9] –population estimates Mid 2019	General population suicide rate[9]	Patient suicide rate (35% of general population suicides) [10]	Reported apparent suicides (1/10/2019-30/9/2020)
Barnsley	245,199	24.3	8-9	11
Calderdale	210,082	20.9	7	8
Kirklees*	438,727	43.7	15-16	18
Wakefield**	345,038	34.0	12	8
Trust wide	1,230,730	123.07	43	45

*Includes one LD service user
**Includes one forensic service user
SWYPT actual rates similar to expected

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* Refreshed data at 15/1/2020 by date reported
[8] National Confidential Inquiry into Suicide and Homicide 2019
[9] 10.0 (West Yorkshire STP) & 10.0 (South Yorkshire and Bassetlaw) per 100,000 popn.
[10] 2017 WY&H rate of suicides in contact with MH services 35% not national 28%

The rolling 4 quarter data (Figure 10 and 12) shows that the Trust had 45 apparent suicides of patients/former patients where last contact was in the last 6 months prior to death occurring. Caution is advised with these comparisons due to the sensitivity of the figures if just one or two more incidents occur, and because the figures are not weighted by characteristics such as age, gender or socio-economic status. Also service provision can differ and some teams (eg police liaison practitioners) routinely report apparent suicides where there has been any contact with the Trust.

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

It must be noted that the figures above are apparent suicides from the circumstances known at the time of reporting and not confirmed by the Coroner. The timeframes used in this report are based upon when the incident was reported in the Trust. All apparent suicides are reviewed by teams, and in line with the learning from healthcare deaths policy and subject to further review. Deaths will either be serious incident investigations, service level investigations, care record review (Structured Judgement Reviews or Managers 48 hour review [first stage case record review]) or considered through safeguarding processes.

Figure 13 All Apparent Suicides reported in the last 12 months between 1/10/2019 – 30/9/2020 by Quarter (date reported) and Trust mortality review process

	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	Total
Manager's 48 hour review (1st stage case note review)	2	4	2	1	9
Structure Judgement Review (SJR)	2	3	3	1	9
Significant Event Analysis (SEA)	0	0	1	0	1
Service Level Investigation	0	0	1	0	1
Serious Incident Investigation	6	10	3	4	23
Other investigation	1	1	0	0	2
Total	11	18	10	6	45

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

Serious Incident Investigations completed during Quarter 2 2020/21

This section of the report focusses on the 10 serious incident investigation reports that were completed and submitted to the relevant commissioner during Quarter 2 2020/21. Please note this is not the same data as those reported in this period as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

Quarter 2 2020/21 Serious incident investigation headlines

- **10** SI Investigation Reports have been completed
- **1** SI investigations closed by the Commissioners
- **24** SI investigations remained under investigation (as at 8/10/2020)
- From the completed investigations, the top 3 action themes were:
  - Staff education training and supervision (1st):
  - Risk assessment, Record keeping and Communication (joint 2nd)

The Trust works to the national guidance on serious incident reporting and management (Serious Incident Framework 2015, NHS England). This includes timescales for completion of investigations of 60 working days. While the Trust tries to achieve this, it has the support of commissioners to complete a quality report above a timely report. The Trust requests extensions from commissioners to agree revised dates and the investigators also keep families informed.

Of the 24 investigations that are underway (at 8/10/20), these are at different stages of progress. During the Covid 19 period, NHS England suspended the 60 working day timeframe. All investigations have continued to progress, and new Serious Incidents have been allocated in lead investigators, demonstrated in the 10 investigations that have been completed during Q2 and sent to commissioners. All meetings, interviews and family contacts have moved to phone contacts and virtual meetings.

SI Action Plans

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

Serious Incident learning and themes

During Quarter 2 2020/21, the number of investigations completed and sent to the commissioners was 10. There were 38 separate actions made to improve the system or process to prevent recurrence**.**

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

Categorisation of recommendations/actions

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

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

Figure 15 shows the action themes arising from the 10 serious incidents completed and sent to commissioners during Quarter 2 2020/21.

Next Steps

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 the Serious Incident Review Accreditation Network officially launched in January 2020. We are currently undertaking a period of self review prior to a peer review visit which is planned for 22 December 2020.

Figure 14 Quarter 2 2020/21 completed Serious Incident investigations, by action theme
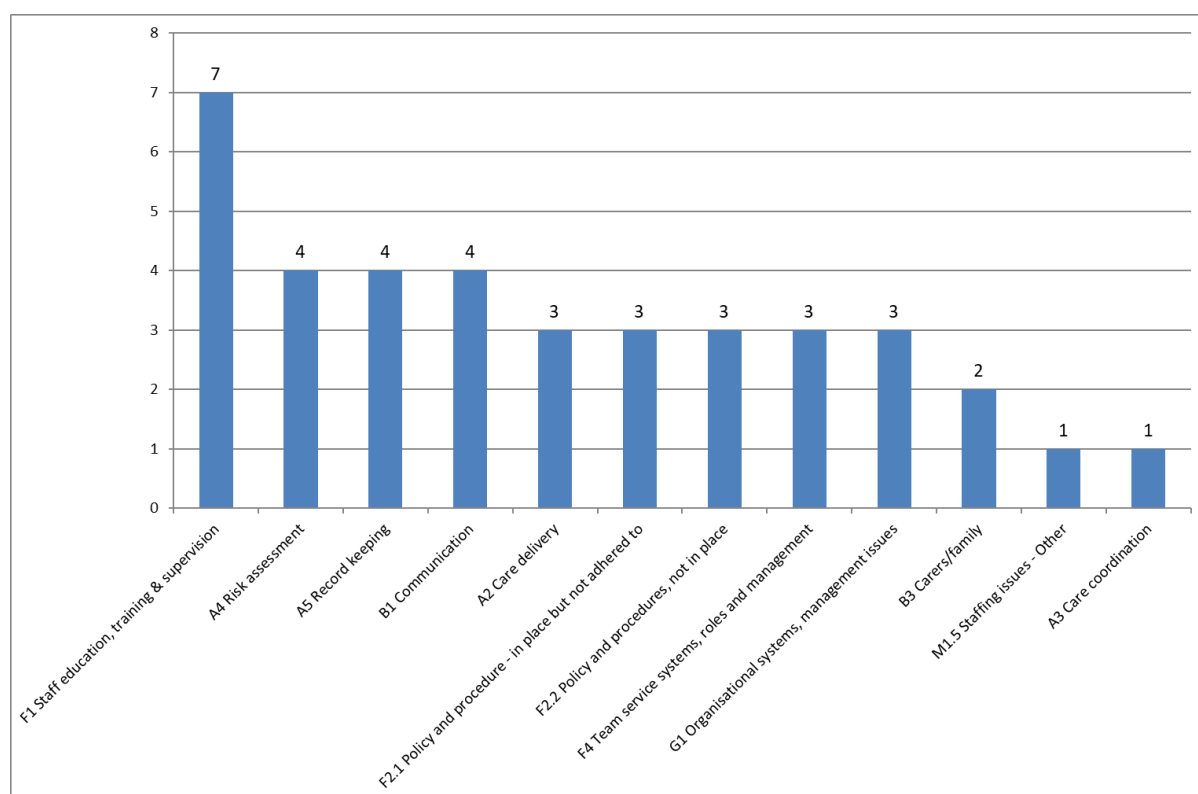
As shown in Figure 16, suicide including apparent (community team care) incidents had the largest number of actions, which correlates with the number of investigations sent to the commissioners in the quarter.

Figure 15 Comparison of action themes from completed Serious Incident investigations in Quarter 2 2020/21, by action theme by serious incident type

	F1 Staff education, training and supervision	A4 Risk assessment	A5 Record keeping	B1 Communication	A2 Care delivery	F2.1 Policy and procedure - in place but not adhered to	F2.2 Policy and procedures, not in place	F4 Team service systems, roles and management	G1 Organisational systems, management issues	M1.5 Staffing issues - Other	A3 Care coordination
Suicide including apparent (inpatient)	3	1	1	1	2	1	3	1	3		
Suicide including apparent (community team care)	4	3	3	3	1	2		2		1	1

The majority of the actions from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator works closely working with the practice governance coaches and BDUs to present learning from recommendations which is included in 'Our

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[learning journey'](#) reports. The Executive summary is fully anonymised to make it suitable for sharing at the end of the investigation process to summarise the learning from an SI investigation.

Top themes this quarter:
An overview of the top action themes from serious incident investigations completed in Q2, are detailed below by action theme:

Staff education, training and supervision

- To ensure a system is put in place to ensure the provision of supervision and training to local authority staff is accurately recorded and available to the Trust.

- Assurance should be provided that the individual training needs of care coordinators, including those employed by the local authority, have been considered and addressed.

- The enhanced teams to improve their knowledge and skills around working with people with personality disorder traits through available training and ongoing supervision. Also understanding and managing risks associated with long term and persistent suicidal thoughts

- That team managers regularly review care plans to ensure they are current, provide evidence of the patient's involvement, are being implemented, and being reviewed to ensure that they are relevant to patients' needs and risks.

- A review of the plans and preparation for the FIRM roll out to be completed – Covid-19 had added a delay and the BDU is to consider readiness for delivery.

- The Trust should consider whether the life support training given to staff should include the management of significant blood loss (it is acknowledged that it would not have made any difference to the outcome in this case but could be a critical factor for other incidents).

- The incident represented a significant trauma to the staff involved and although the post-incident support given was good the majority of staff interviewed became upset when recalling the incident a number of months afterwards. The support needs for individual staff members should be revisited including screening for any symptoms of post-traumatic stress disorder and ensuring their needs for counselling and support have not changed in light of the extent of distress, self-recrimination, critical reflection and learning arising from the incident.

Risk assessment

- There must be a clinical audit in the Enhanced Team 2 to review the current state of risk assessments.

- The acute mental health inpatient ward to provide assurance that risk assessment are updated to reflect new information received

- The acute mental health inpatient ward to provide assurance that formulation of risk is discussed and documented prior to discharge and the crisis and continuity plan reflects this

- The Trust must ensure that the process that allowed risk assessments to be anonymously entered onto SystmOne is resolved during the implementation of the new risk assessment (FIRM).

Record keeping

- To ensure that when a service user is in a funded specialist placement, the care plan for the placement is recorded on System One. That the placement reviews via panel are recorded on the System along with any contact with the service provider.

- Community teams should ensure that risk and comprehensive assessments are updated when a patient is transferred.

- The Forensic Business Delivery Unit should review the CPA Review documentation and practice to ensure that it remains fit for purpose and the practice of completing it meets the requirements of professional record keeping.

- Admission care planning should include the development of an engagement and observation care plan which should be updated to reflect any changes.

Communication
- BDU to bring forward a revised and updated local policy on the appropriate use of text messaging in a clinical context.

- Clear guidance should be provided to clinical staff about how to communicate the management of periods of leave to service users in order to prevent unnecessary anxiety about losing their beds in order that they can focus on the therapeutic value of the leave.

- To inform discharge planning and to support care planning/crisis and contingency planning, the Psychiatric Intensive Care Unit should evidence within the clinical records a detailed assessment of risk to others where there is a history of service users having harmed or made serious threats to harm to others.

- The Psychiatric Intensive Care Unit should ensure that all discharges are safe and effective by communicating with relatives in line with Trust Policy and the Mental Health Act Code of Practice.

7. Learning from Healthcare Deaths Report
Annual Cumulative Report 2020/21 (covering the period 1/4/2020 – 30/09/2020)

1. Background context

1.1 Introduction
Scrutiny of healthcare deaths remains high on the government's agenda. In line with the National Quality Board report published in 2017, the Trust has had Learning from Healthcare Deaths policy which 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 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.

1.2 Scope
The Trust has systems that identify and capture the known deaths of its service users on its electronic clinical information system and on its Datix system where the death requires reporting.

The Trust Learning from Deaths policy was updated in January 2020. It sets out how deaths should be responded to, which deaths are reportable, how we should engage families and how reportable deaths will be reviewed. Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny the Trust has adopted in line with the National Quality Board guidance:

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

1.3 Next Steps

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

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

2. Annual Cumulative Dashboard Report 2020/2021 covering the period 1/4/2020 – 30/09/2020

Figure 16 Summary of 2020/21 Annual Death reporting by financial quarter to 30/09/2020*

	Reporting criteria	2019/20 total	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	2020/21 Total
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death**	3262	1167	737			
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	355	132	74			
3	Total Number of deaths which were in scope	286	93	68			
4	Total Number of deaths reported on Datix that were not in the Trust's scope	51	25	5			
5	Total Number of reported deaths which were rejected following review, as not reportable or duplicated.	17	14	1			

*Dashboard format and content as agreed by Northern Alliance group

**Data extracted from Business Intelligence Dashboards. 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

Since the last report (July 2020), further work has been completed to review the deaths from earlier in the year to ensure those recorded as in scope were correct. There were a number of cases where the patient was under the care of a consultant for annual/bi-annual review which had been recorded as not in scope. A patient under the care of a consultant would meet the criteria for being in scope. This information was not always available at the time of the report in July.

As shown in Figure 1, row 3 shows that 74 deaths were reported on Datix during Quarter 2. This is lower than Q1 (132), but Quarter 1 saw the impact of Covid 19 deaths being reported that occurred in the community. During 2019/20 the average number of deaths per quarter was 89 deaths (range 74 to 108) so the figure for Q2 is at the lower end of this range. During the Covid 19 period earlier in the year, the Learning from deaths policy was considered to see if reporting guidance needed to change. It was felt that the existing reporting requirements did not need to change during this period. There has been a national requirement to report externally any inpatient death related to Covid 19. There is already a requirement to report any inpatient death on Datix, so the guidance did not require revising. This will continue during the second wave.

Figure 2 shows a Statistical Process Control chart of all reported deaths (by reported date) between 1/1/2019 – 30/09/20. There is an area outside the parameters of normal variation which aligns with the impact of Covid 19 (special cause variation) in April 2020.

Figure 17 Statistical Process Control Report of all deaths reported 1/1/2019-30/9/2020 by date reported
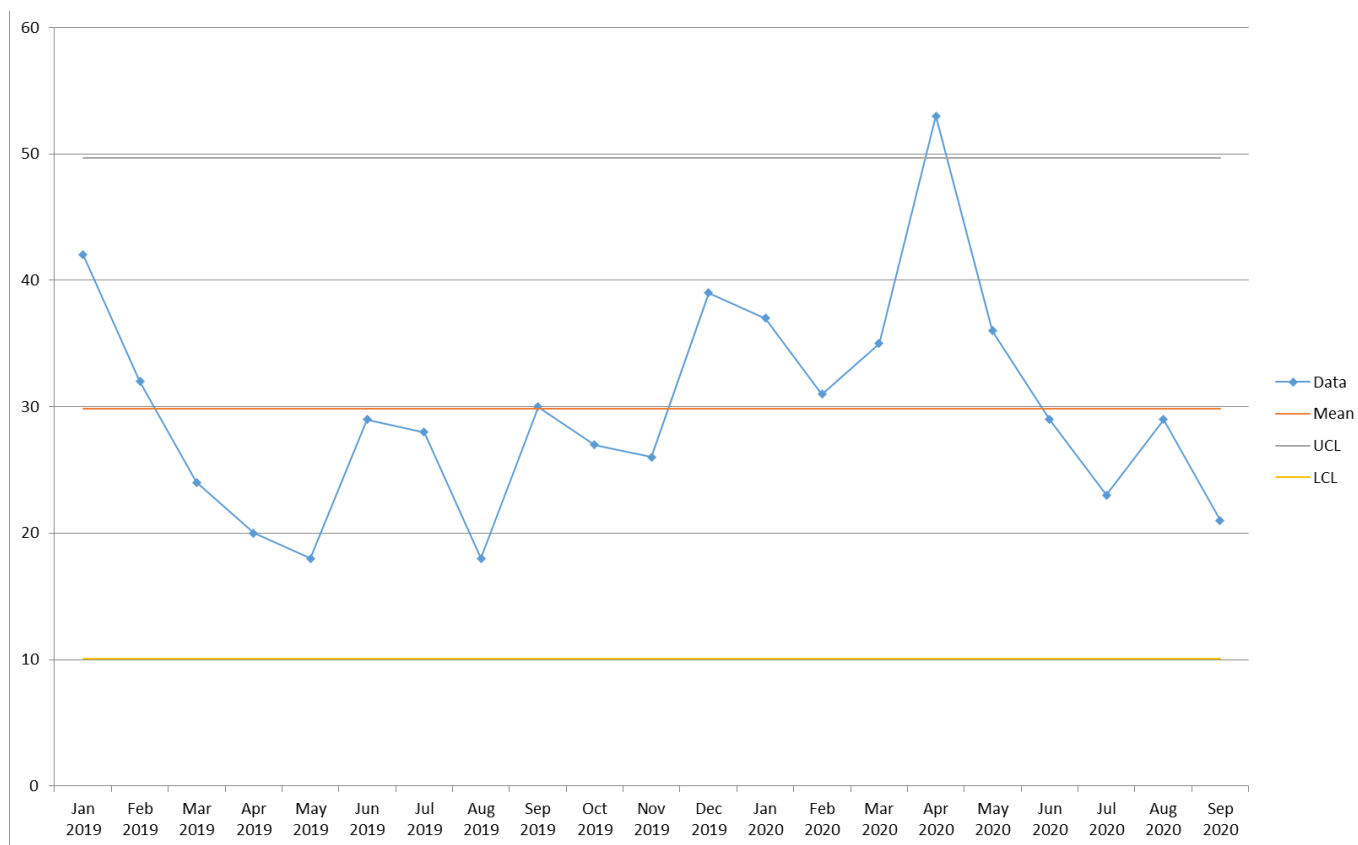
Figure 18 Breakdown of the total number of deaths reviewed in 2020/21 by service area by financial quarter

	Barnsley General Community Services	Barnsley Community Mental Health Services	Calderdale Community Mental Health Services	Kirklees Community Mental Health Services	Wakefield Community Mental Health Services	Mental Health Inpatient Services	Learning Disability services	CAMHS Specialist Services	Total
20/21 Q1	2	8	11	27	27	5	13	0	93
20/21 Q2	3	5	11	18	16	3	12	0	68
20/21 Q3									
20/21 Q4									
Total	5	13	22	45	43	8	25	0	161

Figure 19 Summary of total number of all in scope deaths and the 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)	Significant Event Analysis (SEA)	Other investigation	
20/21 Q1	43	18	7	5	5	14	1	0	93
20/21 Q2	31	9	9	0	6	13*	0	0	68
20/21 Q3									
20/21 Q4									
Total	74	27	16	5	11	27	1	0	161

*One LD death reported to LeDeR is also undergoing an internal SJR to consider any local learning.

In line with national reporting of deaths, we are required to separate our reporting of in scope deaths into learning disability deaths and all other deaths. Figure 5 below is all deaths where the patient did not have a learning disability.

Figure 20 Summary of total number of in scope deaths and Review process (excluding Learning Disability deaths)

	Certification	Manager's 48 hour review (1st stage case note review)	Structure Judgement Review (SJR)	Significant Event Analysis (SEA)	Service Level Investigation	Serious Incident Investigation	Other investigation	Total
20/21 Q1	43	18	7	1	5	5	0	79
20/21 Q2	31	9	9	0	0	6	0	55
20/21 Q3								
20/21 Q4								
Total	74	27	16	1	5	11	0	134

The death of any patient with a Learning Disability has to be reported to the Learning Disability Mortality Review Programme (LeDeR). It should be noted that the figures may not tally in these tables. This is because we identify Learning Disability not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability irrespective of where they were cared for. Figure 3 shows there were 12 deaths reported by Learning Disability teams (all community). Figure 4 and Figure 6 show that 13 deaths were reported to LeDeR. This figure includes a death reported by Epilepsy service where the patient had a learning disabilty but was not under the care of a Learning disabilty service.

Figure 21 Summary of total number of Learning Disability deaths which were in scope

	Deaths reported to LeDeR (by SWYPFT staff)	Deaths reported to LeDeR (by another organisation)	Total
20/21 Q1	14	0	14
20/21 Q2	13	0	13
20/21 Q3			
20/21 Q4			
Total	27		27

Figure 7 shows deaths reported by inpatient services across the Trust during 2020/21. There were none relating to learning disability services.

Figure 22 Inpatient deaths by date reported 2020-21

	Beechdale Ward, The Dales Unit	Crofton Ward (OPS), Wakefield	Melton PICU, Barnsley	Ward 19 (OPS)	Total
20/21 Q1	2	1	0	2	5
20/21 Q2	0	0	1	2	3
20/21 Q3					
20/21 Q4					
Total	2	1	1	4	8

Learning Disability Mortality Review Programme (LeDeR) update

On 16 July 2020, a full copy of the 2019 Learning Disability Mortality Review Programme (LeDeR) Annual Report was published by the University of Bristol. This is the 4th report produced.

A summary of the impact for the Trust is available in Appendix 1.

Learning Disabilities Mortality Review (LeDeR) Update – August 2020

Introduction

The fourth annual report of the Learning Disabilities Mortality Review (LeDeR) programme has been recently published. It presents information about the deaths of people with learning disabilities aged four years and over notified to the LeDeR programme from 1st July 2016 - 31st December 2019, with a focus on deaths reviewed during 2019.

Key themes identified

- A total of 7145 deaths were recorded (6629 adults and 516 children)
- 58% of the recorded deaths were male
- Women with learning disabilities died 27 years earlier; men 23 years, when compared to the general population
- Adults with learning disabilities from Black, Asian and Minority Ethnic (BAME) groups died younger and appear to be under-represented in notifications of deaths
- Greater proportion of deaths reported between October and December
- 60% died in a hospital setting
- 72% had a DNACPR decision in place
- Pneumonia, or aspiration pneumonia, were identified as causes of death in 41% of reviews - conditions which are potentially treatable, if caught in time
- 22% had been prescribed sodium valproate to treat epilepsy or bipolar disorder
- 45% had a LeDeR review completed
- 38% of outstanding reviews remain unallocated as of 31st December 2018
- Just under half of the reviews completed in 2018 reported that the person had received care which met, or exceeded, good practice
- One in ten (11%) of reviews completed in 2018 reported that concerns had been raised about the circumstances leading to a person's death
- 71 adults (8%) were reported to have received care that fell so far below expected good practice that it either significantly impacted on their well-being, or directly contributed to their death
- There was evidence of bias in the care of people with learning disabilities, resulting in unequal treatment

Summary of recommendations

1. A continued focus on the deaths of all adults and children from BAME groups is required.
2. For the Department of Health and Social Care (DHSC) to work with the Chief Coroner to identify the proportion of deaths of people with learning disabilities (and possibly other protected characteristics) referred to a coroner in England and Wales.
3. (Repeated from the House of Lords Select Committee on the Mental Capacity Act 2005).The standards against which the Care Quality Commission inspects should explicitly incorporate compliance with the Mental Capacity Act as a core requirement that must be met by all health and social care providers.
4. Consider the recommendations from the 'Best practice in care coordination for people with a learning disability and long term conditions'4 (March 2019) report and:
   - Establish and agree a programme of work to implement the recommendations.
   - Liaise with NIHR regarding the importance of commissioning a programme of work that develops, pilots and evaluates different models of care coordination for adults and children with learning disabilities.

5. Adapt (and then adopt) the National Early Warning Score 2 regionally, such as the Restore2 in Wessex5, to ensure it captures baseline and soft signs of acute deterioration in physical health for people with learning disabilities by:
    ➢ Involving people with learning disabilities, their families and professional organisations.
    ➢ Disseminating for use across acute, primary and community settings.
6. Consider developing, piloting and introducing:
    ➢ Specialist physicians for people with learning disabilities who would work within the specialist multi-disciplinary teams.
    ➢ A Diploma in Learning Disabilities Medicine
    ➢ Making 'learning disabilities' a physician speciality of the Royal College of Physicians.
7. Consider the need for timely, NICE evidence-based guidance that is inclusive of prevention, diagnosis and management of aspiration pneumonia. The outcome of such considerations should be shared with DHSC and NHSE.
8. Right Care to provide a toolkit to support systems to improve outcomes for adults and children at risk of aspiration pneumonia.
9. Safety of people with epilepsy to be prioritised. The forthcoming revision of the NICE Guideline 'Epilepsies in children, young people and adults' to include guidance on the safety of people with epilepsy, and safety measures to be verified in Care Quality Commission inspections.
10. For a national clinical audit of adults and children admitted to hospital for a condition related to chronic constipation. The National Clinical Audit and Patient Outcomes Programme is one way this could happen.

Action plan for South West Yorkshire Partnership NHS Foundation Trust

Action	Person responsible	Date of completion
To continue to review all deaths via the patient safety team	Weekly Trust Risk Panel	On-going
To continue the mortality work internally and regionally	Nursing Directorate, Patient Safety Manager and Trust Mortality Group	On-going
To roll out the News2 across the Trust	Resus Lead	December 2020
To continue ongoing support of the primary care and acute care to reduce inequalities	Learning Disability Clinical Lead	On-going
To adhere to NICE Guidance inclusive of prevention, diagnosis and management of aspiration pneumonia	QIAT, Respiratory Clinical Practitioner, Dysphasia nurse and Advanced Speech and Language Therapist, Professional Lead	December 2020
To support the CCG's to consider where we can increase capacity to support them to complete LeDeR reviews	Learning Disability Clinical Lead	September 2020
To develop the workforce to become LeDeR reviewers	Assistant Director of Nursing, Quality and Professions	December 2020

Targeted support to ameliorate health inequalities for people with LD in response to COVID-19	Learning Disability Clinical Lead	December 2020
For the Advanced Respiratory Care Practitioner to work Trust-wide supporting respiratory care practice across the health and care system – including acute hospital and ICU	Advanced Respiratory Care Practitioner	August 2020
Continued attendance at the LD steering group within the WY&H ICS	Director of Provider Development	On-going

Trust Board 1 December 2020
Agenda item 9.1

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:	This paper provides an update on key developments across the South Yorkshire and Bassetlaw Integrated Care System and Barnsley Integrated Care developments. **SYB ICS** The overwhelming focus of the ICS work over the recent weeks has continued to be partnership working across the organisations in response to the second wave of the coronavirus. Parts of South Yorkshire and Bassetlaw have been hotspots with significant service pressures in Acute Trusts and Community Services in particular. The position across SYB is a downward trend of Covid-19 cases with hospital bed occupancy in the Acute Trusts starting to flatten off. There is a strong focus on the Flu vaccinations with an acceleration planned across November to hit the target a 70% of Frontline Health Care Workers vaccinated by the end of November 2020. Planning is progressing on the deployment of a potential Covid vaccine in December in with national guidance. Staff absence across the ICS continues to put significant pressure on services.

With **all of us** in mind.

	The ICS Mental Health Executive steering group has resumed and a number of programmes of work have also been resumed including those that have been supported through transformation funding. The work on progressing the development of a mental health provider alliance was on hold due to Covid-19 and has now been resumed with a kick off meeting that was held in November 2020. **Barnsley Integrated Care -** Partners continue to work together to deliver a joined-up response to Covid-19. The integrated Care Partnership has resumed and is overseeing the development of the place-based stabilisation and recovery plans and Covid-19 response. **Risk Appetite** 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 SYB ICS and Barnsley integrated care developments.**
Private session:	Not applicable

South Yorkshire update including the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) update

1 December 2020

1.   Purpose

The purpose of this paper is to update the Trust Board on the developments within the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and Barnsley integrated care developments.

2.   SYB update

The focus of the ICS work over the recent weeks has continued to be partnership working across the organisations in response to the second wave of the coronavirus. Parts of South Yorkshire and Bassetlaw have been hotspots with significant pressure on Acute Trusts and Community Services. The position across SYB is a downward trend of Covid-19 cases with hospital bed occupancy in the Acute Trusts starting to flatten off.

There is a strong focus on the Flu vaccinations with an acceleration planned across November to hit the target a 70% of Frontline Health Care Workers vaccinated by the end of November 2020. This has been seen as particular important to both protect staff from Flu and not to delay the deployment of any Covid vaccine.

Planning is progressing on the deployment of a potential Covid vaccine in December in with national guidance.

Staff absence across the ICS continues to put significant pressure on services

3.   SYB ICS Mental Health, Learning Disabilities and Autism programme

The ICS Mental Health Executive steering group has a number of programmes of work and below is an update on some of these programmes. The Programme group meets monthly. In addition to this the CEOs of Mental health Trusts have been meeting regularly during the last 8 months and over the last month the focus of these meetings has been on developing the Mental Health provider Alliance.

4.   SYB ICS Mental Health Provider Alliance

In January 2020, the Chief Executives and chairs of the Mental Health Providers serving the South Yorkshire and Bassetlaw population, met and agreed to develop a formal Provider Alliance. The key reasons for agreeing this in SYB are:

- To increase collaboration as outlined in national policy.
- Integration across services through provider collaboratives.
- The need to support and maximise the capacity of the local workforce.
- To reduce unwarranted variation in quality.
- To achieve economies of scale and efficiency savings.
- To shape and influence strategic service design and associated investment decisions.

The Health Care Executive Group supported the development of a more formal Mental Health Provider Alliance to strengthen established partnership arrangements. The work on progressing the development of an alliance resumed in November with a kick of meeting that bought the CEOs and Chairs or delegated members to come together to begin developing the Alliance. Over the next few weeks key stakeholders will be interviewed to help shape the development of the alliance and Memorandum of Understanding.

5.   Barnsley Integrated Care update

All partners across Barnsley continue to work together to deliver 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 Community teams continue to play a critical role in supporting timely discharge from Barnsley Hospital and have provided mutual aid over the last few weeks to support the pressures in the hospital.

The integrated Care Partnership has resumed and is overseeing the development of the place-based stabilisation and recovery plan, the key priorities for the partnership have been agreed through the partnership. The system priorities build on the work that the partnership progressed over the last two years and that has been accelerated through the Covid-19 response phase.

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The mobilisation board that is chaired by the CCG has reconvened and is overseeing the development and delivery of the Integrated Care Specification and we have continued to work with the Barnsley Healthcare Federation and Primary Care Networks to progress and develop an approach and framework to support a shared leadership model and strengthen joined delivery of priorities.

Trust Board is asked to NOTE the update from the SYB ICS and Barnsley integrated care developments

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South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYB ICS)

3

Title:	West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships update
Paper prepared by:	Director of Strategy & Director of Provider Development
Purpose:	The purpose of this paper is to provide the Trust Board with: 1. An update on key developments within West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) including response to Covid-19, winter planning and transformation priorities. 2. Local Integrated Care Partnership developments in Calderdale, Wakefield and Kirklees.
Mission/values:	The development of **joined up care and response to Covid-19** through **place-based arrangements** is central to the Trust's 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.** **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 October 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. **WYH Covid-19 response and winter planning** The Partnership has continued to deliver a joined up response to Covid-19 across the region and in each of the places that make up the partnership. The partnership is also currently focused on ensuring system plans for winter are in place. **WYH Independent Review Impact of Covid-19 on our communities and workforce** An Independent review chaired by Professor Dame Donna Kinnair was commissioned by the Chair of the Partnership Board, Councillor Tim Swift. The review focused on the partnership plans and work being progressed as well as identifying any gaps. The review has now

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	concluded and a report setting out the outcomes of the review and recommendations for the partnership to take forward was launched on 22 October 2020. The link to the full report is made available in the paper for Board members to receive the report.

Mental Health, Learning Disabilities and Autism Collaborative and Programme

An overview of key work streams and developments being progressed collaboratively are included in the paper, including transformation funding to support the development of community and crisis services.

Place-based developments

We continue to work with partners to develop and deliver joined up Covid-19 response and winter planning in each of the places that we provide services. We also continue to contribute to place-based recovery and reset planning. Partnership arrangements to deliver joined up care and services have been resumed.

Risk Appetite

The development of the partnership's 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 developments in Calderdale, Wakefield and Kirklees.** |
| **Private session:** | Not applicable. |

West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - Update
Trust Board 01 December 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 Covid-19 and Winter Planning

The strategic health group has resumed meeting weekly to ensure that there is a coordinated approach and response to managing Covid-19, winter pressures and demands. Yorkshire continues to have the highest prevalence rates of Covid-19. The weekly system briefing meetings have continued and provide up to date information on partnership priorities and Covid-19 response plans. SOAG in November focused on system plans for winter.

4. The System Ambition to increase Leadership and Diversity and Independent Review - Impact of Covid-19 on Black and Minority Ethnic (BAME) communities and workforce

National evidence has highlighted the differential impact of Covid-19 on staff and communities from black and minority ethnic communities (BAME). The Partnership has developed 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. Health inequalities is also a priority for the Partnership and there is a significant programme of work across the partnership.

An Independent Review chaired by Professor Dame Donna Kinnair was commissioned by the Chair of the Partnership Board, Councillor Tim Swift. The review focused on the partnership plans and work being progressed as well as identifying any gaps. The review is now complete and a report setting out the outcomes of the review and recommendations for the partnership to take forward was launched on 22 October 2020. You can access the report, which is also produced in alternative formats, the insight used to inform the recommendations and other supporting information.

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The link to the full report is provided for Board members to receive and review the report
https://www.wyhpartnership.co.uk/application/files/7116/0284/2929/bame-review-report.pdf

The System Leadership Executive held a one year on Leadership conversation at its November meeting where a number of CEOs, through short videos, shared their reflections and the action that they have taken in their organisations following the initial Big Conversation last year. The Partnership have also supported Islamophobia Awareness month in November by launching a partnership statement and, through a campaign, shared positive stories and myth busting messages. The WYH Partnership has also been shortlisted for an HSJ award for system leadership and work in this area.

The Trust is a key partner in this 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. In response to the differential impact Covid-19 has on BAME communities, the Trust has carried out significant work to develop a Trust wide Equality Impact assessment and approach as well as completed risk assessments for all BAME staff. A more detailed programme of work has commenced to accelerate our plans to develop a diverse workforce. The refresh of the Trust Equality, Involvement, Communications and Membership strategy that commenced last year will incorporate the key themes and recommendations from the Partnership review, including key objectives and plans to deliver equitable culturally sensitive services to our BAME communities and for those with protected characteristics.

5. Voluntary, Community and Social Enterprise (VCSE) Sector Business Case

The harnessing the power of communities Leadership group presented a proposal for consideration by the System Leadership Executive. From both a strategic and provider perspective, the VCSE contribute to achieving Local Authority Plans, NHS Long Term Plan, WY& H Health and Care Partnership Five Year Plan and the 10 Big ambitions of the Partnership. The sector will also play a role in economic recovery post Covid-19. Nationally the VCSE employ some 3% of the UK workforce (NCVO) and forms a vital part of both the UK economy and the provision of essential services.

However, as the recent VCSE Resilience Survey conducted in WY&H shows, the sector faces unprecedented challenges. 55% of VCSE organisations in WY&H face closure by Christmas due to lack of funding. A second survey in September 2020 shows nearly one in five organisations that employ staff have had to reduce the number of staff they employ; more than half of organisations have had to use reserves or were planning to use reserves by the end of 2020 to cover their bills; and more than half of organisations said their earned income had reduced by more than 50% since the onset of Covid-19.

The proposal sets out the rationale and a proposed model for long term, joined up investment in the Voluntary, Community and Social Enterprise (VCSE) Sector, which supports the sector to become sustainable and resilient and provide continuity of care and support for communities. The proposals set out key areas of change and focus to enable this shift, including the VCS, to have greater representation in decision making, planning and design of services as a key partner in delivering holistic care pathways and services. To create a shift in focus to prevention by refocusing attention and investment on prevention, self-care and community-based services that are accessible to those most at risk. Ensuring that commissioning processes are streamlined, inclusive and accessible. Invest in infrastructure at place and neighbourhood level and invest in volunteering and volunteers.

The proposal sets out an ambition to shift in the initial phase a minimum of 1% into prevention from acute health budgets with an intention to increase this to 3% at both system and place level over five years. Investment should be at place, health footprint and system levels with commissioners collaborating to deliver joined up arrangements across WY&H. The proposal

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was supported in principle and for the leadership to continue working with all key stakeholders in places to develop and agree the principles and plan. **The Trust as a provider of services works in partnership with the VCS in each place and has also invested in and supports investment in communities through its linked charities. There is significant opportunity to strengthen our approach to ensuring our VCS partners and our linked charities are an integral part of developing new models of care, care pathways and securing transformation funding together.**

6. Becoming a global leader in responding to the climate emergency

Becoming a global leader in responding to the climate emergency is one of the 10 Big ambitions for the Partnership.   Two WY&H Climate Change Leads are now in post (totalling 0.8 WTE). Significant work is already underway across the partnership.   The programme leads are working with approximately 30 organisational leads and have established a new steering group and a framework for action has been developed outlining key areas of focus and plans.   Activity to date has included the delivery of a virtual climate summit, the launch of grant schemes focused on sustainable respiratory primary care and active transport and the launch of a training offer for staff. **A full Board paper that sets out a series of recommendations for Trust Board to consider, discuss and support will be shared at the next Board meeting.**

7. Embed Physical Activity across the region - partnership with Yorkshire Sport Foundation

WYH Partnership is adopting a whole system approach to improving physical activity as a key part of improving population health and outcomes.   This will require a step change to embed physical activity into as many parts of the system as possible and make it part of everyone's day job.   This will ensure that physical activity is viewed as part of the solution to a range of outcomes.   West Yorkshire has established multi-agency 'District Activity Partnerships.'   The partnerships are supported by Yorkshire Sport Foundation (largely funded through Sport England) and the councils, which brings vital capacity to the partnerships.   Bradford and Calderdale have received additional funding as two of the 12 National Sport England Local Delivery Pilots - the pilots will attract up to £10 million in each area over the next few years. **The Trust is a key partner in the Calderdale Active Partnership and leading the mental health and wellbeing strand of the programme.   An update on this is provided under the Calderdale section of this paper.**

8. West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Update

The Trust Board was appraised at the October meeting on the work that the Mental Health, Learning Disabilities and Autism (MHLDA) programme board and the Specialised MHLDA programme board are progressing.   The programme boards meet monthly.   Issues to highlight to the Trust Board from the November MHLDA Programme Board meeting include:

- **NED and Governor event** - planned to take place on 27 November 2020.   The event will focus on sharing learning during Covid-19 and collaboration and progress on key priorities.

- **Transformation Funding - Community Mental Health; Crisis Alternatives**:   WY ICS submitted to NHS England the Transformation Funding plan on 18 November 2020 in the prescribed format (3-year funding profiles).   These two plans comprised a summary of proposals that had been developed in each 'Place.'   All STPs/ICSs in England will receive their 'fair share' of central transformation funding to deliver new models of integrated primary and community mental health care for adults and older adults with severe mental health problems.   This is not a competitive process between STPs/ICSs.

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- **Learning Disability Mortality Review (LeDeR) programme**, Action from learning: deaths of people with a learning disability from Covid-19 (NHSE): This report has been published following the University of Bristol's report into the deaths of 206 people with a learning disability at the start of the Covid-19 pandemic. A West Yorkshire (WY) Task & Finish group is being established, comprising leads from the main WY ICS workstreams, to agree actions across workstreams in the context of the report content. This group will report through the Systems Leadership Executive Group (SLEG).

- **Complex Rehabilitation (Mental Health):** The business case was endorsed and next steps approved. This will include proposing a collaborative commissioning approach across the CCGs for the specific tertiary (ICS) model – intensive community team; women's pathway; longer term complex care unit. CCGs proposed to retain responsibility for other aspects including the requirement for specialised placements and solutions. It is proposed to have an 'alliance partnership' between the CCGs and the 3 Trusts.

- **Housing for Health**: A number of workshops have taken place over the last few weeks, particularly focused on housing needs in respect of mental health and learning disability. A collaboration framework is being drafted between WY housing providers and the ICS programme collaborative. This will be specifically relevant for the Trust in the context of its role as Lead Provider for the WY Adult Secure Provider Collaborative and the development of housing solutions for service users being discharged from in-patient care.

- **West Yorkshire Adult Secure Lead Provider Collaborative**: Following the discussion and agreement at the Trust Board meeting on 27 October 2020, the Business Case, plus supporting documentation, was submitted to NHS England on 6 November 2020. The NHSE North East and Yorkshire Regional Approval Panel to discuss the Business Case and next steps with the Collaborative is taking place on 30 November 2020.

9. Local Integrated Care Partnerships - Key developments
We continue to work with partners to develop and deliver joined up Covid-19 response and stabilisation and recovery approach in each of the places that we provide services.

Calderdale
SWYPFT is a strong partner in delivering the Calderdale vision 2024 and Calderdale Cares. We have resumed partnership work that includes commissioners and providers collaborating to achieve integrated care provision driven by the needs of the local Calderdale population and involving local people to develop solutions. As part of this work, the evolving Alliance has developed a partnership agreement that sets out the principles, approach and ways of working and is currently going through partnership Boards for approval and support. **The agreement in full was discussed in private Board and is included as a separate paper for Board approval this time.**

The Calderdale Community Collaborative Partnership Board meets monthly to deliver the agreed programme of work in line with the alliance objectives. At the meeting on the 12 November 2020, the Board undertook a deep dive into Mental Health Transformation. This update was very well received, particularly by the Clinical Directors for the Primary Care Networks in Calderdale who could clearly see the benefits of the transformation. The Board have agreed that this programme will report into them with regular updates.

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The Trust is also a key partner in the Calderdale Arts and Health programme - to ensure that arts, creativity and culture is used across Calderdale to support people's health and wellbeing. The Arts and Health Programme Manager started in position in September 2020. He is delivering a programme of work, agreed by the steering group, to accelerate the developments of system wide approach to using arts and creativity to improve health, wellbeing, and tackle inequalities.

We continue to be a partner in the Active Calderdale programme and have secured two years funding. A Change Co-ordinator commenced in early October to embed physical activity into systems and processes of teams within Calderdale to ensure that the people they support can live a larger life and for longer through physical activity. The role will link with and support the physical activity offers already in place including through the Recovery College and Creative Minds. A campaign to encourage movement 'Moving SWFTLY' is in development and will seek to engage staff and service users across the Trust in increasing awareness of movement and its positive impact.

Wakefield

The Trust continues to be a partner in the Wakefield Integrated Care Partnership (ICP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance, the emotional health and mental wellbeing strand in the Children and Young Peoples Partnership Board.

At the October ICP Board meeting, the meeting agenda focused primarily on the pressures being experienced within the Wakefield place health and care system. In addition, there were discussion items on developing 'commissioning futures'; next steps for tackling health inequalities, where it was agreed that a meeting would be convened with organisational executive leads to identify place-based actions. The November ICP Board meeting has been cancelled in the context of substantial current operational pressures.

Kirklees

The Kirklees Integrated Health and Care Leadership Board has recently been established. At the November meeting of the Board, there was a focus on the following: Outcomes framework; personalised care future priorities; current pressures being experienced within the Kirklees place health and care system.

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 - https://www.wyhpartnership.co.uk/meetings/partnershipboard
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

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

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Title:	**Calderdale Care Closer to Home Alliance Partnership Agreement**
Paper prepared by:	Director of strategy
Purpose:	The purpose of this paper is • To share with Trust Board the Calderdale Care Closer to Home Alliance Partnership Agreement • To confirm formal support for the agreement and ways of working that it sets out
Mission/values:	The agreement provides a formal framework to strengthen partnership working in Calderdale. The way in which we work in partnership in each of our places is in line with our Trust values and supports the delivery of our strategic ambitions and priorities.
Any background papers/ previously considered by:	Updates on place based developments and partnership arrangements including Calderdale are provided regularly to Trust Board as part of the business development section. The development of the partnership and draft agreement was referenced in the West Yorkshire and Harrogate Integrated Care Partnership update last month. The Trust Board have had the opportunity to consider an earlier draft for discussion and feedback in Private Board.
Executive summary:	The Trust has been working with partners in Calderdale to develop integrated joined up care in localities as part of delivering the ambitions of Calderdale Cares. The Board has received previous updates on Calderdale Cares and Vision 2020. The agreement will enable the existing partnership to continue working together under more formalised arrangements that are set out in this document. The agreement is not legally binding and does not create a new organisation. Each provider remains a legal entity in its own right and retains its usual statutory and legal frameworks and responsibilities. Provision and delivery of services remain subject to the individual organisation's respective contractual/funding arrangements. The agreement has been considered and discussed previously in Private Board. The agreement does not introduce any additional risk over current arrangements.
Recommendation:	**Trust Board is asked to REVIEW the agreement and agree formal SUPPORT for the agreement and Trust role within the partnership.**
Private session:	Not applicable.

With **all of us** in mind.

Calderdale Care Closer to Home
Alliance Partnership Agreement

February 2020

1. Partners to the Agreement

The members of the Calderdale Care Closer to Home Alliance and the parties to this agreement are:

Calderdale Clinical Commissioning Group (CCG)	5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX
Calderdale Council	Town Hall Crossley Street Halifax HX1 1TS
Voluntary Action Calderdale (VAC)	Resource Centre, Hall Street, Halifax, HX1 5AY
Calderdale And Huddersfield NHS Foundation Trust (CHFT)	Acre Street, Lindley. Huddersfield HD3 3EA
South West Yorkshire Partnership NHS Foundation Trust (SWYFT)	Fieldhead, Ouchthorpe Lane, Wakefield, WF1 3SP
Locala Community Partnerships CIC	Beckside Court 286 Bradford Road, Batley WF17 5PW
Calderdale Primary Care Networks (PCN) • Central Halifax • Calder & Ryburn • Lower Valley • North Halifax • Upper Calder Valley	Lead surgery for Central Halifax, Calder and Ryburn, Lower Valley and Upper Calder Valley PCNs is Spring Hall Medical Centre, Spring Hall Lane, Halifax. HX1 1PB Lead surgery for North Halifax is Keighley Road Surgery, Keighley Road. Illingworth, Halifax, HX2 9LL

As members of the Partnership all of these organisations subscribe to the vision and principles stated below and agree to participate in the governance and accountability arrangements set out in this Agreement. The organisations collectively will be referred to in this agreement as the 'Partners'
.
2. Term of the Agreement

This Agreement will commence on the date of signature of the Partners. It will be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Alliance and thereafter be subject to an annual review of the arrangements by the Care Closer to Home Alliance Board.

3. Introduction and context

This Agreement is an understanding between the Calderdale Care Closer to Home Alliance Partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the people who live in Calderdale, and to improve the quality of their health and care services.

Our partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. Commissioner and Provider organisations in Calderdale have come together to agree how we can improve people's health and improve the quality of their health and care services.

4. Purpose

The purpose of this Agreement is to formalise and build on existing partnership working arrangements. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. The purpose of this approach is to strengthen genuine partnership work and try and streamline the governance, making it effective and simple, enabling timely decisions to be made. This proposal does not set out to undermine the statutory responsibilities of the partners respective Boards and Governing Bodies. We remain accountable for the services and the care provided by our respective organisations.

The Agreement is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Agreement. It is a formal understanding between all of the Partners who have each entered into this Agreement intending to honour all their obligations under it. This Agreement does not replace or override the legal and regulatory frameworks that apply to statutory NHS organisations and the Council. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the Agreement, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

5. Developing new collaborative relationships

Our partnership working and approach to collaboration will focus on the five Calderdale Cares neighbourhood localities to prevent ill health, support people to stay well, and provide them with high quality care and treatment when they need it. This will increasingly move away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment. The work of the Alliance will aim to deliver person-centred Health and Social Care against defined whole-population health outcomes, promoting people to start well: develop well; live well; and age well; across Calderdale.

We have recognised that there are clear benefits in working together across Calderdale to achieve better outcomes for people. The arrangements described in this Agreement set out how we will organise ourselves to provide the best health and social care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

6. Promoting Integration and Collaboration

The Partners acknowledge the statutory and regulatory requirements which apply in relation to competition, patient choice and collaboration. Within the constraints of these requirements we will aim to collaborate, and to seek greater integration of services, whenever it can be demonstrated that it is in the interests of patients and service users to do so.

The Partners are aware of their competition compliance obligations, both under competition law and, in particular (where applicable) under the NHSE&I Provider Licence for NHS Partners and shall take all necessary steps to ensure that they do not breach any of their obligations in this regard. Further, the Partners understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHSE&I and the Partners will keep this position under review accordingly.

The Partners understand that no decision shall be made to make changes to services in Calderdale or the way in which they are delivered without prior consultation where appropriate in accordance with the partners statutory and other obligations.

7. How we will work together in Calderdale

7.1 Our vision

Partners in Calderdale have all committed to support delivery of Calderdale Vision 2024.

A place where you can realise your potential whoever you are, whether your voice has been heard or unheard in the past.	A place where talent and enterprise can thrive
Calderdale Vision 2024	
A place defined by our innate kindness and resilience, by how our people care for each other, are able to recover from setbacks and are full of hope.	Calderdale will stand out, be known, and be distinctive. A great place to visit, but most importantly, a place to live a larger life.

The Calderdale Health and Wellbeing Board has set out a strategy and identified high level priorities based on the four life stages of:

- **Starting well (0-5)**
- **Developing Well (6-25)**
- **Living & working well**
- **Ageing well**

Partners to this Alliance Agreement will work together to deliver Care Closer to Home that will support achievement of the Calderdale Vision 2024 ambitions and the Calderdale Health Wellbeing Strategy.

Through the work of this Alliance Agreement Partners aspire to achieve the following:

- People are empowered to take greater control over their lives and outcomes;
- Resources and assets are used to address the wider determinants of health and support well-being;

- The health and care system shifts towards prevention – changing the ways in which organisations and their staff work;
- Community services have a strong sense of local place;
- Care should be personal and based on what matters to each patient;
- The type and route of care delivery should suit the type and preferences of patients. This can mean different modalities for different types of patients;
- Professionals providing community-based care will deliver at the top end of their licence, enabling general practice to focus on population health management and acute teams to focus on specialist provision;
- Services are delivered in a way that constantly improves health outcomes of the population, by providing high quality care, efficiently and within the financial resources available

The Calderdale Care Closer to Home Alliance will focus on three key interventions, which are:

- maintaining the health and well-being of people in their home through prevention and pro-active care;
- providing care and support to people that are in a crisis; and
- providing step down to home or to a new residence for people - ensuring they are supported in their care transition.

The Alliance will also aspire to:

- "transform the relationship between me and my health and wellbeing";
- "transform the relationship between me and the services which help me"; and
- "transform the relationship between the people who work together to help me, and their relationship with their work".

7.2 Our Objectives

The Partners to this Alliance Agreement have agreed to deliver sustainable, effective and efficient voluntary and community sector infrastructure services with significant improvements over the term of this Alliance agreement. In particular partners have agreed the following:

- to develop an Alliance of Commissioners and Providers focused on the delivery of high-quality Care Closer to Home services in Calderdale - based on individual need;
- to focus on reducing health inequalities and delivering support closer to where people live;
- to provide safe services in partnership with other services, closer to home;
- to ensure that patients, colleagues and communities are fully involved in the development, design and delivery of service plans.

8. Overarching leadership principles for our partnership

We have agreed a set of guiding principles that will shape everything we do through our Alliance Partnership:

- We will be ambitious for the people we serve and colleagues;
- We will do the work once – duplication of systems, processes and work will be avoided as wasteful and potential source of conflict;
- We will undertake shared analysis of problems and issues as the basis of acting;
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level.

We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation and of Calderdale Place;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to and adopt a culture of 'no fault, no blame' between the Alliance Partners and seek to resolve any disputes in an open, amicable and communicative manner;
- We assume good intentions;
- We implement our shared priorities and decisions, holding each other mutually accountable for delivery and assume collective responsibility and risks for ensuring achievement of the Alliance aims and objectives;
- We make decisions on the basis of the needs of the population;
- We appoint and select key roles on a best person basis.

9. Partnership Governance

The Alliance Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and the Council remains directly accountable to their electorate. The Partnership provides a mechanism for collaborative action and common decision-making.

9.1 Alliance Partnership Board

A Partnership Alliance Board will be established to provide the formal leadership for the Partnership.

The Alliance Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum. The Alliance Partnership Board has no formal delegated powers from the organisations in the Partnership.

The Partnership Alliance Board will be made up of senior representatives (typically at Executive Director level or equivalent) of all the organisations that are party to this agreement. The chair of the Alliance Partnership Board will be nominated from among the members and a vice-chair will be also be nominated. The chair and vice-chair roles will be reviewed annually with the aim that these roles will rotate across the organisations represented on the Alliance Board.

9.2 Roles and Responsibilities of Alliance Partnership Board Members

Through this Alliance Agreement the Partners agree to take a collaborative approach and collective responsibility for, managing performance, resources and the totality of population health. The partners will:

- agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our formal collaborative groups for decision making, engaging people and communities across Calderdale, and;
- identify good practice and innovation and ensure it is spread and adopted.

The following roles and responsibilities have been agreed:

The Commissioner Partners will:
- promote effective collaborative processes;
- clearly articulate:
    - performance and quality standards;
    - the scope of services and technical requirements;
    - known risks, escalation processes and triggers;
- have effective and streamlined works allocation processes;
- constructively negotiate and manage contracts.

The Provider Partners will:
- take responsibility for and manage the risks of delivering their services;
- provide on-going improvement in the delivery of their services;
- establish an environment to encourage collaboration;
- act in good faith in the best interests of service users;
- aspire to achieve high performance to generate enhanced quality, efficiency and value for money.

If an Alliance Partner wishes to admit a new person or organisation to join the Alliance a proposal will be considered at the next Alliance Partnership Board meeting.

The proposal will set out the details of the proposed New Alliance Partner, reasons and rationale for the proposed admission and the likely impact on the services. The Partners intend that any organisation who is to be a partner to this Agreement (including themselves) shall commit to the Principles of this Agreement and ownership of the system success/failure as set out in this Agreement.

A New Alliance Partner shall only be admitted on the agreement of each Alliance member. If this is confirmed the Partners will cooperate to enter into the necessary documentation and revisions to this Agreement if required.

9.3 Proceedings of the Alliance Partnership Board

The Alliance Board will meet bi-monthly or more frequently as required.

The Alliance Board will meet in private where appropriate to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the members.

The necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Partners respective organisations and the reporting arrangements.

9.3 Decision-Making and Resolving Disagreements

The approach to making Alliance Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with the Leadership Principles described in this Agreement. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

There are two levels of decision making:
- Decisions made by individual organisations - this Agreement does not affect the individual sovereignty of Partners or their statutory decision-making responsibilities.

- Alliance Partnership decisions - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum. Decision making will be based on all Alliance Partners unanimously agreeing to proposals.

The Partnership Alliance Board has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for co-ordinating collaborative decisions that will progress achievement of the Care Closer to Home ambition and objectives described in this Agreement.

Partners to the Alliance Agreement will attempt to resolve in good faith any dispute between them in line with the Leadership Principles described in this Agreement.

The Alliance Partnership will apply a dispute resolution process to resolve any issues which cannot otherwise be agreed through these arrangements. This will involve escalation of the issue disputed (where it has not been possible to achieve a unanimous decision) to the Calderdale Executive Leadership Group that includes Chief Officer representation from all members of this Agreement.

10. Financial Framework

All members of the Alliance Partnership Board are ready to work together, manage risk together, and support each other when required. The Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

The Partners to this Agreement will:

- aim to live within our means, i.e. the resources that we have available to provide services;
- develop a Calderdale system response to the financial challenges we face;
- develop payment and risk share models that support a system response;
- collectively manage our NHS resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to deliver financial sustainability.

The health Partners to this Agreement are committed to considering the adoption of payment models which are better suited to whole system collaborative working (such as Aligned Incentive Contracting). The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

Through this Agreement the Alliance Partners commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across Calderdale in the event of the emergence of financial risk outside plans.

11. Charges and liabilities

Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement. By separate agreement, the Partners may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a "Contributions Schedule" to be

developed by the Partnership and approved by the Alliance Partnership Board. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

11. Information Sharing

Provider partners will commit to work transparently and provide to each other all information that is reasonably required in order to achieve the Alliance objectives and to design and implement changes to the ways in which services and new models of care are delivered (and where the services are delivered from).

Partners will agree and establish appropriate ethical walls between and within the Provider Participants so as to ensure that sensitive Information and confidential Information is only available to those members of the Provider Participants who need to see it for the purposes of the Alliance and for no other purpose.

The Partners to this Agreement will provide to each other all information that is reasonably required in order to achieve the Objectives and take decisions on a Best for Calderdale basis. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

12. Confidential Information

Each Partner will keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Agreement. No Partner shall use any Confidential Information received under this Agreement for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

13. Signatures

This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same document.

The expression "counterpart" shall include any executed copy of this Memorandum transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

SIGNATURE PAGE

SIGNED by ....
(Signature)

for and on behalf of **Calderdale Clinical**
....
Commissioning Group
(Date)

WITNESS:

Signature ....

Name ....

Address ....

....

....

....

Occupation ....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....
(Signature)

for and on behalf of **The Borough Council of**
....
Calderdale
(Date)

WITNESS:

Signature ....

Name ....

Address ....

....

....

....

Occupation ....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

                                                       (Signature)

for and on behalf of **Voluntary Action Calderdale**

                                           ....

                                                       (Date)

WITNESS:

Signature ....

Name ....

Address ....

....

....

....

Occupation ....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

                                                       (Signature)

for and on behalf of **Calderdale and Huddersfield**

Foundation Trust

                                           ....

                                                       (Date)

WITNESS:

Signature ....

Name ....

Address ....

....

....

....

Occupation ....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

                                                       (Signature)

for and on behalf of **South West Yorkshire**

Partnership NHS Foundation Trust

                                           ....

                                                       (Date)

WITNESS:

Signature ....

Name ....

Address ....

....

....

....

Occupation ....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **Locala Community Partnership** (Signature)

....

(Date)

WITNESS:

Signature ....

Name ....

Address ....

....

....

....

Occupation ....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **Primary Care Network** (Signature)

....

(Date)

WITNESS:

Signature ....

Name ....

Address ....

....

....

....

Occupation ....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....
                                                                                                                    (Signature)
for and on behalf of **Primary Care Network**
                                                                    ....
                                                                                                                         (Date)

WITNESS:

Signature ....

Name ....

Address ....

....

....

....

Occupation ....

(PLEASE COMPLETE IN CAPITALS)

Trust Board 1 December 2020

Agenda item 9.3 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	8 October 2020
Member	Chief Executive / Director of Strategy
Items discussed	• Understanding our new health and wellbeing landscape. • Covid-19: Surveillance and local response update. • Creating our Mental Health Partnership. • The mental health impact on our employers and employees. • National Food Strategy: part one. • Our next steps: a day in the life of: Our new normal.
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	15 October 2020
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	• Personalised Care Programme and Carers Programme. • Covid-19 Impact Update. • Co-producing and Action Plan to reduce the Impact of Covid-19 on BAME Communities. • Health & Wellbeing Strategy Update. • Involving People: an update. • Implementing Calderdale Cares – The Next Steps. • Calderdale and Huddersfield Service Reconfiguration Update. • Forward Plan.
Minutes	Papers and draft minutes are available at: https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=27436

Kirklees Health and Wellbeing Board

Date	26 November 2020
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	• Covid-19 Update. • Community Engagement during Covid-19. • Kirklees Children and Young People's Plan - November 2020 Updates.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

With **all of us** in mind.

Wakefield Health and Wellbeing Board

Date	The meeting scheduled for 19 November 2020 was cancelled
Member	Chief Executive / Director of Provider Development
Items discussed	• N/A
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	11 October 2020
Member	Chief Executive
Items discussed	• ICS System Leader Update. • Priorities of Joint Working for Local Authorities. • Developing the South Yorkshire and Bassetlaw 5 Year Strategy 2019 – 2024. • ICS Finance Update. • ICS Highlight Report. • Sheffield City Region team on the Health Led Employment Trial. • Developing the ICS focus on the Voluntary and Community Sector.
Minutes	Approved Minutes of previous meetings are available at: https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings

West Yorkshire & Harrogate Health & Care Partnership Board

Date	1 September 2020 Next meeting scheduled for 1 December 2020
Member	Chief Executive
Items discussed	• Update from the West Yorkshire & Harrogate Partnership CEO Lead. • Planning for System Stabilisation and Reset. • Supporting our Black, Asian and minority ethnic staff and communities. • Third Sector Resilience: Before and during Covid-19.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard

Trust Board 01 December 2020
Agenda item 10.1

Title:	Equality, Involvement, Communication and Membership Strategy
Paper prepared by:	Marketing, Communications, Engagement and Inclusion Lead Presented by: Director of Nursing and Quality and Director of Strategy
Purpose:	The purpose of the paper is to provide a final draft of the integrated Equality, Involvement, Communication and Membership Strategy for Trust Board sign off. On approval of the strategy, accompanying action plans will be developed through the Equality and Inclusion Committee.
Mission/values:	The strategy is insight driven and offers a joined up approach to delivering equality, involvement, communication and membership. Staff, governors, members and people who use our services and the communities we serve are clear that these components need to work together to ensure we can demonstrate an inclusive approach. The strategy will ensure **people reach their potential to live well in their communities** through this holistic way of working. The strategy will ensure we improve the health and wellbeing of everyone. Our inclusive approach will ensure the involvement of those who use our services, through person centred care and planning, driven by robust insight and data will **put the person first and in the centre**. Equality and diversity will act as the golden thread to ensure our approaches and services are inclusive and equitable so we can continue to **improve and aim to be outstanding**. We will remain relevant to the communities and stakeholders we serve by working in partnership to co-create the right conditions and ensuring that **families and carers matter**. We will ensure that what people tell us shapes our services, improving quality and experience for all. We will demonstrate **respectful, honest, open and transparent** communication and information that has inclusivity at its core. By developing a systematic and integrated approach to inclusion, we will ensure that equality, involvement, communication and membership become an integral way of working for everyone. The strategy will align the internal resources we have and external assets we can draw on to ensure a systematic and integrated approach. By working this way, the Trust can be assured that we are **relevant today and ready for tomorrow.**
Any background papers/ previously considered by:	The existing Communication, Engagement and Involvement Strategy had previously been agreed by the Trust Board in 2016. The strategy was due to expire in December 2019. The new strategy was to incorporate the functions of marketing, communications, engagement, equality and membership. The integrated approach was agreed at the November 2019 Trust Board and several updates on strategy development have been submitted to the E&I Forum and Trust Board.

With **all of us** in mind.

Executive summary:	The timescale for developing the strategy had been delayed following the COVID-19 Pandemic but the timeline and plan for involving people in the development of the strategy was successfully delivered. The findings from engagement resulted in the Trust gathering views from 720 people from across our places and communities. The Trust also used insight from several existing sources including the Integrated Care Systems and Healthwatch. Conversations took place during the summer with Governing Body members, staff networks, partners and equality, communication, engagement professionals across the Trust footprint. The feedback from these conversations has been positive and the integrated approach was endorsed and well received. The Equality and Inclusion Committee received the strategy on 22 September 2020 and recommended that the narrative and objectives set out in the strategy may need to be strengthened if the Trust were to demonstrate a commitment to addressing inequalities. It was also agreed that the strategy would cover a 3-year period with a review after the first year. Trust Board also received a first draft of the strategy on 29 September 2020 for comment. The Equality, Involvement, Communication and Membership Strategy will demonstrate a responsive and integrated approach to strengthening inclusion. The Strategy will ensure the Trust meets its statutory legal obligations and act as an enabler to a number of Trust Strategies. The strategy includes clear objectives and measures for each function that will be supported by a **website refresh and individual action plans, incorporating timely actions that will improve the outcomes and experience of our services, users, carers and communities as well as improve the diversity of our workforce.** The website will include a **summary and easy read** version of the strategy, a **short film** (which will be translated into BSL with the option of translating into different languages as required) and a **still image. This will ensure the strategy is fully accessible to our diverse audience.**
Recommendation:	**The Trust Board are asked to:** Consider the final draft strategy and:- - Approve and sign off the 'Equality, Involvement, Communication and Membership Strategy' as the final version covering the period until March 2024. - To delegate full responsibility, development, sign off and monitoring of annual action plans to the Equality and Inclusion Committee.
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Equality, involvement, communication and membership strategy

Sept 2020- March 2024

'An inclusive, values-based approach to support our mission and vision'

Final Draft V0.8

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Version control			
Version	**Change**	**Title**	**Status/date**
V0.1	Dawn Pearson – using the report of findings	Marketing, communications engagement and inclusion lead	Draft June 2020
V0.2	Salma Yasmeen	Director of strategy	Draft July 2020
V0.3	All staff comments	Communication, engagement and equality team Members council – content review	Draft August 2020
V0.4	Wider staff and partners feedback	Wider audience: • Equality and inclusion committee members • Staff networks • Staff side	Draft August 2020
V0.5	Wider staff and partners feedback	• Communication, engagement and equality partners • Operational Management Group (OMG)	Draft September 2020
V0.6	Comments	• Equality and inclusion Committee • Trust Board	Draft 22 Sept 2020 Draft 29 Sept 2020
V0.7	Final comments/additions	• Equality and inclusion Committee • Members Council • Trust Board • Executive Management Team (EMT)	Draft October 2020
V0.8	Final draft for approval	• Trust Board	Final draft to sign off

Foreword

Our mission here at South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) is to help everyone to fulfil their potential and live well in their community. This is supported by a clear set of values that put people at the heart of everything we do.

Thousands of people use our services across south and west Yorkshire each year and we make over a million contacts with them. Each is an opportunity to work together on their mental, physical and social needs. This strategy sets out our commitment to recognising the power in their lived experiences, life skills and personal histories. This extends to our service users, carers, families and friends who we know all matter. It also includes our staff, foundation trust members and people who live in the local communities we serve. All of us can help make our services outstanding.

In 2020, collaborative working and joined up care is more important than ever. Health and care services have undergone rapid changes to respond to the global public health emergency presented by the coronavirus pandemic (COVID-19). Whilst it has been an incredibly difficult time, the pandemic has given us the opportunity to work differently, often without barriers, to do the best we can as a partner in integrated systems.

We know we have more to do if we are to meet the diverse needs of our communities. The pandemic has further exposed the gross inequalities in our society. Inequalities in health, housing, income, barriers to accessing services and discrimination remain and there is a need for improvement across the region. We know these inequalities put people at greater risk of ill health, mental ill health or distress. We also know that people who are mentally ill, those with a learning disability and those who live in poverty face wider health consequences as a result. Systemic racism and prejudice also affect our black, Asian and minority ethnic communities. More work needs to be done to ensure our services are accessible to everyone and reflect the populations we serve by ensuring we understand, inform, communicate with and involve those communities.

We must continuously improve and develop our services through effective communication, involvement and engagement. By working with people, we will develop services that are person centred, culturally appropriate and better than they were before.

This strategy sets out how we will build on the work we have done so far with our valued and diverse communities to make local health and care services better for everyone.

Rob Webster
Chief executive

Angela Monaghan
Chair

1. About the strategy

Our Trust belongs to us all. It considers the voices of service users, carers, families and friends, our staff, board members and people who live in the local communities we serve. We take this responsibility very seriously. It is fundamental to how we communicate with and work alongside everyone.

Our ambition is driven by those who need care and support to live a long and healthy life - this is what motivates us to drive consistent high-quality care, 365 days a year. We want our care to meet that standard we would want for ourselves, our family and friends. We want to demonstrate our commitment by ensuring we are inclusive, meet the needs of our diverse communities and by working in partnership. We know that when we do this, we get our services right, our staff thrive, our outcomes improve for those people who use our services, their family, friends and carers.

We exist to provide service to our local communities and in turn our communities have a wealth of insight, talent and skill they can offer. We are committed to taking full advantage of this opportunity to ensure we provide the best possible high quality and effective services now and in the future.

2. About us

South West Yorkshire Partnership NHS Foundation Trust is a specialist NHS Foundation Trust that provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. We also provide some medium secure (forensic) services to the whole of Yorkshire and the Humber. All our services are focused on principles of recovery and co-production, working with the strengths of each person and those of their carers and wider community.

The Trust also provides services that promote health-producing communities and prevention through supported self-care, recovery focused approaches, peer support and community involvement, volunteering to supported employment. The Trust's recovery colleges, linked charities Creative Minds, Spirit in Mind, Mental Health Museum and significant volunteering services, as well as Altogether Better (a national organisation that is hosted by the Trust) further contribute to this.

Our daily mission is to help people reach their potential and live well in their communities. We employ over 4,500 staff, in both clinical and non-clinical support services. Our staff work hard day in day out to make a difference to the lives of service users, families and carers. How we work is as important to us as what we do. Our values and how we behave really matter to us. Set out below are our vision, mission and values.

Our vision:
To provide outstanding physical, mental, and social care in a modern health and care system.

Our mission:
We help people reach their potential and live well in their community.

Our values:
We are a value based organisation. This means our values are followed by all our staff and underpin everything we do:

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

Our strategic objectives are:
- ✓ Improve health
- ✓ Improve care
- ✓ Improving resources
- ✓ Make this a great place to work

Who we serve
We primarily serve 1.22m people who live across south and west Yorkshire in the local authorities of Barnsley (239,300 people), Calderdale (209,800), Kirklees (440,000) and Wakefield (332,000). However, we also have services and staff in North Leeds, Sheffield, Doncaster and Rotherham.

Most of the care we provide is delivered in local communities. This means we work in all the villages, towns and cities from Todmorden and Hebden Bridge in the west, to Castleford and Pontefract in the east and to Hoyland and the Dearne Valley to the south of Barnsley – and all points in between. Our population lives in a mix of rural and urban areas.

Diversity

We know that there are differential impacts on different groups in our population and this will have an impact on health and wellbeing outcomes. For example, if you experience a mental health problem or have a learning disability, your years of life will be reduced. People with a learning disability have worse physical and mental health than people without. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017).

Black, Asian and Minority Ethnic staff and service users are also more likely to experience poor health. Black men are three times more likely to have a psychotic condition than any other group and there is evidence that Black women are more likely to have depression or anxiety (McManus et al 2016). People from Gypsy, Roma and Traveller communities face large barriers to accessing services. Barriers can include language and lack of interpreters, stigma, trust and concerns about discrimination.

People with a physical or sensory disability experience impacts relating to communication, information and the built environment and people living in more deprived areas have a lower average life expectancy than those living in less deprived areas. Men living in the most disadvantaged communities can now expect to live for 9.5 years less than those living in the wealthiest areas, while for women, the difference is 7.5 years (The Kings Fund: Health inequalities: our position). A national survey to understand the experiences of lesbian, gay, bisexual or transgender (LGBT) people living in the UK found that 51% of survey respondents who accessed or tried to access mental health services said they had to wait too long. The evidence that LGBT people have disproportionately worse health outcomes and experiences of healthcare is both compelling and consistent.

We know that White British people make up 87% of our region's local authority population, more than the England average of 81%. The other main minority groups include Black or Black British people comprised 1%, less than the England average of 3%, while Asian or Asian British people comprised 8%, the same as the England average (2011 census). The local authorities with the largest proportions of Asian people are Kirklees (16%) and Calderdale (8%). This profile is likely to change significantly over the next 20 years with BME groups accounting for almost 80% of the UK's population growth (Policy Exchange, 2014). Whilst the UK population is generally ageing, among BME communities specifically, this pattern is reversed.

Understanding the diversity of our audience plays a key role in getting our services right. For example, West Yorkshire and Harrogate Health and Care Partnership commissioned an Independent review to take stock of the existing work across the partnership and to identify gaps in order to accelerate progress in tackling inequalities across the region. The report from the review sets out several recommendations which are embedded in our approach. You can read the full report here (add link)
https://www.wyhpartnership.co.uk/publications/tackling-health-inequalities-for-bame-communities-and-colleagues

Delivering for our communities

The overarching Trust strategy (add link) sets out the Trust's ambitions for each of these places. This strategy will act as an enabler, helping the Trust deliver on its ambitions and plans. This strategy sets out the relationship we will have with our communities to achieve our goals. It acknowledges our diverse audience and range of local partners and stakeholders.

We know that if we are to truly involve people, a one size fits all approach will not work. Our internal approach will be driven by clear and consistent processes with equality as the golden thread. Our external delivery will be locally focussed, agile and flexible enough to respond to the needs of the people we serve. Due to the timing of the strategy refresh, we have also embedded the requirements of both the NHS People Plan 2020/21 (add link) and 'Implementing phase 3 of the NHS response to the COVID-19 pandemic recommendations' (add link).

The Trust will deliver on all our strategic ambitions as an active partner in both South Yorkshire and Bassetlaw Integrated Care System (formerly known as Accountable Care System) and West Yorkshire and Harrogate Health and Care Partnership (formerly known as STP), and through the development of ambitious shared plans for each of the places in which we work; Barnsley, Calderdale, Kirklees, and Wakefield.

3. An integrated approach

The Trust believes that an integrated approach to equality, involvement, communication and membership will ensure we deliver on our inclusion agenda. We know that each of these areas has its own drivers and legal obligations which we will need to adhere to and deliver on.

Our approach to equality will be driven by involving people and will ensure our methods and approaches are reflective of the audience we are aiming to reach. This means that a one size fits all or single approach will not provide the right conditions. Our commitment will be to always understand our audience before we start any activity.

We will map audiences using the approach set out below and ensure three lines of enquiry before we get started:

o Person at the centre: We will identify the individuals we need to reach and how we involve individuals now. We will use mechanisms already in place to support our work. This

would include using existing service user groups and feedback from those individuals using complaints and patient experience data. We will capture the equality data so we have the right profile in the first place and create culturally and religiously sensitive services.

o People at the centre: We will involve people who have a shared or common interest. This would include staff networks, service user, carer, family and friends' groups, staff groups, governors and members. We will look at any feedback we have gathered before that we can use. We will go to where people are with a genuine interest in listening to gather more views, ensuring equality of voice.

o Communities at the centre: We will involve communities at a place based, locality or neighbourhood level. We will map our stakeholders and understand the groups or organisations already in place. We will harness the voice of those communities and work together to ensure equality of access to information, communication and ensure insight and understanding is representative of the population.

By working this way, we can build on the community assets and resources that already exist. This will include working with our consumer champions Healthwatch, the voluntary and community sector and key agencies and partners. Our staff networks and workforce will inform, shape, design and deliver changes as part of our 'all of us improve' approach.

Essentially at the heart of this strategy is the commitment to '***put people first and in the centre'*** and that ***'families and carers matter,'*** which when delivered using an integrated and insight led approach fosters partnership as a central component which makes us '***relevant today and ready for tomorrow'.***

Using the principle of involvement to underpin everything we do; we will drive the equality and inclusion agenda. This strategy sets out the core components that will enable us to deliver a clear and comprehensive approach to meaningful involvement and inclusion. Underpinned by communication and supported and driven by our members. This will ensure our ambition to ensure;

- Every person living in the communities we serve will know our **services are appropriate and reflect the population** we serve;
- That our **workforce reflects communities**, ensuring our services are culturally appropriate and fit for purpose;
- Service users, carers and families receive timely and **accessible information** and **communication,** ensuring a **person-centred approach** to care;
- That our services are **co-created and designed with our staff and communities**

3.1   A co-created approach

The content of the strategy has also been informed by extensive engagement with over 700 service user, carer and community views, staff and key stakeholders [add link to report]. People told us the areas we needed to deliver on to ensure that the strategy could meet the needs of our local population. To ensure we **deliver on our values, people** told us that:
- They want the Trust to be more visible
- They want an honest, trusting and reciprocal relationship

- They want to help us get our services right
- We should 'listen before we talk' and not just come when there is a set agenda
- They want a 'human to human' relationship built on dignity and respect
- They want to feel valued when they work with us

People told us **our approach** should be:
- To communicate in plain jargon free language appropriate to the target audience
- To use images and pictures with accompanying clear, short and to the point text
- To go where people are
- To use our assets and networks to involve and include people
- To reimburse any out of pocket expenses and think about other support requirements when involving people
- To provide feedback on what we have done, remain accountable and demonstrate real improvements through involvement and inclusive approaches

To ensure we deliver on our **Equality Duty** we need to:

- Ensure people who do not have English as a first language feel equally treated
- Have support and access to conversations to ensure they can contribute
- Make sure the use of internet, social media and computers are part of but not the main source of information
- Use large print and different languages in posters and produce information in audio
- Employ bilingual speaking staff
- Demonstrate an understanding of community, culture and belief
- Use local community contacts including faith leaders to support mental health and wellbeing
- Posters and leaflets need to also be in Urdu and other community languages
- Use community images to reflect the audience in printed material
- Use symbols and images more than the written word
- Help break the mental health taboo and barriers that exist in Asian communities by working with those communities

3.2 Alignment with other strategies

The ambitions set out in this strategy will also inform and align with other Trust strategies and approaches. The strategies and approaches aligned are:

- Our **organisational development (OD) strategy** (add link) contains the essential enablers to a successful organisation (structure, strategy, systems, shared values, skills, staff and style).
- Our **workforce strategy** (add link) sets out a strategic approach to leadership, management and development to ensure the Trust is well led and has the right people to achieve the strategic direction, deliver the mission and demonstrate the values.
- Our **digital strategy** (add link) is an essential enabler to effective communication and involvement and aims to help reduce inequalities.

- Our **volunteering policy/strategy** (add link) sets out ways for people to be involved in the organisation and influence how services are developed and delivered.
- Our **customer services policy** (add link) supports seeking the views of people who use our services and their carers and responding appropriately to feedback, including when things go wrong.
- **Quality strategy** (add link) and specifically the change and improvement framework that underpins our approach to driving quality to support the outcomes of this strategy.
- **Estates strategy** (add link) and the importance of ensuring that our environments are safe and sensitive to the needs of all our communities and stakeholders.

In addition to Trust strategies, we must ensure that we maintain our duty under the NHS Constitution (add link) and deliver on our constitutional commitments in line with the Human Rights Act 1998. The NHS Constitution states that the **NHS works across organisational boundaries.** It works in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

3.3   Collecting the right data

Underpinning our integrated approach is the effective use of insight and data required. Without quality data, the Trust will not be able to demonstrate the effectiveness of our approach. Plans for developing and implementing shared care records, allowing the safe flow of patient data between care settings and the aggregation of data for population health is ongoing. The data we will use to the drive strategy is demonstrated in the diagram below:

Person at the centre

About me: A person centred approach involves capturing **equality data** at the first point of contact and using this data to inform care that is personalised. **'SystmOne'** will be the tool to capture data for people who use our services and **equality monitoring at recruitment** stage for staff. There will be more support, training, information and communication to ensure staff and patients understand the importance of this data. The Trust will also create the right conditions to ensure this information is captured in a respectful and sensitive way.

People at the centre

About us: Having an **Equality Impact Assessments** (EIA) for every service. Using the EIA to ensure our service meets the needs of the target audience, are culturally sensitive, appropriate and relevant. We will capture the diversity of voice using **equality monitoring,** using this intelligence to identify gaps in reach. Findings from our involvement will also include a dedicated **equality** section.

About places: We will know who our places are by using place-based intelligence. This information will come from our local government partners who have a Joint Needs Assessment, Healthwatch and the voluntary and community sector. We will use this information when we are planning services, preparing for involvement, designing information or communicating with audiences. This intelligence will help to inform our service design, workforce and place-based offer.

4. Our promise to you – a clear set of principles

The Trust has developed a set of principles using the feedback we had from the engagement conversations we held as part of the strategy refresh process (add link to report). The principles reflect the findings and have incorporated the organisation's vision and values and our legal obligations whilst building on existing good practice.

The principles will drive the work we do to achieve our mission and values. The principles are set out below:

- We will **demonstrate we know our audience** using data intelligence and local network approaches.
- **We will use what we already know** as a starting point and we will not duplicate effort or repeat conversations.
- All our work will be supported by **accessible and clear information,** so people feel informed.
- We will use diverse and inclusive approaches consistently across all services/teams.
- We will also be **honest and transparent** in our day to day communication.
- We will ensure that we **include the right people at the right time** in all our work.
- The Trust will be **honest** about what people can and can't influence and **transparent** by using the website as one approach, mindful of "digital exclusion."
- For the things people can influence, the Trust will provide **a genuine opportunity for involvement.** This will include providing the right conditions for people to get involved.
- The views gathered from any involvement will be properly **documented** so people can see the information they have provided and feel confident that it is gathered in such a way that it will inform a decision.
- We will **value lived experience** and actively demonstrate an approach to embed this in everything we do.
- We will remain humble and ensure that we **thank people for their contribution** with out of pocket expenses and hospitality.
- We will keep people with us on our journey by **providing feedback** when we say we will and describing our next steps.
- We will keep people **informed and in the loop** by providing information and a communication platform which everyone can access.

Embedded in these principles and a golden thread throughout is our continuing duty to ensure that the Trust demonstrate **due regard to the Equality Act 2010, Public Sector Equality Duty (PSED).**

We must remain committed to the mission of ensuring people reach their potential and live well in their community by reaching communities who may be under-represented or not always heard. By ensuring the voices of those groups and communities that experience or are impacted by structural disadvantage or discrimination are also engaged with through each of our places and the work we do with our partners in communities.

5. Principles into practice

5.1 Fostering the right conditions

As a Trust we will work hard to foster the right conditions to ensure we can demonstrate better outcomes for all. This means ensuring we work hard to understand our communities by building meaningful and reciprocal partnerships and relationships. Our staff and members will act as our ambassadors to drive our inclusive approach. We will do this by equipping and enabling staff to work with different and diverse service users, carers in a sensitive way to ensure we deliver culturally sensitive care. This will include faith communities, gender sensitive and culturally appropriate care and support to those who have experienced trauma, using models and new approaches as they become available.

5.2 Skilling our workforce and wider networks

As a Trust employing over 4,400 staff, we will ensure that all staff receive the relevant training required to deliver the approach. Processes will be put in place to ensure that we remain consistent in our delivery and maintain best practice. Our staff will be trained in and supported to understand;

- **Our Equality Duty** – this is undertaken by core mandatory training for all staff within a three year cycle and bespoke one-off training.
- **Legal obligations for involvement** – training will be available for key staff, volunteers, peer workers, members, service users and carers.
- **Involvement techniques and approaches** – this will be delivered through quarterly in-house courses for anyone who would like to attend.
- **Communications** – toolkits and short workshops will be made available on using communications, including social media. These will be underpinned by insights from the different groups and communities we serve.
- **Information will be tested** with people before we use it. This approach already informs our branding and communications approach.
- **Branding** – consistent branding guidelines are already available, supported by templates and guidance.

5.3 Knowing our audience

Knowing our audience is a key component if we are to get the strategy right. The Trust covers a diverse geographical footprint which means we need to work hard to understand who our stakeholders are. Our approach will cover the following groups of people:

- People who use services now or in the future
- Families, friends and carers
- Staff
- Membership and members council
- Local councillors and MPs

- Partner agencies including Clinical Commissioning Groups (CCGs), NHS England, NHS Trusts, Local Authority and voluntary and community sector services in each of our places
- We are also partners in two Integrated Care Systems (ICS) in West Yorkshire and Harrogate and South Yorkshire and Bassetlaw

Using a stakeholder mapping approach (add link to stakeholder map), a local Joint Needs Assessment (JNA) for communities, localities and neighbourhoods and an Equality Impact Assessment (EIA) at a service level, we will ensure we identify the right audience. This intelligence will be used as a baseline to identify the audience and inform the approach we should take.

5.4 Processes we have in place

For any conversation on service change, service leads will complete a **checklist for equality, engagement and communication** (add checklist link). The checklist will be assessed by the communication, engagement and equality team and shared with the patient experience team who will also support the completion of a Quality Impact Assessment (QIA). This will ensure that we get our approach right and audit trail any activity. A delivery plan for each service can be developed and actions identified. This form will identify if the Trust are required to do any work in relation to each of these areas.

5.5 Using insight

Our commitment is to use what we already know as a starting point, so we are not repeating conversations. We will always conduct a desk top review of all relevant data held which has been gathered from people who use services, including their families, carers and friends and staff. Intelligence will be considered as far back as 2 years and would include:

- Staff and members survey
- Patient experience data
- Customer service comments, complaints and compliments
- Patient opinion and NHS Choices postings
- Friends and Family Test feedback
- Serious incident learning reports
- Any previous engagement or consultation activity

This data will act as a baseline and used to inform the direction of travel for any future conversations, whilst highlighting any specific areas of service improvement. A short summary report of the key themes from this mapping approach will be considered prior to any planned activity. This information will be included in our plan and reflected in a final report of findings.

5.6 Maintaining communication and providing feedback

Existing communication channels will be used to reach key stakeholders, including our staff, who will remain informed so they can represent the Trust at all levels and in the communities we serve.

The Trust website will act as our shop front and provide accessible and up to date information on Trust services, approaches, strategies and governance. Social media, written

information and images will provide proactive platforms to reach audiences.   An annual communication plan (add link) describes our priority programmes and approach.

When we have a conversation about a service change or improvement, a report of findings will be created for each engagement and consultation activity. The report will be published and include:

- The methods and approaches we used
- The audience reached, who was in the room
- What people told us and key themes
- Equality data and any emerging themes
- What we will do with the information and next steps

A report will be published on the Trust website no later than 8 weeks following an involvement activity. This will be accompanied by a 'you said we did' section that can be updated as developments take place. We will acknowledge the contribution of those attending and thank people for their time.

6. Equality and diversity

Equality is about creating a fairer organisation in which everyone can fulfil their potential. **Diversity** is about recognising and valuing difference in its broadest sense.

This strategy is about treating everyone with fairness and understanding, not necessarily treating everyone the same, including those linked to deprivation and the Equality Act protected characteristics. It aims to reduce inequalities in our services as well as to tackle stigma and discrimination.

The Trust is committed to being responsive and supporting the needs of the diverse population it serves, reflected in the Trust's values. Equality and diversity are not an 'add on', but central to all we do as a provider of services, as an employer and as part of the public sector. People who use the Trust's services are all different - in terms of social circumstances.

To ensure we comply with our statutory responsibilities under the Equality Act 2010 and our Public Sector Equality Duty (PSED), we must aim to gather accurate equality data. By doing so, it will ensure we have the right data to consider all impacts on each protected group at every decision-making stage.

What this means in practice is that we will aim to capture 100% of our equality data using consistent tools (link to equality monitoring form) and evidence this data in a format (link to EIA template) that demonstrates we have considered equality in the development of our services and any proposals. This will **enable us to make fair and informed decisions**; identify where we need to take action to **mitigate any negative impacts or maximise any positive impacts** on equality and ensure we comply with our statutory responsibilities under the Equality Act 2010.

The Equality Act 2010 requires all public sector organisations to be able to show that in the **development of any changes or decisions that impact people, they have shown 'due regard**.'

To evidence that equality is being properly considered as part of the decision-making process, an **equality impact assessment (EIA**) will be carried out to ensure this process is documented and adhered to and action is taken to address unequal impacts.

It is essential that the Trust considers the content of an equality impact assessment (EIA) in the planning, development and design of future services. The EIA will act as a baseline of evidence. This will ensure the Trust designs services that are appropriate and reflective of the population.

An EIA will be developed to support every service, describing the target audience using intelligence from our local authority partners through the Joint Needs Assessments (JNA) in each local area. Each EIA will need to identify the following:

- The demographic audience of those who will use the specific service
- The demographic audience of staff working in the specific service

Once we have this data, there will be more work to do as we move forward to implementation stage and future service models. We will ensure these are developed and co-designed by those who work in and use the service.

The Trust has clear guidelines on the completion of an EIA (attach link). By following the guidelines, the Trust can be confident that they are working to ensure the required legislation has been met.

In situations where we must make a quick decision such as an urgent or emergency, we will still maintain our commitment to evidence that equality is being properly considered. A compact equality impact assessment (EIA) (add EIA short form) will be used to ensure all known impacts have been considered and any action required been recorded, therefore, identifying the need to complete or update a full EIA.

We also know that to fully consider equality, we need the right people in the room. We will ensure that we have diverse representation in decision making structures that reflect the voice of the workforce and population. This will mean including staff that have lived experience who can work with and alongside system leaders.

And finally, we need to ensure we have a diverse workforce representative of the communities we serve at every level of the organisation, including increasing the value placed upon lived experience in roles. All systems will develop a local 'People Plan' to support this approach.

6.1   Legislation

The Equality Act 2010
The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act: Gender, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. In addition, the Trust includes carers as an additional priority.

Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity' and c) foster good relations.

All public authorities have this additional duty so partners will need to be assured that "due regard" has been paid through the delivery of all communication and involvement activity.

The Public Sector Equality Duty
The Public Sector Equality Duty states that public authorities must consider how they ensure people have equal access to services. The Trust must:

- Remove or minimise discrimination in different groups
- Take steps to meet the needs of people from different groups by using creative approaches and the principles of co-production
- Encourage people from different groups to have a say and influence the way services are planned and delivered
- Make sure people from different groups can participate by removing unnecessary barriers
- Tackle prejudice and promote understanding

This means the Trust must consider the needs of all individuals in its day to day work, for example in shaping policies or how services are delivered. The Trust must ensure that everyone, no matter what their background or personal circumstances, is treated with dignity and respect. This strategy provides a framework to ensure that this consideration takes place.

NHS Constitution
The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains several patient rights which are a legal entitlement protected by law. One of these rights is that t**he NHS provides a comprehensive service, available to all**:

It is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to everyone that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

Equality Delivery System 2 (EDS2)
The Equality Delivery System (EDS2) was designed by the Department of Health and reviewed by NHS England to help the NHS measure equality performance. It helps organisations evaluate practices and procedures and understand how driving equality improvements can strengthen accountability to service users and the public. EDS2 helps the Trust to ensure it meets the Public Sector Equality Duty and includes 18 outcomes grouped into 4 goals.

2 of the goals are about services:
- Better health outcomes for all

- Improved patient access and experience

And 2 are about NHS staff:
- Empowered, engaged and included staff
- Inclusive leadership.

The Trust's strategic aims for Equality are linked to these goals. The Trust Board approach is to assess Trust performance via assessment of 4 outcomes from the 18 covered by EDS2, reflecting the incremental nature of the journey to improved performance. Priorities are agreed by the Equality and Inclusion Committee, with EDS2 goals to be included in Director objectives.

Workforce Race Equality Standard WRES

The 2019 Workforce Race Equality Standard (WRES) is delivered through the workforce strategy but supported by this strategy. This is because *'evidence suggests that improving racial inequality in the workplace not only improves staff experience and organisational innovation but improves safety and outcomes for service users.'* The standard has the following key roles:
- To enable organisations to compare their performance with others in their region
- Aim of encouraging improvement by learning and sharing good practice
- To provide a national picture of WRES in practice to colleagues, organisations and the public on developments in the workforce race equality agenda
- Nine indicators of staff experience and opportunity are reported nationally and figures are analysed to understand improvements

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is made up of ten specific measures to help compare the experiences of disabled and non-disabled staff. Mandated through the NHS standard contract, its aim is to support positive change for existing employees and enable a more inclusive environment. The specific measures are:

- Line management and the recruitment and retention of disabled staff
- Improving disability declaration rates
- The role of senior leaders in supporting workplace disability
- Developing WDES action plans

Sexual Orientation Monitoring Information Standard

Research shows that LGBTQ+ people experience greater health inequalities compared to heterosexual people. This includes a higher risk of poor mental health or missing out on routine health screening. If a healthcare service collects information on patient sexual orientation, they will be able to target specific health promotion and services to LGBTQ+ patients. Sexual orientation monitoring questions need to be part of the data we gather to ensure we meet the needs of this group. This standard provides the categories for recording sexual orientation but does not mandate data collection. Data must only be collected where there is a definite purpose/use for the data, which is a requirement under the Data Protection Act. In order to meet the requirements of the Public Sector Equality Duty, there is no need to collect data from every patient; representative sampling across services is acceptable.

6.2 Objectives

The strategic objectives for equality are set out below. Each year the objectives will be supported by an annual action plan which will be published on the Trust website. You can find the latest action plan here (add link). Our objectives are;

- ➢ Ensure we gather **good quality data** which can be used to support performance monitoring of service use and **improve outcomes,** among those from the most deprived neighbourhoods including Black, Asian and Minority Ethnic communities, people with a Learning Disability, ASD and Autism and people who identify as LGBTQ+, young people and carers
- ➢ Ensure **we provide person centred care which promotes inclusive, culturally and gender sensitive services**, delivered by a **diverse and representative workforce** who seek to understand and pro-actively address inequalities and challenge discrimination
- ➢ Ensure we work in partnership with partners and communities, including the voluntary, community and faith sector to **improve access to services** and ensure those from our most deprived neighbourhoods have **equal access to pathways of care**
- ➢ Develop and sustain an equality competent organisation that **demonstrates inclusive and diverse leadership** and workforce, addressing the balance of power and ownership at all levels and improve equality of opportunity for staff and volunteers

We will know we have got this right when:

- ✓ We can demonstrate an improvement in outcomes and experience for people who use our services.
- ✓ We can demonstrate meaningful engagement with communities to understand population needs, strengths and experiences.
- ✓ The Trust has a representative workforce that demonstrates we are reflective of our population and exemplars in employing people with lived experience.
- ✓ All services will have an equality impact assessment (EIA) with annual review and delivery of actions monitored through governance arrangements.
- ✓ All change programmes will be co-produced where appropriate and include equality considerations informed by EIA.
- ✓ We will improve data capture and accuracy of recording in respect of protected characteristics, monitoring of service access by ethnicity in relation to the local population.
- ✓ Services will evidence equality considerations in support of Equality Delivery System (EDS2) to demonstrate how driving equality improvements can strengthen accountability to service users and the public.
- ✓ We will monitor any complaints and reported incident about access to services where discrimination was a factor.
- ✓ An increase in positive stakeholder perceptions via Friends and Family Test and feedback via customer services and dedicated surveys.
- ✓ Our staff wellbeing survey results see improvements in feedback regarding equality of opportunity in training, support and career progression.
- ✓ NHS staff survey feedback will report increased staff satisfaction with equality of opportunity.

The achievement against each objective and the measures in place will be captured using a range of methods which will include publishing our EIAs used to inform decision making.

7. Involvement

A key component to delivering our strategic ambition is to ensure we involve and encourage the active participation of all our stakeholders. This includes listening to the voice of our stakeholders to ensure our services are designed to meet the needs of our audience and communities.

Involvement should not be confused with 'patient experience' which is in place to gather real time feedback to monitor existing service arrangements. Patient experience information will be used however to identify hot spots or areas for improvement that require solutions. Involvement will help to identify those solutions by involving others.

When we refer to involvement in the development, design and delivery of services, it includes the following:

- **Redesigning a pathway** in which people may access a service and the workforce who will deliver that service
- **Adapting or changing an environment** in which people may receive a service or a staff base
- **Identifying a new way of working** which would have an impact on people who use the service including staff
- **Enhancing or developing a new service**
- **Any change to a service which would impact on the way it is currently provided or delivered** (it is important to note that if this was deemed as significant service change, then the Trust would follow the steps below and an additional approach of formal consultation which is not set out. A separate consultation plan would be developed to support this).

All NHS organisations need to work within the legal obligations set out below. Some of the duties described are delegated directly to commissioners but the Trust will be required to work within this legislation under any contract agreement.

We will also be expected to build on the work the CCG has delivered to ensure the legal obligations continue to be delivered. In addition, there may need to be joint arrangements in place to support any significant service change to ensure the CCG can assure the work. The Equality Act and NHS constitution applies directly to all NHS organisations.

To identify the target audience for involvement, we will go back to the EIA and identify the gaps in intelligence as a starting point. The aim will be to deliver on all or some of the following;

- To involve the audiences highlighted as a gap through the EIA
- To engage on specific topics where there are gaps in intelligence
- To engage on changes to services
- To co-design and create systems

Any involvement will be proportionate to the target audience and meet the needs of our equality duty. Stakeholders will be identified through stakeholder mapping.

The Trust will need to use the appropriate methods and approaches to involve each stakeholder. Care should be taken to ensure that seldom-heard interests are fully engaged and supported to participate.

All involvement activity will be equality monitored using an equality monitoring form (add link). This will ensure that the Trust can assess the representativeness of the views gathered during the process. Where there are further gaps in gathering the views of specific groups relating to the protected characteristics, this will be addressed with more targeted engagement.

The legal responsibilities we must work to will ensure that the Trust continue to involve people in the development and design of any future proposals. Any proposals that constitute significant service change will be subject to formal consultation and the Trust will be required to work closely with the CCG and Overview and Scrutiny Committees (OSC) to support this work. If significant service change is required, a separate consultation plan will be developed to support the process

Significant service change
For any proposals that may be deemed as significant service change, an approach to delivering a more formal process using the functions of 'Communication, engagement and equality' will be implemented. This will include the development of a plan and timeline to support the process.

Significant service change would include any large-scale transformation programmes which would result in a change to the way a service is currently provided and/or delivered. The CEE checklist will pick this up at an early stage and ensure that an integrated approach, process and audit trail are in place. The approach will be supported by a plan on a page, see diagram below (or add link):
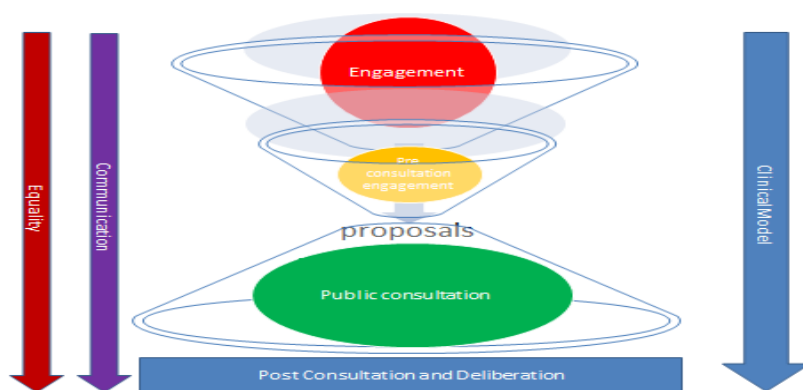
7.1   Legislation

All NHS organisations need to work within the legal obligations set out below. Some of the duties described are delegated directly to commissioners but the Trust will be required to work within this legislation under any contract agreement.

We will also be expected to build on the work the CCG has delivered to ensure the legal obligations continue to be delivered. In addition, there may need to be joint arrangements in place to support any significant service change to ensure the CCG can assure the work. The Equality Act and NHS constitution applies directly to all NHS organisations.

Health and Social Care Act 2012
The Health and Social Care Act 2012 makes provision for Clinical Commissioning Groups (CCGs) to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners. It also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution – and to promote awareness of the NHS Constitution. Specifically, CCGs must involve and consult patients and the public:

- In their planning of commissioning arrangements

- In the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them

- In decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSCs) on any proposals for a substantial development of the health service in the area of the local authority or a substantial variation in the provision of services.

The NHS Constitution
The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains several patient rights which are a legal entitlement protected by law. One of these rights is **the right to be involved directly or through representatives**:
- In the planning of healthcare services
- In the development and consideration of proposals for changes in the way those services are provided
- In the decisions to be made affecting the operation of those services

7.2   Objectives

The strategic objectives for involvement are set out below. Each year the objectives will be supported by an annual action plan which will be published on the Trust website. You can find the latest action plan here (add link). Our objectives are:

- **To use what we already know** as a starting point and working with our partners so we do not repeat conversations or create involvement fatigue.
- To use equality and demographic data to ensure we inclusively **involve the right people at the very beginning** of a process in order to influence the development and design of services.
- To ensure people who access health and social care services, families, carers and the **public are involved in shaping health and care** developments, proposals and plans. Going to where people are and using the **assets that already exist in our**

communities to reach audiences by creating the right conditions to involve local people.

➢ To ensure we are an exemplar in **co-production** - through equal and reciprocal relationships with communities and professionals; recognising that both partners have vital contributions to make and ensuring we have a clear reward and recognition approach.

➢ **To be transparent in our approach by publishing our approach and insight** so people can see the information driving our service decisions and actively demonstrating how we are **using the intelligence we capture** to deliver service improvement and patient centred outcomes

We will know we have got this right when;

- ✓ Our communities know who we are and we have fostered reciprocal relationships
- ✓ Voice is representative of the population we serve
- ✓ We can demonstrate the number of services co-designing and co-creating services with key stakeholders
- ✓ Our stakeholders feel listened to, able to contribute and involved
- ✓ Patient experience demonstrates service improvement and we reduce customer complaints
- ✓ We publish the findings from all our involvement activity and can demonstrate an inclusive approach representative of the population we serve
- ✓ We can demonstrate real influence using a 'you said we did' approach

The achievement against each objective and the measures in place will be captured using a range of methods which will include an annual perception survey for staff and stakeholders, which will inform the following years' action plan.

8. Membership

Membership of the Trust means local people and our staff have a greater say in how services are provided in the areas the Trust serves. Members are made up of local people and staff. Membership is an opportunity to get involved and to shape the services we provide and as a foundation trust we are accountable to members.

Our aim is to develop an effective membership which is reflective of the populations we serve. All members are equal but the Trust recognises that some members may wish to be more actively involved in the life of our Trust than others.

We know that an effective membership can only be achieved if we embrace an inclusive approach, encourage diverse representation, demonstrate effective involvement and ensure accessible information and communication. We will strive to create a culture of active involvement for as many members as possible through active engagement of the membership.

Membership is free, with few specific requirements apart from a lower age limit of 11 and no upper age limit. The Trust's Constitution (add link) sets out the role and duties of members.

The details of current members are publicly available on the members section of the website (add link).

The Members' Council
The Members' Council is made up of elected representatives and nominated members from key local partner organisations. The council's role is to make sure that the board of Directors, which retains responsibility for the day to day running of the Trust, is accountable to their local communities. Representatives from the members' council (governors) will be actively involved in key local community groups

8.1 Legislation

Foundation Trust governor and membership arrangements (add link) – ensuring local people have a greater say in how services are provided, supporting our governance arrangements and ensuring we are accountable to local communities.

8.2 Objectives

The strategic objectives for members are set out below. Each year the objectives will be supported by an annual action plan which will be published on the Trust website. You can find the latest action plan here (add link). Our objectives are;

➢ The Members' Council will work with the Communication, Equality and Engagement teams to publicise the Trust throughout the population of the area they represent and work to increase the membership of the Trust and increase enthusiastic engagement at all levels.

➢ Quality is at the heart of delivering an outstanding service to the Trust's service users, carers, families, friends, other partners and stakeholders. The Members' Council will endeavour to ensure continuous improvement throughout the Trust by providing feedback and constructive challenge from the communities that they serve.

➢ The Members' Council has a legal requirement to support the work of SWYPFT. It can only fulfil this role if the Governors are well trained, informed, committed and active within the Trust and the wider communities that they represent.

We will know we have got this right when;
✓ Our members and Members' Council reflect the population we serve
✓ Members feel informed
✓ Members feel engaged and actively involved
✓ Our approach to supporting members is accessible and inclusive

The achievement against each objective and the measures in place will be captured in the member annual survey. The findings from this survey will be published (add link) and presented each year at the annual members' meeting and will inform the following years' action plan.

9. Communication

Any information and communication requirements will be supported by a planned approach to communication or a separate communication plan. We will ensure that our communication approach is;

- **Accessible and inclusive** – to all our audiences following the accessible information standard
- **Clear and concise** – allowing messages to be easily understood by all
- **Consistent and accountable** – in line with our vision, messages and purpose
- **Flexible** – ensuring communications and engagement activity follows a variety of formats, tailored to and appropriate for each audience
- **Open, honest and transparent** – we will be clear from the start of the conversations what our plans are, what is and what is not negotiable, the reasons why and ultimately how decisions will be made
- **Insight driven and targeted** – making sure we get messages to the right people and in the right way
- **Timely** – making sure people have enough time to respond and are kept updated
- **Two-way** – we will listen and respond accordingly, letting people know the outcome

We know that digital technology and platforms need to be fully utilised to communicate and engage with our members but we also recognise that many people do not have access to digital solutions. We will therefore use our intranet, website, social media channels and i-hub as one approach to reaching people whilst maintain face to face and accessible information and communication methods to involve and include everyone. Our approach to communication will be fully appreciative of all our audiences so we do not widen health inequalities by replacing all communications with a digital only offer.

When we do use technology, we will work closely with our information technology colleagues to make sure we are using the most up to date technology as effectively and inclusively as possible to implement our objectives; whilst being mindful of digital literacy and exclusion amongst staff and people who use our services. As the EIA will be used as a tool to identify the target audiences we serve, the Trust will create a clear and consistent narrative which will be adapted to ensure it meets the needs of the target audience and remains inclusive open and honest.

A key principle of the way we work in partnership is to build on existing communication and engagement work already in place at a local level – rather than developing new mechanisms and channels. Our focus is on informing, sharing, listening and responding.

The Trust has developed a clear brand which will be used in all our information and communication to ensure people recognise our services.

9.1 Legislation

In the delivery of our communication approach, there are several obligations we will adhere to. These are set out below:

- **Accessible Information Standard** (add link) – ensuring that people who have a disability, impairment or sensory loss are given information in a way that they can

access and understand and any communication support that they need is identified and provided.

- **NHS identity guidelines** (add link) – ensuring that the NHS identity, one of the most recognised brands in the world, is consistently and clearly applied. It acts as a signpost, helping people to identify NHS organisations and services. It represents high quality care, free at the point of delivery, and evokes high levels of trust and reassurance.

- **NHS standard contract** (add link) – including service condition on communicating with and involving service users, public and staff. It further strengthens the requirements on providers to communicate properly with service users about their care. It adds new obligations to put in place efficient arrangements for handling service user queries promptly and publicising these arrangements to service users on websites and in appointment and admission letters.

- **GDPR and data protections regulations** – which protect people on the use of personal data and information. This puts an obligation on us to seek and maintain consent for the sharing of information and images.

9.2 Objectives

The strategic objectives for communication are set out below. Each year the objectives will be supported by an annual action plan which will be published on the Trust website. You can find the latest action plan here (add link). Our objectives are;

- Be visible, a recognised provider in communities and recognised by the population we serve.
- To ensure we always use a tone of voice that is human, professional, reliable and has people at the centre.
- Maintain and proactively support stakeholder communications including our staff, service users, carers and families, members of parliament (MPs), councillors and partner organisations.
- Maintain credibility by being open, honest and transparent throughout our communications.
- Ensure communications are in line with national and local priorities; and follows national regulations.
- Strengthen our communications and marketing approach to share success stories, receive feedback and engage and involve members, service users, carers, volunteers and partners in all we do.
- Reframe perceptions that make us known as a mental health provider by doing more to communicate the full range of our activities we can deliver.
- Further develop two-way dialogue and communications so that it becomes fully inclusive and participatory.
- Reset and stabilisation (communication and engagement support – in partnership with local place leads).
- We will raise awareness and understanding of the need for joined up health and care across the Trust and with the ICS.
- Keep public, partners and staff updated on the positive difference our partnership is making.

> ➢ Making the most of digital information – whilst supporting people to take advantage of the digital opportunities (both through access and skills development), including VCS organisations that provide invaluable support.

We will know we have got this right when;

- ✓ We are a recognised provider in all the places we serve
- ✓ Our audiences feel informed
- ✓ Our approach to communication is both accessible and inclusive
- ✓ We communicate messages that proactively reduce stigma and discrimination

The achievement against each objective and the measures in place will be captured in the annual staff and stakeholder survey. The findings from this survey will be published and will inform the following year's action plan.

10. Providing assurance/governance

This strategy is subject to Trust Board approval with delivery through the Trust's Executive Management Team. The Director of Nursing and Quality will be the lead Director who will be accountable for delivery of this strategy. This will be supported by the Director of Human Resources, Organisational Development and Estates in respect of workforce related matters and day to day support from all executive directors, deputy directors, business delivery units (BDUs) championed by the Trust chair and non-executive directors.

Implementation of the strategy will see involvement from teams across the organisation, in both business delivery units and in support service functions. Delivery will be monitored by the Trust's equality and inclusion committee, who will sign off annual action plans and agree priorities and goals with clear measurable targets to evidence progress against this agenda.

10.1 Equality and inclusion committee
The Trust's equality objectives are decided by the equality and inclusion committee (formerly the equality and inclusion forum) which was set up by Trust Board in 2015 and is a sub-committee of the Board. The committee's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through promoting the values of inclusivity and treating people with respect and dignity.

The committee will oversee this strategy, including the approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and wellbeing of local communities.

Committee membership includes the staff side representative with the lead for equality and diversity, representation from the Trust staff networks and a representative from the Members' Council. Duties of the equality and inclusion committee are:

- o To promote the values of inclusivity, mainstreaming equality, diversity and inclusion across the Trust.

- To ensure a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers and staff and Members' Council.
- To ensure that the Trust embeds diversity and inclusion in all its activities and functions.
- To agree an annual work plan/schedule of priorities that link to the Trust's strategic direction, workforce plan and the wider transformation of services and to monitor progress.
- To ensure that as a consequence of promoting the values of inclusivity, the Trust's services comply with legal and national guidance, including EDS2, WRES (Workforce Race Equality Standard) and WDES (Workforce Disability Equality Standard).
- To provide updates to Trust Board following each meeting.

The committee will oversee this strategy which will be evaluated and updated in 2023. Progress will be monitored via the equality and inclusion committee and via an annual report to Trust Board, with a public facing summary report to demonstrate the Trust's commitment to equitable services.

10.2 Members' Council
Our Members' Council is made up of elected representatives of members, including staff and nominated members from key local partner organisations. The role of the Members' Council is to make sure the Board of directors, who are responsible for the day-to-day running of the Trust, remain accountable to our local communities. The council will play a key role in delivering the strategic objectives set out in the strategy.

11.   Accountability to local people

The Trust has several established approaches, networks and relationships that remain at the centre of our approach to ensure we are inclusive and relevant to the population we serve. These established relationships are used to support us in our work. The approaches we have are set out below:

11.1 Public Board meetings
We hold eight Board meetings a year. These meetings are open to anyone – including people who use our services, their carers, our members, partner organisations, members of the public and the media. Key performance information and board meeting minutes will still be published on this website and interested members of the public are invited to submit questions to membership@swyt.nhs.uk

11.2 Freedom to Speak Up Guardians (FTSU)
Our FTSU guardian network consists of the staff governors on our Members' Council and representatives from our staff network. The guardians' role is to support the Trust to continually build a healthy culture where staff feel safe and confident to raise concerns at work. They also can provide confidential advice and support to staff in how to raise their concerns about patient/service user safety and/or the way their concerns were handled.

11.3 Staff networks

The Trust already has several staff networks and is committed to developing more. The Trust regularly involve and consult network members on areas of Trust business; each network is set up to support improvements in the workplace. Networks foster good relationships between staff, service users, carers, friends and families. This also supports our work with communities. The current networks are detailed below:

- The LGBT+ network (add link)
- The BAME network (add link)
- The Disability network (add link)
- Staff who are Carers network (add link)

Each network has been set up with a view to ensure the Trust is supportive of those from the LGBT+, BAME community and those with a disability. Demonstrating a commitment to this agenda means the Trust can promote itself as a great place to work, encouraging a diverse range of staff to join. A diverse workforce means the Trust can better reflect the population we serve resulting in better outcomes for all.

11.4 Peer support workers

Recruiting staff with a lived experience ensures that the Trust can enrich care by gaining insight from workers who have experience of services. The Trust will continue to focus on the opportunities to increase peer support worker posts. This will ensure that services remain connected to lived experience of mental health.

11.5 Membership

The Trust has a membership database covering the Trust footprint which consists of 13,000 members. Our plans are to fully utilise the database we hold. A refresh of the database will take place so the Trust can use the equality monitoring data to identify members by geography and protected group. This will enable a more targeted approach to involving members going forward. By actively engaging our members and championing membership, the Trust can ensure that we are reaching, involving and hearing the voice of individuals who have actively shown an interest in the work of the Trust.

11.6 Involving our patients, carers, families and friends

The Trust has an ongoing commitment to ensure it involves people who use our services. Inpatient areas and services include and involve people using several different approaches. Each approach is set out below;

- **Patient groups** are in place in all our inpatient areas. Each group is set up differently to meet the needs of the patients during their stay. Inpatient areas have notice boards, comments, complaints and compliments mechanisms and a range of published information to support their stay.
- **Carers support groups** are in place for some of our services. The Trust recently co-created a 'carer's passport' which describes our commitment to carers. The commitments set out what a carer can expect from our Trust. The commitment is visible in all our service settings. You can access a copy here (add link). The Trust will continue to build on this work by creating an annual action plan for carers. The latest version can be found here (add link).
- **Creative Minds** is all about the use of creative approaches and activities in healthcare; increasing self-esteem, providing a sense of purpose, developing social skills, helping community integration and improving quality of life. Based on partnerships, Creative Minds co-funds and co-delivers a range of projects for local

people. To date, Creative Minds has enabled 500+ projects, 100 sports events in partnership with 130 Creative Minds partner organisations from across all localities. Find out more about Creative Minds here (add link).

- **Spirit in Mind** is an innovative project that brings together community-based spiritual bodies in collaboration with the Trust. Working in partnership with faith leaders, the project provides an opportunity for community connections as a source of comfort and support for people who use Trust services. Find out more about Spirit in Mind here (add link).
- **Recovery colleges** are in each of our places: Barnsley, Calderdale, Kirklees and Wakefield. Recovery colleges offer a range of courses and one-off workshops with the aim of improving mental health through learning. Courses are co-designed with local people and focus on staying mentally healthy and well. Each course is co-delivered by people with real life experience, who work in conjunction with health professionals. Find out more about recovery colleges here (add link).
- **Trust-wide volunteer service** – 230+ volunteers and growing means that we are involving people in the day to day work of our Trust. The Trust is nationally accredited for the work it does with volunteers. Volunteers provide annual feedback on their volunteering experience using surveys and events. Find out more about our volunteer service here (add link).

11.7 Patient feedback and insight

Gathering the views of service users, carers, friends and family following an episode of care is an embedded way of working. The Trust has a customer service function which acts as a first point of contact and a patient experience function which systematically gathers feedback using several methods including 'The NHS Friends and Family Test'.

Patient experience is one element of the Quality Improvement and Assurance Team's (QIAT) portfolio. The QIAT triangulate quality information from various sources including clinical audit, service evaluation and from the Care Quality Commission. These are discussed within the wider Nursing and Quality Directorate in a weekly risk meeting.

A monthly risk and quality report is being developed by the Nursing and Quality Directorate to build upon current reporting reviewed by the Operational Management Group. This information is used to support The Trust in its Vision, Mission and Values and to inform our journey of continuous quality improvement. Annual patient experience surveys are managed by the QIAT and staff surveys managed by the human resources (HR) Directorate. Annual staff and members surveys also form part of the insight gathered on an ongoing basis. We will be working closely with our Nursing and Quality Directorate to ensure we always use what we know as a baseline.

11.8 Involving our partners in each place

The Trust is committed to playing an active role as a partner in each place. This means the Trust meets regularly with partner organisations, plays an active role in place-based planning, workshops, events and conversations. Our partners include;

- Wider health partners including Clinical Commissioning Groups (CCG) and providers
- Local government in each of our local areas
- Healthwatch organisations
- Voluntary and community sector umbrella organisations and groups
- West Yorkshire and Harrogate Health and Care Partnership
- South Yorkshire and Bassetlaw Integrated Care System

Appendix 1: Glossary of terms

Term	What it means
Foundation Trust	NHS foundation trusts provide NHS services. They were created to devolve decision making from central government to local organisations and communities.
Inequalities	The unfair situation in society when some people have more opportunities, money, etc. than other people.
Systemic racism	Policies and practices that exist throughout a whole society or organisation, and that result in and support a continued unfair advantage to some people and unfair or harmful treatment of others based on race.
Prejudice	Prejudice is a bias or a preconceived opinion, idea, or belief about something.
Peer support	Peer support workers are people who have lived experience of mental health challenges and choose to support others receiving services.
Recovery college	A Recovery College is a course of workshops that have been specifically designed to increase awareness and understanding of recovery and what it means to everyone. South West Yorkshire NHS Foundation Trust have a recovery college in Calderdale, Kirklees, Wakefield and Barnsley.
Creative Minds	Creative Minds is a charity hosted by South West Yorkshire NHS Foundation Trust. Our charitable aim is to develop creative activities in partnership with community organisations that help improve the health and wellbeing of people who use Trust services.
Spirit in Mind	Spirit in Mind is an innovative project that brings together community-based spiritual organisations in collaboration with South West Yorkshire NHS Foundation Trust.
Mental health museum	The Mental Health Museum houses a remarkable collection of mental health-related objects that span the history of mental health care from the early 19th century through to the present day.
Altogether better	Altogether Better is a project which helps health services and local people find new ways of working together – making a difference to people's lives, releasing resources, and improving services.
IAPT	Improving Access to Psychological Therapies (IAPT) is the treatment of adult anxiety disorders and depression using treatments such as talking therapies.
Talking therapies	The term 'talking therapy' covers all the psychological therapies that involve a person talking to a therapist about their problems.
NHS People Plan	NHS People Plan 2020/21 sets out guidelines for employers and systems within the NHS, as well as actions for NHS England and NHS Improvement and Health Education England throughout the coming months and year.
Phase 3 response	The letter from Simon Stevens NHS Chief Executive setting out the priorities for the third phase of NHS Covid19 response.
Integrated Care System (ICS)	ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to collectively plan and integrate care to meet the needs of their population.
Sustainability transformation plan (STP)	STPs are five-year plans covering all aspects of NHS services and spending in England.

Healthwatch	Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care.
Voluntary and community sector/ Third Sector	The community and voluntary sector, or third sector is huge and incredibly diverse and covers everything from neighbourhood watch groups to social enterprises to national and international charities and everything in between.
NHS Constitution	The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains several patient rights which are a legal entitlement protected by law.
Human rights Act	The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to.
SystmOne	SystmOne is a clinical IT system used by the Trust. It permits healthcare professionals to record patient information securely onto a computer. It is possible for this information to be shared with other healthcare professionals.
Equality Impact Assessment	An equality impact assessment (EqIA) is a process designed to ensure that a policy, project or scheme does not unlawfully discriminate against any protected characteristic.
Joint needs assessment (JNA)	A Joint Needs Assessment (JNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.
Equality Act 2010	The Equality Act 2010 requires all public sector organisations to be able to show that in the development of any changes or decisions that impact people, they have shown 'due regard' to all protected groups set out in the act. Nine characteristics are protected by the Act: Gender, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
Public sector equality duty	The Public Sector Equality Duty states that public authorities must consider how they ensure people have equal access to services.
Discrimination	Discrimination is the practice of treating one person or group of people less fairly or less well than other people or groups.
Clinical commissioning group	Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible.
NHS England	NHS England is an executive non-departmental public body of the Department of Health and Social Care.
NHS Trust	An NHS trust is an organisational unit within the English National Health Service, generally serving either a geographical area or a specialised function.
Local Authority	A local authority is an organisation that is officially responsible for all the public services and facilities in a particular area.
Quality Impact Assessment	An impact assessment is a continuous process to ensure that possible or actual business plans are assessed and the potential consequences on quality are considered and any necessary mitigating actions are outlined.
Patient experience	Patient experience is what the process of receiving care feels like for the patient, their family and carers.
Care opinion	Care Opinion is an online organisation where you can share your experiences of UK health and care services.
NHS Choices/website	NHS website (formerly called NHS Choices) is the public facing website of the NHS. It includes directories of local health services, information on a wide range

	of conditions and treatments and accessible public health information. The site also provides comparative data about healthcare providers, to help people make informed choices about their healthcare and allows patients to provide online feedback on services.
Friends and family test	The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided.
Equality	Creating a fairer organisation in which everyone can fulfil their potential.
Diversity	Recognising and valuing difference in its broadest sense.
Equality Delivery System	The Equality Delivery System (EDS2) was designed by the Department of Health, and reviewed by NHS England, to help the NHS measure equality performance.
Workforce Race Equality Standard WRES	The Workforce Race Equality Standard (WRES) has been developed as a tool to measure improvements in the workforce with respect to Black & Minority Ethnic (BME) staff.
Workforce Disability Equality Standard (WDES)	The Workforce Disability Equality Standard (WDES) is made up of ten specific measures to help compare the experiences of disabled and non-disabled staff. Mandated through the NHS standard contract its aim is to support positive change for existing employees and enable a more inclusive environment.
Sexual Orientation Monitoring Information Standard	This standard provides the categories for recording sexual orientation but does not mandate data collection.
Overview and Scrutiny Committee	Local Government scrutiny was created by the Local Government Act 2000 which required every local authority to have a scrutiny function. Scrutiny is a way of holding the council and external service providers to account on behalf of residents.
Co-production	Co-production is an approach where people work together in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.
Accessible information standard	The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.
NHS standard contract	NHS Standard Contract is mandated by NHS England for use by NHS commissioners for all contracts for healthcare services other than primary care.
GDPR and data protections regulations	The General Data Protection Regulation (GDPR) came into force on 25 May 2018. This wide-ranging piece of legislation governs data protection requirements for any entity managing personal data across the entirety of the European Union.
Care quality commission	The Care Quality Commission (CQC) regulates all health and social care services in England.

Appendix 2 – Equality impact assessment

Date of assessment: November 2020

	Equality Impact Assessment Questions:	Evidence based answers & actions:
1	**Name of the document that you are Equality Impact Assessing**	Equality, Involvement, Communication and Membership strategy
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**	The single strategy replaces and combines previous strategies. The previous strategies are the Communication, Engagement and Involvement Strategy, Equality and Inclusion Strategy and Membership Strategy. The strategy is insight driven and offers a joined-up approach to delivering equality, involvement, communication and membership. Staff, governors, members and people who use our services and the communities we serve. The strategy will ensure we improve the health and wellbeing of everyone. Our inclusive approach will ensure the involvement of those who use our services, through person centred care and planning, driven by robust insight and data will put the person first and in the centre. Equality and diversity will act as the golden thread to ensure our approaches and services are inclusive and equitable so we can continue to improve and aim to be outstanding.
3	**Who is the overall lead for this assessment?**	• Director of Nursing and Quality • Director of Strategy • Director of Corporate Development • Director of HR, OD and Estates
4	**Who else was involved in conducting this assessment?**	• Staff, governors, members and people who use our services and the communities we serve • Stakeholders and partners • Equality and engagement managers
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**	The timescale for developing the strategy had been delayed following the COVID19 Pandemic but the timeline and plan for involving people in the development of the strategy was successfully delivered. The findings from engagement resulted in the Trust gathering views from **720 people** from across our places and communities. The Trust also used insight from several existing sources including the Integrated Care Systems and Health watch findings, staff survey and members survey. A full report of findings can be found here (add link) Conversations also took place during the Summer with Governing Body members, staff networks, partners and equality, communication, engagement professionals across the Trust footprint. The feedback from these conversations has been positive and the integrated approach was endorsed and well received. The Equality and Inclusion Committee received the strategy on 22 September 2020 and recommended that the narrative and objectives set out in the strategy may need to be strengthened if the Trust were to demonstrate a commitment to addressing inequalities. It was also agreed that the strategy would cover a 3-year period with a review after the

first year. Trust Board also received a first draft of the strategy on 29 September 2020 for comment.

The feedback has been used to inform the strategy and accompanying action plans. People told us the areas we needed to deliver on to ensure that the strategy could meet the needs of our local population. To ensure we deliver on our **values** people told us that:

- They want the Trust to be more visible
- They want an honest, trusting and reciprocal relationship
- They want to help us get our services right
- We should 'listen before we talk' and not just come when there is a set agenda
- They want a 'human to human' relationship built on dignity and respect
- They want to feel valued when they work with us

People told us **our approach** should be

- To communicate in plain jargon free language appropriate to the target audience
- To use images and pictures with accompanying clear, short and to the point text
- To go where people are
- To use our assets and networks to involve and include people
- To reimburse any out of pocket expenses and think about other support requirements when involving people
- To provide feedback on what we have done, remain accountable and demonstrate real improvements through involvement and inclusive approaches

To ensure we deliver on our **Equality Duty** we need to:

- Ensure people who do not have English as a first language feel equally treated
- Have support and access to conversations to ensure they can contribute
- Make sure the use of internet, social media and computers are part of but not the main source of information
- Use large print and different languages in posters and produce information in audio
- Employ bilingual speaking staff
- Demonstrate an understanding of community, culture and belief
- Use local community contacts including faith leaders to support mental health and well-being
- Posters and leaflets need to also be in Urdu and other community languages
- Use community images to reflect the audience in printed material
- Use symbols and images more than the written word
- Help break the mental health taboo and barriers that exist in Asian communities by working with those communities

| 6 | **What equality data have you used to inform this equality impact assessment?** | Population statistics for our localities in respect of race equality, disability, gender, age and sexual orientation, religion and belief, marriage and civil partnership from census data. We also have access to JNA and public health profiles for our localities.

The communities we serve:

In all communities the 2011 census tells us there is on average across all areas there is a 1% difference in the population reported as male and female, with female reporting higher. Across all ages Calderdale has the |

highest 0-15 population at 19.6% and Barnsley has a higher working age population 30-44 at 26% and older population 60+ at 23.8%. Christianity and Islam respectively are both the highest reported religion and belief.

We know that White British people make up 87% of our region's local authority population, more than the England average of 81%. The other main minority groups include Black or Black British people comprised 1%, less than the England average of 3%, while Asian or Asian British people comprised 8%, the same as the England average (2011 census). The local authorities with the largest proportions of Asian people are Kirklees (16%) and Calderdale (8%). This profile is likely to change significantly over the next 20 years with BME groups accounting for almost 80% of the UK's population growth (Policy Exchange, 2014).

We know that those who report having a disability that impacts them a lot is higher than the census 2011 national average of just over 4% in our local areas range from 8% to over 13% in the communities the Trust cover.

Workforce data
As per workforce annual report 2020

The Trust currently employs **4,328** staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services.

- The Trust split of 77.9% female to 22.1% male is reflected approximately across most areas, except for Medical Staff (36%/64%). As in previous years, female staff make up over three quarters of Trust staff
- As in previous years, the highest number of Trust staff fall in the age bands 40-49 and 50-59 with over 55% of the total staff being between 40 and 59. Just over 42% of medical staff are between 40 and 49. Support Services have the highest percentage of staff in the 60-69 age bands with 14% (102) being 60 or over
- The data shows that 6.1% of our staff consider themselves to have a disability, the same figure as last year. The total number of staff is 266, this is an increase of 11 since last year.
- The Trusts staff profile has a larger White British representation than the local demographic of the people that it serves collectively. Trust wide, 90% of the total staff in post are white British which is similar to previous years and equates to an over-representation of 1.3% (last year 1.1%). Mixed race staff are underrepresented by 0.2%, Chinese staff are over-represented by 0.2%, Black staff are over-represented by 1.6% and South Asian staff are under-represented by 3.2%. However, the Trust's local demographic has large variation in BAME representation and there is a significant under-representation of South Asian staff in Kirklees/Calderdale (exact figures not available due to mixed teams)
- The number of staff who have not stated their religious belief (Unknown) has decreased slightly from 2018 (23%) to just below 21% currently. Staff reported as 48% Christianity, 3%Islam, 12% other and 17% Atheism.
- There has been a significant increase in the number of staff reporting their religion and sexual orientation. Currently 83% of staff have provided data indicating their sexual orientation, which is a slight improvement on last year's figures.

Volunteers review 2020

The diversity of volunteers recruited by the Trust will be improved following a targeted piece of work to reach communities which highlighted several recommendations. The current position for volunteers is reported below and the service will aim to ensure the volunteer offer is reflective of the communities we serve.

Ethnicity	Number of
Arab	1
Asian or Asian British Chinese	1
Asian or Asian British Indian	3
Asian or Asian British Pakistani	4
Black British	1
Black or Black British African	2
Black or Black British Caribbean	2
Black or Black British Other	1
Caribbean	1
Mixed White & Black Caribbean	1
White British	210
White Irish	4
White Other	3
Not Stated	2
Cognitive Delay	4
Learning Disability	5
Long Term Condition	5
Mental Health	102
No Disability	93
Other	8
Physical Impairment	13
Blank	6
Bi-Sexual	9
Gay	8
Heterosexual	195
Lesbian	6
Transgender	0
Prefer not to say	13
Blank	5
Agnostic	2
Buddhist	3
Christian	127
Hindu	1
Jewish	1
Muslim	6
No Religion	66
None stated	3

		Other		**16**
		Prefer not to say		**7**
		Blank		**4**
		No of Volunteers		**236**

7	**What does this data say?**		The local population we serve and the staff who work in our services represent a diverse population. Our public sector equality places a legal duty to ensure we do not discriminate and ensure fair and equal access to our services making sure they are cultural appropriate and that working conditions for staff offer equality of opportunity in employment and development.
			From the figures shown in the data there is more work to do to ensure that our services reach and support our diverse population and that workforce and volunteers continue to reflect and represent the population we serve. This work will be reflected in the annual action plan for equality and inclusion, workforce and volunteers.
8	**Taking into account the information gathered above, could this strategy affect any of the following equality group unfavourably:**	No	**Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.** The purpose of the strategy is to support an equality competent and inclusive organisation who involve people to ensure care is person centred, environments and services are inclusive and accessible, culturally appropriate. This approach supported by clear, accessible timely information and communication and membership will help to achieve this ambition. In addition to the strategy each discipline will co-develop an action plan. Action plans will drive the work required to deliver the strategy in workplace settings, service settings and in the communities we serve. Working with partners and stakeholders the strategy will demonstrate through clear metrics and measures year on year improvements for people with protected characteristics and carers, families and friends to ensure we improve the lives of everyone. The strategy will have a positive impact on the groups set out below and will drive service improvements to ensure the voice of these groups is gathered, recorded, reflected and considered in the decisions we make as a Trust. **Each of our services has an Equality Impact Assessment (EIA) which sets out the intended audience** for this strategy. It is worth noting that the Trust have services in North Leeds, Sheffield, Rotheram and Doncaster and this information will be used to support services in those areas. The information below describes the demographic makeup of the communities we serve, and figures are based on the 2011 census. The Trust will update these figures following the information from the census due in 2021.
8.1	**Race**	No	The Trust need to consider services which meet the needs of our diverse population. Specific targeted work to ensure the **diverse population of Kirklees** are served well and the emerging growth of an **Asian population in Wakefield** will be considered in all service development and delivery.

Race equality

	White	Asian	Black	Mixed	Chinese & Other
England % av.	85.5	5.1	3.4	2.2	1.7
Kirklees					
% average	79.1	15.7	1.9	2.3	0.7
Barnsley					
% average	97.9	0.7	0.5	0.7	0.2
Calderdale					
% average	89.6	7	0.9	1.3	0.6
Wakefield					
% average	95.4	2.6	0.77	0.9	0.29

Taken from Census 2011 for each area

8.2	**Disability**	No	Across all communities the Trust will ensure that **services remain fully accessible due to a higher than national average** proportion of people whose day to day activities are limited 'a lot' by their disability. We will use the **service EIA to ensure we fully understand the nature of the disability** so we can adjust and adapt our services according to need, remaining person centred throughout.

Disability groups

	Day to day activities limited by disability		
	Not at all	A little	A lot
England % av.	47.2	13.2	4.2
Kirklees			
% average	45.5	12.5	13.7
Barnsley			
% average	76.1	11.3	12.6
Calderdale			
% average	56.5	12.2	13.8
Wakefield			
% average	77.93	9.33	8.31

Taken from Census 2011 for each area

8.3	**Gender**	No	Gender equality is reported as part of our workforce approach and services continue to ensure **environments and workplaces remain gender sensitive** and appropriate.

	Male	Female
England % av.	49.2	50.8
Kirklees		
% average	49.4	50.6
Barnsley		
% average	49.1	50.9
Calderdale		
% average	48.9	51.1
Wakefield		
% average	49	51

Taken from Census 2011 data

8.4	**Age**	No	The Trust provides services to children and young people through to older age adults. The table reflects the population age of the communities the Trust serve and there is increasing evidence that **Barnsley represent a higher than average older population** and **Calderdale a higher than average age range of 0-15 age range**. The Trust will ensure that information, communication and environments support people of all ages.

	0-15	16-29	30-44	45-64	65+
England % av.	18.9	18.6	20.3	22.4	16.9
Kirklees					
% average	15.8	18.5	20.3	22.2	15.8

Barnsley (2011 data)		16-24	25-44	45-59	60+
% average	18.5	10.8	26	20.9	23.8
Calderdale					
% average	19.6	16.4	20.1	24.2	16.6
Wakefield					
% average	18.4	17.2	19.6	24.2	17.6

Taken from Census 2011 data

8.5	**Sexual orientation**	**No**	The Trust will **improve on the recording of sexual orientation in line with the 'Sexual Orientation Monitoring standard'** so the Trust can ensure that services and workforce adequately represent the population they serve. The 2020/21 census may contain further baseline information which can be used to support the Trust understanding further. A campaign to support better data collection will improve our reporting.
8.6	**Religion or belief**	**No**	Faith and spiritual care and support in an important component of **person-centred care** provided. The Trust have a **spirit in mind** service who play a central role in engaging faith and spiritual leaders in the communities we serve and involving them in the work of the Trust. Understanding religion and belief plays an important role in driving our offer.

The information below tell us that **Calderdale and Kirklees require a focus on Muslim faith, with Christian faith representing a large proportion of people who use our services in all areas**. Other faiths will be reflected in geographical areas and in line with **service EIAs and person-centred care and planning**.

	Christian	Buddhist	Hindu	Jewish	Sikh	Muslim	Other	No religion
England % av.	71.8	0.3	1	0.5	0.7	10.1	0.2	15.1
Kirklees								
% average	67.2	0.2	0.3	0.1	0.7	10.1	0.2	14
Barnsley								
% average	59.4	0.5	1.5	0.5	0.8	5	0.4	24.7
Calderdale								
% average	60.6	0.3	0.3	0.1	0.2	7.8	0.4	30.2
Wakefield								
% average	66.4	0.16	0.25	0.04	0.12	2.0	0.3	24.4

Taken from 2011 Census data

8.7	**Transgender**	**No**	A **trans equality policy** aimed at workforce and people who use services will be co-designed and the approach endorsed by partner organisations. The policy and agenda for transgender people will remain a key focus and data collection will be reviewed and improved using a campaign to support improvements to disclosure and recording. The 2020/21 Census report may provide further baseline data.
8.8	**Maternity & Pregnancy**	**No**	**Workforce policies** and services aimed at maternity and pregnancy will be **co-designed** with people who represent this group. **Peer support worker roles** in areas of work that support people with maternity and pregnancy mental health issues are increasing, this ensures that lived experience is reflected in our service offer.

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8.9	Marriage & civil partnerships	No	Marriage and civil partnerships will be recorded in line with **workforce recruitment** and selection procedures and as part of **person-centred care and planning.**

	Married	Single	In a [registered] civil	Divorced	Widowed	Separated
England % av.	46.6	34.6	0.2	9.0	6.9	2.7
Kirklees						
% average	48.4	32.4	0.2	9.3	6.8	2.8
Barnsley						
% average	46.6	34.6	0.2	9	6.9	2.7
Calderdale						
% average	46.7	32.1	0.3	10.5	7.3	3.0
Wakefield						
% average	48.2	30.9	0.18	10.5	7.5	2.6

Source unknown

8.10	Carers (Our Trust requirement)	No	It's likely that every one of us will have caring responsibilities at some time in our lives with the challenges faced by carers taking many forms. Many carers juggle their caring responsibilities with work, study and other family commitments. Some, younger carers, are not known to be carers and this means that the sort of roles and responsibilities that carers must provide varies widely.
			Within the local footprint of South West Yorkshire Partnership NHS Foundation Trust, there is an estimated **160,000 unpaid carers.**
			The Trust will continue to record carers as part of equality monitoring and continue to develop and deliver actions to support carers as part of the strategy action plans.

9	What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy: -	This strategy is subject to Trust Board approval with delivery through the Trust's Executive Management Team. The Director of nursing and quality will be the lead director who will be accountable for delivery of this strategy. This will be supported by the Director of Human Resources, Organisational Development and Estates in respect of workforce related matters, and day to day support from all executive directors, deputy directors, business delivery units (BDUs) championed by the Trust chair and non-executive directors. Implementation of the strategy will see involvement from teams across the organisation, in both business delivery units and in support service functions. Delivery will be monitored by the Trust's equality and inclusion committee, who will sign off annual action plans and agree priorities and goals with clear measurable targets to evidence progress against this agenda. The committee will oversee this strategy, including the approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and wellbeing of local communities. Committee membership includes the staff side representative with the lead for equality and diversity, representation from the Trust staff networks and a representative from the members' council. Duties of the equality and inclusion committee are:

		Progress will be monitored via the equality and inclusion committee and via an annual report to Trust Board, with a public facing summary report to demonstrate the Trust's commitment to equitable services. Current governance processes include monitoring of WDES/ WRES and EDS2 indicators and customer service and patient experience data capture processes.
9a	**Promotes equality of opportunity for people who share the above protected characteristics**	The Trust ensure that all **training is recorded and monitored**, study leave forms are completed and that training outcomes are identified through formal learning needs analyses. From the workforce data in 2020 the Trust sees no adverse barriers to training access for any of its staff regardless of their ethnicity, disability or sexuality. The number of coursed accessed exceeds the Trust population for BAME, disabled and LGBT+ staff. **Development of BAME staff** – The Trust supports the BAME network, the development of both 'Stepping Up' and "Ready Now", the NHS Leadership Academy inclusive leadership programmes; and partnering with Bradford District Care Trust on the 'Moving Forward' programme. **Supporting staff with a disability** – Continuing to focus on improving staff disability experience remains a priority, and we have established a Staff Disability network across the Trust and are implementing the Workforce Disability Equality Standard (WDES). The Trust encourages all staff to access Occupational Health and wellbeing services, access health checks and attend Trust wellbeing workshops. **A representative workforce** that is reflective of its localised need – The Trust considers workforce diversity issues as part of our annual planning process and will continue to support the 'New Horizons' project, working with schools and engaging with local communities in the areas of mental health awareness, employability skills and promoting the NHS as an employer of choice, particularly regarding apprenticeships and HCSW opportunities in the Trust. The Trust is continuing with its participation in the Insight programme which seeks to increase Trust Board BAME representation.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics**	**Harassment & Bullying** – The Trust has introduced a new model for preventing Harassment and Bullying and has 12 months communications plan. A senior leadership forum with a focus on Making SWYT A Great Place to Work being rolled out and will include local action plans on creating a team culture to prevent harassment and bullying. The RACE Forward network has been established to review the approach to harassment and bullying from service users, carers and visitors.
9c	**Promotes good relations between different equality groups**	The Trust values promote good relations and these form part of recruitment, training and appraisal functions. Other areas are: • Mandatory training • Staff Networks • WRES and WDES monitoring information • Race forward • Accessible information standard • Translation and interpreter services
9d	**Public Sector Equality Duty – "Due Regard"**	The Equality Delivery System (EDS2) captures our progress against several standards. These standards are reported on each year and a report is shared at the Equality and Inclusion Committee who identify a grading for the Trust. EIAs are routinely completed at a service level and updated every 3 years. These documents are used in the planning and development of services. A short form EIA and process supports decisions a that are required urgently.

		Each assessment has an identified action plan to support service improvement.
		The voice of people who use our services is captured using feedback and involvement. All activity is equality monitored and the findings are reported for each protected group to ensure the reach and audience are reflective of the target audience and that any differential impact is recorded and considered.
10	**Have you developed an Action Plan arising from this assessment?**	There will be an annual action plan, plans will be published on the website. Each plan will be co-designed, and progress monitored by the Equality and Inclusion Committee. The action plans will be for; • Equality and Inclusion • Involvement • Communication • Membership
11	**Assessment/ Action Plan approved by (Director Lead)**	**Sign: Dawn Pearson on behalf of Tim Breedon** **Date: November 2020** **Title: Director of Nursing and Quality**
12		*Once approved, you **must** forward a copy of this Assessment/Action Plan to the Equality and Engagement Development Managers:* **Aboobaker.bhana@swyt.nhs.uk Zahida.mallard@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on the web. Failing to complete an EIA could expose the Trust to future legal challenge.**

Title:	Exclusions or Addendums to Trust policies as a result of Covid-19
Paper prepared by:	Director of Finance & Resources
Purpose:	To update the Trust Board in relation to policies amended or extended during the Covid-19 pandemic, and to note the governance procedure for the approval of policies outlined below.
Mission / values:	Policies and procedures covering core Trust systems and processes are a key part of the Trust's governance arrangements, supporting the Trust to achieve its mission and adhere to its values.
Any background papers / previously considered by:	N/A
Executive summary:	Once review of a policy is complete, the following steps are taken before approval: • An Executive Management Team (EMT) policy approval proforma is completed which outlines the updates made and consultation undertaken in accordance with the Policy for the development, approval and dissemination of policy and procedural documents (Policy on policies). • Policies are scheduled for review and approval at EMT and peer reviewed by another director prior to the meeting. • EMT review and discuss any comments arising from the peer review before final approval of the policy. In March and April 2020, EMT agreed to extend all policies due for review within three months for a further period of six months to allow additional time for reviews to take place and to reduce the burden on staff during the pandemic. EMT agreed that silver command would review any impact of the pandemic on policies and provide tactical response for sign off by gold command. Decisions made at gold command are recorded in the decision log. Since the beginning of the pandemic, the following policy changes have been made with specific reference to Covid-19:

With **all of us** in mind.

Policy / procedure	Date	Update
Fire safety policy	EMT 26/03/2020	Note added to the policy relating to Covid-19: increased risk of fire due to additional oxygen tanks being present on wards. This is a greater risk for acute trusts but will continue to be monitored by the Trust.
Values based induction policy	EMT 07/05/2020	Addendum to policy: corporate Welcome Event will be delivered via e-learning. Healthcare Support Workers will be provided with an e-learning induction which will include introduction to Care Certificate qualification.
Disclosure and Barring Service (DBS) policy	EMT 07/05/2020	Addendum to policy: in line with arrangements put in place by the Home Office and DBS service, if an individual is being recruited due to the pandemic and has had a DBS check in the past three years, their suitability will be assessed based on all the information received and relevant risk assessments completed to enable them to start in post.
Recruitment and selection policy	EMT 07/05/2020	Addendum to policy: new measures adapted to ensure staff are appointed into roles within the quickest timeframe possible whilst maintaining safe standards including Bring Back Staff (national scheme), retire and return, and 'above the line' appointments.
Professional registration policy	EMT 07/05/2020	Addendum to policy: a temporary register for the duration of the Covid-19 pandemic is in place in like with emergency legislation introduced by the Government.
Special leave policy	EMT 07/05/2020	Addendum to policy: special leave criteria for Covid-19 related absence.
Resuscitation policy	EMT 14/05/2020	Policy now includes guidance for resuscitation of patients with Covid-19.
Disciplinary procedure	EMT 09/07/2020	Extension requested to allow further research into best practice around approaches, together with learning from actions undertaken during the pandemic.

	Claims and inquest management policy	EMT 08/10/2020	Purpose and scope updated to include Clinical Negligence for Coronavirus.
Recommendation:	**Trust Board is asked to NOTE the update.**		
Private session:	N/A		

Trust Board 1 December 2020
Agenda item 11.1

Title:	Emergency Preparedness, Resilience and Response Update: Contingency Planning for EU Exit
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper updates the Board on the Trust's planning for the possibility of the United Kingdom (UK) leaving the European Union (EU) with no deal in place at the end of the transition period on the 31 December 2020.
Mission/values:	This 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 and regional levels.
Any background papers/ previously considered by:	Executive Management Team (EMT) and Operational Management Group (OMG) are receiving updates.
Executive summary:	The Trust established a EU Exit Working Group in 2019 to assess the potential impact of a no deal Brexit on the Trust, its services, service users and staff and to ensure we have appropriate contingency plans should it arise. In line with the national guidance, following agreement of the transition deal on the UK's exit from the EU, the work of the group was slowed down and it met intermittently during 2020. However, the group continued to monitor the potential impact of a no deal exit from the EU and linked into national and regional developments. Nationally the whole of the NHS has been asked to step up preparations for a no deal given the UK will be leaving the EU on the 31st December 2020 and no agreement has been reached to date.
	The Trust has updated its risk assessment and action plans to ensure they meet national guidance. The EU Exit Working Group now meets weekly and has undertaken a tabletop exercises on pharmacy supply and continues to undertake tests on the key areas contained in the report. An update report is attached together with the updated risk assessment.
	Risk Appetite
	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 and comment on the content of the report.**
Private session:	Not applicable

With **all of us** in mind.

Trust Board: 1 December 2020

Brexit - Contingency Planning

Introduction

This paper is intended to further update the Board on the preparations being made should there be a no deal when the UK at the end of the transition period for leaving the European Union on the 31 December 2020.

As previously stated, the Trust has long standing plans to deal with exit from the European Union especially given the possibility of a no deal. The EU Exit Working Group has been reconstituted and now meets weekly in order to understand and manage the possible scenarios.

The government advice remains broadly the same in all key areas. The EU Exit Working Group has recently met several times to review and update the risk assessment, which is attached in appendix 1, in line with national guidance.

Advice continues to be that supply chains will be maintained in key areas and that Trusts should not stockpile goods, especially pharmaceuticals. The assurance remains that despite the issues caused by Covid, stocks are in place to deal with a no deal exit. The Trust continues to update its internal risk assessments and participate in all regional activities.

Process

The departments listed below continue to monitor developments in their specific areas and update their risk assessments and plans as appropriate.

- Pharmacy – Kate Dewhirst
- General Procurement – Tony Cooper
- Workforce – Richard Butterfield
- Food supplies – Karen Whittam
- Information Technology – Paul Foster
- Estates and Facilities lead – Nick Phillips
- General EPRR issues arising from the centre – Martin Brandon
- Communications – Paul Cartwright
- Medical devices and professions – Emma Cox

The group provides updates to the Operational Management Group (OMG) and where appropriate issues are escalated to the EMT.

The Trust is in the process of setting up a revised "Silver Command" which will have responsibility for overseeing the "Brexit" process. This approach will harmonise the management of the issue in line with the reporting for other major incidents most notably the ongoing pandemic.

The essences of the updates for each key area have not changed from the initial reports and for completeness are as follows:

Internal Issues

Pharmacy

Advice remains that centrally purchased drugs should not be stockpiled. There are a few lines not from this supply chain and in these cases the Trust has received assurances on continuity of supply. The pharmacy plan has been tested by the EU EXIT Working Group through a tabletop exercise and where it was found to be resilient and in line with national guidance.

Procurement

The Trust again purchases most items through NHS supply chain and is working to their guidance. Where we do not purchase through NHS supply chain, key suppliers have given assurance around continuity of supply. This assurance includes continuity of supply of foods supplies.

Workforce

The situation for workforce remains that EU nationals will still be able to work in the UK. Communications to reassure EU staff that they are valued and offering them support has been developed and will be issued shortly.

Food Supplies

The main concern here remains the supply of fresh foods, which means that menus may need to be revised, but the advice remains that food will generally be available with some unknown restrictions, especially around fruit. This will have to be managed at the time and alternatives will be available.

No further information has been received on import/export arrangements, so the group has worked on the basis of existing advice. If this changes it will be responded to as appropriate

Information Technology

At present no major issues are anticipated.

External Issues

- Initial SITREP reporting has been undertaken to regional EPRR teams, with regular SITREPs expected to increase.

- Alan Davis as Trust lead attends the Yorkshire and Humber LHRP meetings to provide assurances for the Trust relating to EPRR and EU Exit.

- Head of Security and Resilience (Martin Brandon) attends West Yorkshire CIAG (Community Impact Assessment Group) to provide assurances.

- Trust emergency planning lead (Emma Hilton) attends regional and national conference calls with NHSE and NHSI to both provide assurances and obtain up to date information on EU Exit, along with providing assurances to CCG and local health partners at local meetings

- The date of exit is within a period where the impact of Covid is still being felt, guidance around this has not been forthcoming and its potential to impact is not fully understood. This is reflected in the risk assessment but remains an unknown quantity

Recommendation

Board is recommended to

- Note the content of this report
- Note risk assessment at appendix 1.

Nick Phillips
Head of Estates and Facilities

What are the risks?	Potential impact?	What are you already doing?	Do you need to do anything else to control this risk?	Risk owner	Completion Date	Status	RAG rating (Low/Medium /High Risk)
Medicines	Patients – lack of suitable provision due to stock shortages, leaving patients potentially unwell	National instruction in place not to stockpile medicines or write longer scripts. DHSC NHSE are monitoring stock levels nationally and locally. Goods bought direct (unlicensed goods), such as from Germany can be stockpiled. All goods being reviewed and any items that can be stockpiled will be ordered accordingly – space for storage identified. Guidance on medicines due out before the end of January MOU of shared medicines across NHS. May be pressure to release medicines, however assurances provided by Chief Pharmacist that measures in place to meet demand.	Monitor stock levels. Maximise stocks of pharmaceuticals. Purchase unlicensed medicines. Complete weekly SITREP requirements. 15.10.2020 – no updates from central, to continue to monitor. Risk remains the same 13.11.20 – monitor unlicensed medicines accessibility from Germany in advance of EU Exit.	Kate Dewhirst	December 2020		Risk rating L = 2 C = 2 RR = 4
Medical Devices and Clinical Consumables	Patients and Staff – risk of injury if incorrect devices in use Risk of inability to undertake clinical procedures if correct devices are not available	Standard levels of stock at BICES Asset register details location of all medical devices to enable transfer where necessary. 20 packs of defibrillator pads ordered to store to replace old stock. – complete. Audit of defib pads complete and stock levels identified. MD's and subsequent repairs to be monitored at Medical Devices Trust Action Group pre/post EU Exit. Email sent 23/10/2020 to the Modern Matrons requesting that they contact clinical areas to ensure that they have sufficient stock of defibrillator pads and plan to replace/ order if required. Email sent 23/10/2020 to the Resus lead to request additional stock to be ordered. All other actions above still in place	15.10.2020 – no update on risk – to continue to monitor 23/10/2020 – update required from Modern Matrons week commencing 2nd November to ensure action is complete 13.11.2020 – confirmed audit completed.	Emma Cox	November 2020		Risk rating L = 1 C = 2 RR = 2

Non clinical Consumables, Goods and Services i.e. Food & Laundry	Patients Lack of suitable food provision and/or laundry service	Number of suppliers already contacted by Procurement as they are on the national supply chain (see Procurement) Local suppliers of fresh goods and suppliers of catering equipment identified and contacted Guidance re non-medical goods and consumables due out end of February.	07.03.19 – response not yet received from ISS April 2019 – Assurances Received. **07.08.19 – risk reduced** **18/09/19 – hard FM comfortable** *20/10/2020 – update to be obtained* *16.11.2020 – chased for an update*	Karen Whittam	December 2020		Risk rating L = 2 C = 2 RR = 4
Workforce	Patients due to loss of clinical staffing; Trust reputation due to loss of workforce	14 employees identified. 3 of these staff members are Irish and therefore no action is needed due to protected rights to work and live in the UK. International nurse recruitment is now being planned on a collaborative basis within a WY&H MH alliance with SWYPFT as lead. Nurse recruitment from India and Philippines primarily which will be fully supported for staff being clear to work in UK (EILTS, OSCE) – no issues envisaged. Primarily approx. 50 nurses into SWYPFT over 12 months from April 2021. 21/10/20 – Targeted ad campaign being distributed via Headlines for posters asking for staff to come forward regarding work status post leave date. Targeting clinical areas and wards across SWYPFT.	All staff communicated with via Payslips in January to identify any additional staff that need to apply for settled/ pre-settled status. Workshops/1-2-1 assistance to be put in place to help staff apply for settlement status when the application window opens in March.- COMPLETE All staff provided with details on how to access Settlement Scheme application and provided with contact details/support if needed. COMPLETE Linked to Covid-19 response, SWYPFT utilising retire and return and BBS scheme to provide clinical support. A number of staff have been placed on retention for potential emergency deployment. These staff to be assessed for any areas of need going forward should issue arise. 15.10.2020 – update provided 16.11.2020 – EUSS posters to be cascaded to wards.	Richard Butterfield/ Sandy Stones	December 2020		LOW Risk rating L = 1 C = 2 RR = 2

							Risk rating
Reciprocal Healthcare	Impact on the provision of services due to an increase in demand due to the return of British Citizens from abroad.	Each BDU assessing potential impact ensuring Business Continuity plans would still be fit for purpose in the event of an increase in demand. Feedback noting that services will manage the demand increase via the implementation of OPEL levels – no noted concerns regarding impacts. System in place to liaise with Overseas Management Team in partner Trusts is transfer of care places patient in the care of SWYPFT. 18.09.19 – Trust to be aware of potential for over 450,000 ex-pats returning to the UK in a no deal BREXIT – to monitor any impact on services however assurance remain the same as above.	Ongoing monitor 15.10.2020 – confirmed risk remains the same. Monitoring to continue 16.11.2020 – risk confirmed to be the same	EPRR Team	Ongoing		Risk rating L = 2 C = 2 RR = 4
Research and Clinical Trials	Access to devices/pharmaceuticals to undertake/finalise any trials the Trust are involved in.	One clinical trial underway in the Trust. Sponsor contacted and confirmed that no impact will be had as a result of a no deal Brexit	No action 15.10.2020 – update to be obtained 16.11.2020 – emailed Wajid Khan for update	Rachel Moser	January 2019		Risk rating L = 1 C = 2 RR - 2
Data Sharing, Processing and Access	Transfer and storage of clinical data	All suppliers of IM&T services are UK based. When tendering for any new services it is stipulated that hosting/processing of Trust data by carried out in the UK.	No further action required. 15.10.2020 – confirmed risk and status remains the same 16.11.2020 – update from Paul Foster*: I can confirm that for this instance, IG colleagues provided the required assurance for this solution.* *Please note that the Northern, Yorkshire & Humber IG Group are presently drafting a letter regarding such arrangements in future in light of EU EXIT. Once drafted and available, we can utilise this letter via procurement to ask Suppliers to confirm that there will be no changes resulting from the EU EXIT. Note this only relates to data outside of the UK and within the EU presently.*	Paul Foster	Ongoing		Risk Rating L = 1 C = 3 RR = 3
Procurement of Goods	Patients, Staff, Trust Inability to obtain suitable/sufficient stock to maintain patient care and back room functions	Undertaken self-assessment as instructed by Department of Health & Social Care. Response provided following cross reference of companies on assessment document.	Contact those companies not on the national framework to identify contingency arrangements. All companies contacted and contingencies confirmed. 15.10.2020 – conformed risk rating remains the same. 17.11.202 – confirmed risk rating remains the same.	Tony Cooper	December 2020		Risk Rating L = 1 C = 3 RR = 3

Diesel Access	Back Up Generators for clinical areas	In the event of power failure 25k litres of fuel will keep generators running (at full operation) for 4 days. Fill all generators and order spare barrel of fuel for storage at the end of February. Plans to test generators and refill all generators and order spare goods by the end of March. Fuel tank ordered which will be situated in the gardeners compound at Fieldhead – holds 1200 litres of white diesel (equate to 20 tanks of fuel) which will be utilized to run Trust vehicles to deliver food and linen in the event of a fuel crisis.	Complete 15.10.2020 – to check still accurate 13.11.2020 – confirmed accurate – holds approximately 8 days fuel.	Tony Tipton	December 2020		Risk Rating L = 1 C = 2 RR = 2
Fuel Crisis	Staff access to fuel limited in the event of a national fuel crisis. Patients – staff unable to attend appointments in the community or get to work on inpatient wards	Fuel plan drafted for implementation. Liaison with Community lead in Barnsley BDU to update BCPs to encompass loss of fuel	Finalise and implement Fuel Crisis BCP Cascade to all teams Request teams to update BCP's in line with Trust plan and processes. Plan in draft format and out for comment 07.03.19 March 2019 – Trust Fuel Crisis Plan implemented – all BCP owners asked to review BCP's in line with new plan, adding appropriate action card. 15.10.2020 – risk remains the same 13.11.2020 – risk remains the same	Emma Hilton	December 2020		Risk Rating L = 1 C = 3 RR = 3
Registration Process for Smart Card Issue	There may be instances where staff cannot provide the required documentation for accessing NHS systems (such as NI numbers for access to smartcards)	Contingency is to provide a temporary username and password access to SystmOne. This temporary username/password SystmOne access is time-limited and will be only be invoked in such instances where appropriate to do so. Any such requests will need approval by Senior IM&T Management and confirmation from HR.	Continue to monitor *07.08.19 – risk and control measure remain the same – to continue to monitor* 15.10.2020 – confirmed risk and status remains the same 13.11.2020 – risk remains the same	Paul Foster	Ongoing		Risk Rating L = 1 C = 2 RR = 2
Hate Crime	There may be an increase in hate crime being reported during EU Exit.	Ensure awareness across the Trust of such instances. If increase noted, appropriate measures to be put in place via PREVENT lead.	Discuss potential communications relating to such an event. 20.10.2020 – confirmed risk remains the same 13.11.2020 – risk remains the same	Emma Cox	Ongoing		Risk Rating L = 1 C = 2 RR = 2
Covid 19	Covid 19 and its consequences has the potential to disrupt both within the Trust and within wider supply chains etc. The consequences of this are not clear and depend on the severity of any outbreak	As part of Covid preparedness plans have been put in place internally through the BCP process to mitigate issues, these can be applied to Brexit The wider supply chains have been tasked with doing the same and assurances on BCP's include Brexit and pandemic planning	The known contact arrangements continue to be monitored for advice and information	Marti Brandon	Ongoing		Risk rating L = 1 C = 2 RR = 2

NHS
**South West
Yorkshire Partnership**
NHS Foundation Trust

Trust Board 1 December 2020
Agenda item 11.2

Title:	**Safer staffing and workforce report**
Paper prepared by:	Director of Nursing & Quality
Purpose:	This is the prescribed six-monthly report that provides an update and overview of work undertaken by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) in response to the safer staffing challenge. The paper outlines the work undertaken and our future plans to ensure that our clinical areas remain appropriately staffed so that we continue to run safely and effectively.
Mission / values:	Honest, open and transparent, person first and in the centre and improve and be outstanding.
Any background papers / previously considered by:	This report builds on the safer staffing paper presented at Trust Board in April 2020, which now includes updates on Workforce Planning, the Nursing Strategy and financial plans within the trust. Safer staffing reporting is included in every board Integrated Performance Report This report has been scrutinised by the Clinical Governance and Clinical Safety committee.
Executive summary:	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 several forums, considering a variety of interventions and developing our response to the ongoing 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 enough numbers in times of increased demands.
	From May 2020, we report our fill rates for acute mental health wards against the new establishment staff numbers. Initial review reveals that overall capacity of actual versus planned staffing is at 115% when new establishment staff numbers used.
	A shortfall of registered nurses has resulted in the use of existing HCA staff, bank and agency staff to cover. Clinical risks are considered to ensure safe and effective delivery of care.

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	Despite the overall pressure caused by acuity the usage of agency remains consistent and we will be embarking on a further recruitment drive to reduce agency further. The tender process for both Allied health Professionals and Nursing have been completed and awarded.

Continuing to utilise Care Hours Per Patient Day (CHPPD) has allowed us to analyse and understand the skill mix needs as well as giving further evidence-based indicator of whether we have the correct establishment figures. This is considered in conjunction with ward sizes, which influence the figure. It should be noted that the national CHPPD data collection was halted in February, thus the benefit of comparison is compromised

The staffing plans developed as part of business continuity plans have remained resilient in the face of significant challenges. Focussing on critical functions, redeploying staff, modifying mandatory training requirements, staff voluntarily limiting annual leave, prompt testing of staff, offering overtime payments and ensuring sufficient staff bank capacity and capability have ensured that many services have remained at Operational Pressure Escalation Levels (OPEL) level 2 and services remain safe and effective.
New plans for Quarters 3 and 4 2020/21 are included in the report however, due to COVID-19, re-prioritisation of these actions may take place.

The Clinical Governance and Clinical safety committee scrutinised the report on 10/11/2020 and commented as follows;
- Additional assurance is required to understand the cross-cover arrangements where registered staffing falls below planned levels
- Progress on the use of Safecare is a priority
- The significant effort and commitment shown by staff to maintain staffing levels during a challenging time is noted.
- The work on community staffing establishments should be progressed as soon as practicable
- Some suggestions on reporting format will be proposed |
| | **Risk Appetite**
Failing to maintain safe staffing within the clinical, operational and support services within the Trust is likely to result in risks to service users, staff and other stakeholders. There are also significant reputational risks, 1-6.

The Trust has invested in a safer staffing project to mitigate the risk to supplement existing environmental, procedural and relational solutions and policies and procedures. Capacity and demand are monitored closely and escalation processes in place to maintain safe staffing levels, 1-6. |
| **Recommendation:** | **The Trust Board is asked to note the report and the assurance taken by the Clinical Governance & Clinical Safety Committee** |
| **Private session:** | N/A |

Safer Staffing & Workforce Report

Trust Board Report
November 2020

Authorship

Specialist Advisor for Safer Staffing

Supported by
Deputy Director of Nursing and Quality
Associate Director of Nursing and Quality
Workforce Planning Manager
HR Business Manager
Senior Finance Manager

PURPOSE OF THE REPORT

Safer Staffing within health care has been an ongoing issue since the formation of the National Health Service in one form or another. There have been various attempts at staffing models over the years from professional judgement to financially driven. It came sharply back into focus following publication of the Francis report on Mid Staffordshire (Francis 2013), the Keogh review into the quality of care and treatment provided in 14 hospital trusts in England (Keogh 2013) and the Berwick report on improving the safety of patients in England (Berwick 2013), the Department of Health and NHS England asked NICE to develop evidence-based guidelines on safe and effective staffing.

The need for guidelines on safe and effective staffing was been highlighted in subsequent policy documents and responses: How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity and capability (National Quality Board, 2013), and Hard Truths, the journey to putting patients first (Department of Health, 2014).

From a professional nursing perspective, the responsibilities in terms of safer staffing are clear;
"It is the responsibility of every registered nurse in the UK to ensure they are working in environments that have safe staffing and to report to senior management when safe staffing levels are not achieved".(Nursing and Midwifery Council, 2014).

Several systems and tools are available to support safer staffing calculations which have certain attributes but are largely unproven in mental health services. The trust therefor developed a staffing judgement tool based on several available models which were available albeit not ideal for mental health services.

Since then the safer staffing agenda has remained a focal point in care settings and has been influenced by policy and, it has to be said, public opinion.

Over the last 3 - 4 years the Shelford Group, in collaboration with Imperial College London and National Health Service Improvement (NHSi), have developed the most evidence-based staffing judgement tool to be utilised within mental health, learning disability and forensic services. Our trust was involved in the development and testing of the tool and in 2019 were licensed to utilise the Mental Health Optimal Staffing Tool (MHOST).

This has subsequently formed the bedrock of staffing profiling within our transformation work, establishment reviews and will be utilised in the trust wide establishment reviews going forward.

This is the six-monthly Trust Board report that provides an update and overview of work undertaken by SWYPFT in response to the safer staffing challenge. Following presentation, discussion and amendments from the Clinical Governance and Clinical Safety Committee it is being presented to the November 2020 Trust Board.

The paper outlines the work we have undertaken and what our future plans are to ensure that our clinical areas remain appropriately staffed so that we continue to run safely and effectively.

This report builds on the safer staffing paper presented at Trust Board in April 2020, which now includes updates on Workforce Planning, the Nursing Strategy, and financial plans within the trust.

A Trust Board Safer Staffing Checklist is also provided in appendix 3 to provide additional assurance.

The Trust Board is asked to NOTE the report.

1. INTRODUCTION

At a national, regional and local level, all efforts regarding staffing are currently being concentrated on the resurgence of the COVID-19 outbreak and winter pressures, this includes our Trust.

Although, through various interventions and initiatives, we are currently not experiencing the same level of challenge as colleagues in the acute hospital sector, we are not immune to these challenges and anticipate that these will be heightened in the coming weeks.

With that in mind we will be looking at our preparedness. The steps we have taken so far are summarised in Section 9.

At a national level, there continues to be some key changes around the delivery of the safer staffing agenda. Interest in safer staffing arose from concerns nationally regarding acute inpatient staffing levels.

At the time there was no single accredited tool for calculating safe staffing levels in mental health and learning disability wards. Therefore, we developed a safer staffing decision support tool to consider variables within a ward-based environment that reflected skill mix and existing professional judgements.

Since then we have been involved in the development of the Mental Health Optimal Staffing Tool (MHOST), which has now been published and we have been licenced to utilise. This will be considered within the report.

The Trust is required through National Health Service Improvement (NHSI) to publicly declare staffing fill rates for inpatient settings as well as the Care Hours per Patient Day (CHPPD) for each inpatient area. The CHPPD is categorised according to ward type. As a Trust, we are proactively comparing ourselves to our peers regionally by utilising the regional data, which is more diversified than the national figures. It includes, for example, a clear difference between Psychiatric Intensive Care Units (PICU) and acute mental health admission wards.

The focus of much of the work to date has been on ensuring safer staffing levels on inpatient wards. However, we continue to engage with our community teams providing mental health, learning disability and physical health care to scope what safer staffing means to them and what support can be provided following transformation processes.

An implementation plan for the introduction of *SafeCare* into the Unity Centre at Fieldhead had been put on hold due to the current challenges of COVID-19. We are looking to roll this out in December 2020.

The implementation of *SafeCare* allows us to move away from the traditional view of having a set "number" of staff on inpatient areas and utilise the acuity and demand to flex the staffing resources appropriately. This would allow us to ensure our skill mix within the teams is optimised and should lead to a reduction of the dependency on our flexible staffing resource.

2. COMPOSITE INDICATORS TAKEN FROM ELECTRONIC STAFF RECORD SYSTEM (ESR)

The Trust continues to maintain accurate and up-to-date information of "composite indicators "on the Electronic Staff Record System (ESR) in relation to the proposed Safer Staffing Indicators as follows:

Staff sickness rate, taken from the ESR at the end of September 2020;

Inpatient areas – 5.7% compared to the Trust average of 3.9%

This is lower than the previous report by 1.2% and 1.1% respectively. There continues to be a supportive, but challenging, process for managing sickness which managers are following. As shown in the COVID section of the report these figures do not include COVID related absence.

The proportion of mandatory training completed at the end of September 2020;

Inpatient areas: - 90.9% compared to the Trust figure of 93.2%

This has also remained consistent with the previous report and exceeds targets.

Based on the 2020 Wellbeing at Work survey compared to 2019s Staff views have improved on:
- *resources and communication*
- *Job security and change*
- *Balanced workloads*

There have been challenges around several issues which have deteriorated and particularly in the following:
- *Physical Health*
- *Psychological health*

Staff engagement events are ongoing to explore and discuss these outcomes and supportive measures that have been put in place.

Based on these indicators, we continue to be faced with on-going challenges. However, overall, our results are similar to other organisations.

Within SWYPFT, significant financial investments have been made to develop interventions around the safer staffing agenda. This includes a significant new investment in staffing to increase the baseline figures following a review of the skill mix available within Working Aged Adults (WAA). There are similar establishment reviews being undertaken within Forensic services and as part of the older people's transformation process.

3 SUMMARY OF PREVIOUS REPORT AND ACTIONS

In previous safer staffing assurance reports, we identified a need for the following:

1. Continue to build upon and improve data in exception reports

Action: Monthly exception reports continue to highlight areas where staffing levels fall below 90% overall and below 80% for Registered-qualified staff. Ward Managers in areas that do not achieve these thresholds are asked to provide updates to help improve our understanding of why we have shortfalls (Appendix 1 for fill rates). We are constantly reviewing this report to ensure it provides an accurate picture of the acuity on our inpatient areas matched against the available resources. This in turn has allowed the continued refinement of local escalation plans to support inpatient areas (Appendix 2) who are experiencing staffing challenges.

2. Extend and maximise functionality within current e-rostering system as part of the centralisation programme for the Trust staff bank

Action: A report will continue to be sent weekly to the inpatient ward Managers and General Managers providing an analysis of each ward's staffing and use of the e-roster system. This allows for anticipating pressures but also ensures that we extend out challenging processes in line with Lord Carter's report. We will be looking to ensure consistency with this requirement across our services.

We are looking at bringing all health care professionals, including community teams, onto the electronic health roster. This is as a result of the successful bidding process by the West Yorkshire collaboration to secure funding to process this. To be completed by Feb 2020.

3. Continue to provide effective and efficient support to meet establishment templates

Action: We will continue to utilise the robust process in place to ensure any changes to the establishment templates are to support the effective and safe management of resources. This has been particularly helpful in the current transformation work which is ongoing in several areas. These include Enfield Down, Lyndhurst and Older People's services. Delayed due to COVID issues.

4. SafeCare

Action: *SafeCare* will be rolled out across all inpatient areas. A Standard Operating Procedure as well as a guidance paper have been produced and approved by EMT. This is scheduled to be rolled out in Autumn 2020. However, given the current challenges, relating to COVID–19, this was delayed until it is both practical and safe to engage staff in its implementation. To be reviewed in November 2020 and initiated in Dec 2020.

5. Involvement in the National Performance Advisory Group

Action: Continued representation within the National Performance Advisory Group for Safer Temporary Staffing, which ensures we are kept abreast and involved in national developments around Safer Staffing. We continue to collaborate with Northern NHS Trusts to get a consensus on reporting and managing safer staffing.

6. Continue to develop, manage and deploy the peripatetic workforce

Action: We have continued to utilise a small (up to seven staff) centrally managed peripatetic resource, which has helped in providing support across the inpatient areas. Given the number of bank HCAs we continue to utilise we are reviewing the size and effectiveness of this resource. All peripatetic staff, apart from one, have been deployed into substantive posts as a result of the COVID-19 response and supporting the inpatient areas.

7. Enhance the availability of resources within the Trust staff bank

Action: There continues to be various recruitment drives for all disciplines being supported by the BDUs. This includes on-going adverts for band 5 Registered Nurses (RN), HCAs (for students and agency staff only) as well as any other requirement. The medical staff bank has now been established, although there is still a requirement to access agency medics.

There was a series of staff bank forums to ensure that bank staff always have a voice within the organisation and feel supported. This was well attended and supported by the trust board through attendance.

We continue to build on our existing Medical Bank resource and are looking at different options of supporting the temporary deployment of medical resource particularly at weekends and bank holidays.

We have also introduced a shortened process for bank staff to transition into available vacancies as well as agency staff transitioning onto bank. We have also ensured that there is a more robust engagement from staff on the bank and have 348 active staff, meaning they have booked a shift within the last 4 weeks up until the end of August when the latest figures were available

The trust Bank has also been involved in collating staff who could support trust interventions regarding COVID-19 response including drive through stations, test and trace and anti-body testing.

8. Monitor any NHS Improvement guidance for safer staffing and impact on the Trust

Action: We were involved in the development, and have acquired the license to utilise, the Mental Health Optimal Staffing Tool (MHOST), staffing judgement tool. This is a multi-disciplinary, evidence base system that enables ward-based clinicians to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that ward establishments reflect patient needs in acuity and dependency terms. It is appropriate for use in any mental health hospital within the UK. This tool is being adopted across the country and we have utilised it for our transformation work as well as the current forensic staffing review. MHOST will be the cornerstone of this year's establishment review which is due to begin at the end of November.

We will continue to monitor and respond to any future guidance.

9. Finalise Staffing Models within Older People's transformation Project

Action: Although initial modelling and data collection was done this has been paused primarily as other priorities, including our COVID-19 response, have taken precedence. We will be revisiting this utilising the MHOST as the bedrock for the staffing establishment. Data to be submitted by the end of November.

10. Support the Forensic BDU's establishment and skill mix review

Action: All data to utilise the MHOST has been collected and initial discussions about the outcomes have taken place. The final report will be delivered within the first 2 weeks of November. There will then follow further discussions around skill mix and taking this forward. The headlines will be that a recommendation to increase the HCA establishment on most wards will be made as well as a continued review of the skill mix.

11. Tender process for Nursing and Allied Health Practitioner Master Agency

Action: This process has been completed and the contracts have been separated. This will allow for a   more adaptable approach in filling our agency requirements whilst ensuring we get value for money in both these processes. We have seen some early successes in the AHP contract with a higher fill rate remaining at the agency framework capped rate.

12. Participate and Support to the collaborative bank project as well as Service Line Agreements (SLAs) with neighbouring trusts.

 Action: We remain involved in discussions across the West Yorkshire Trust's to explore the creation of a collaborative bank which includes understanding the parameters of this.

We are also close to finalising SLTs with our neighbouring Acute Trust's to provide specialist support from our bank resource for bespoke specialist care requirements within their inpatient services. To be finalised by end of December.

4 INTERPRETATION OF NHSI CARE HOURS PER PATIENT DAY (CHPPD)

We continue to review CHPPD data monthly within the safer staffing group and this will be viewed by OMG.

There has been no collation of the national data regarding the CHPPD stats since the model was released and the collation of regional wide data for CHPPD purposes have been

suspended since February due to the COVID-19 outbreak. This does lead to a devaluation of the comparison to both the national and regional figures. At present the best indicator is our own month on month comparison.

Figure 1.

Figure 1 shows that, following a slight dip in the average CHPPD for our inpatient areas in March and April this year, they have recovered and remained constant throughout the following 5 months. This would have been expected following the successful engagement of 80 students in paid placements as well as the return to work scheme successes.

Care Hours per Patient Day - Overall - Inpatient wards

	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020
Overall	10.5	10.5	10.5	10.6	11.0	9.8	9.3	9.3	9.6	9.5	9.6	9.8	9.4
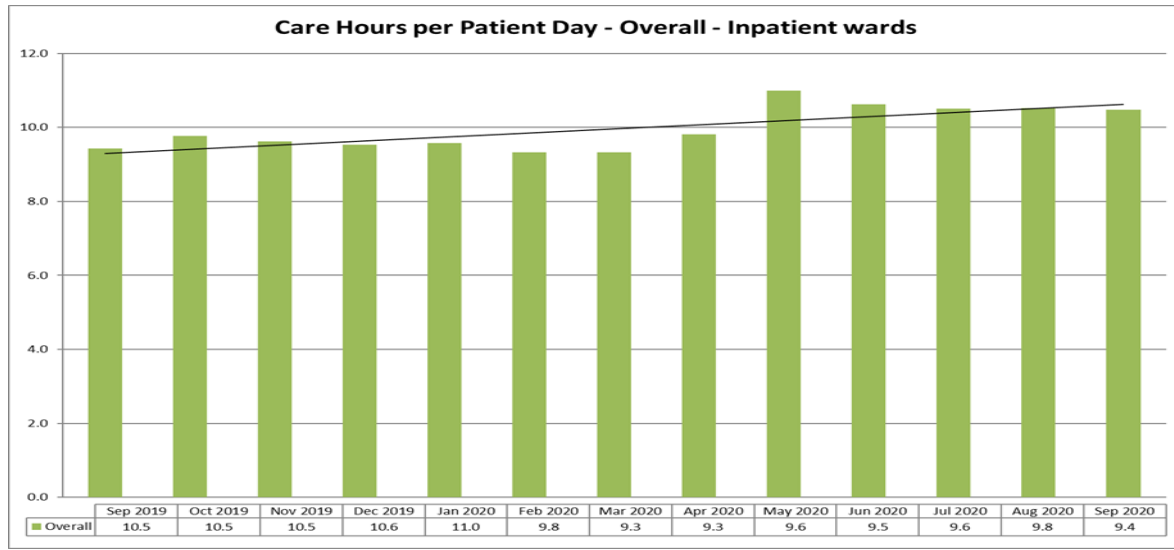
Figure 2.

In figure 2 we see the split in RN and HCA CHPPD which reinforces what we stated above. There was a constant number of HCA hours until the engagement of student nurse paid placements, counted within the HCA numbers, which resulted in a marked increase in these hours of engagement whilst the RN figures has remained relative constant. This is also influenced by numbers of admitted Service Users and staff fill rates.

Care Hours per Patient Day - Trust wide inpatients

	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020
RN	3.3	3.3	3.3	3.4	3.7	3.5	3.3	3.3	3.6	3.4	3.5	3.5	3.3
HCA	7.2	7.2	7.2	7.2	7.3	6.3	6.0	6.0	6.0	6.2	6.1	6.2	6.2

Figure 3.

The most recent review of our data compared to our regional partners within Y&H is summarised in figure 3 below. We will also utilise this in the current transformation work and any future establishment reviews.

There has been a slight improvement in comparison to other Trusts across our regions, but we are all faced with similar challenges, not enough registered staff and higher acuity and demand.

Caution is advised when interpreting some of the data as comparison is made against figures for one month only and the rate can fluctuate from month to month and the figures also rely upon accurate and reliable reporting by respective Trusts.

As we expected in this month there has been a decrease in the CHPPD hours for HCAs. This is largely due to students leaving the paid contracts. The RN picture should be improved with the increase in RNs starting in September and onwards.

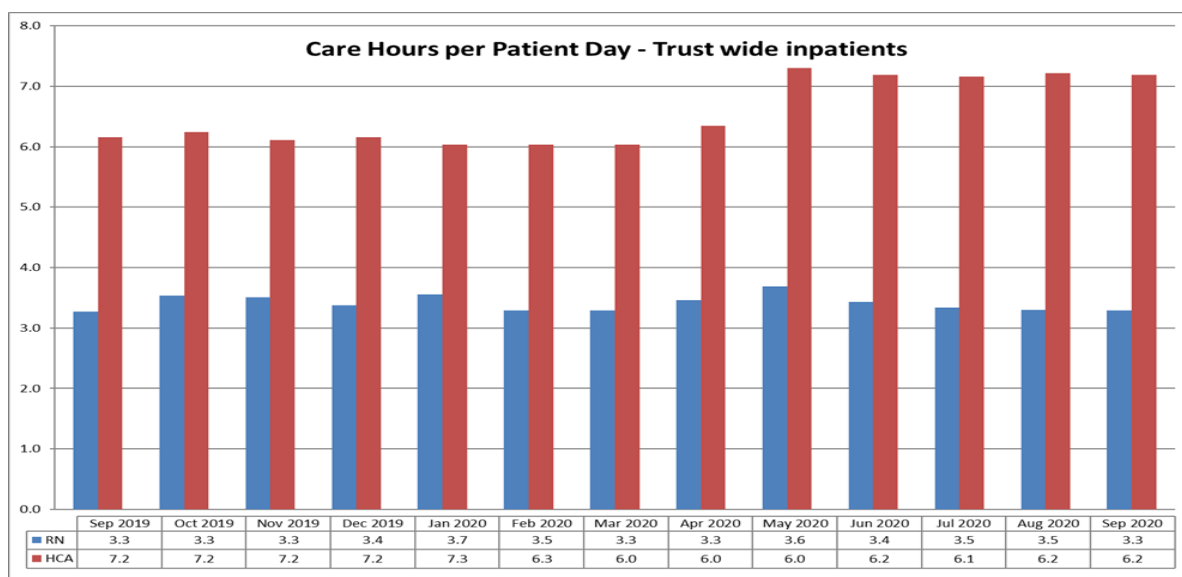The main exceptions are the forensic wards where work to tackle their registered vacancies is ongoing with bespoke recruitment drives, block booking and offers of temporary contracts to bank staff. Medium and Low Secure units will normally manage their staffing establishment across all 11 wards, so shortfalls on one ward will be covered by additional staff in other wards.

The higher outliers can be traced back to smaller bed numbers, bespoke care packages thus increasing staff numbers. This is particularly evident in Barnsley and Horizon centre.

Ward Name	Care Hours Per Patient Day (CHPPD)			
	Trust		Regional Average	
	Registered Nurses	HCA	Registered Nurses	HCA
Beamshaw	3.0	4.4	3.6	5.8
Clark	3.3	7.0	3.6	5.8
Melton Suite PICU	6.7	16.2	5.7	16.8
Neuro Rehab Unit	6.4	8.0	3.4	5.3
Stroke Rehab Unit	13.0	21.9	3.4	5.3
Willow Ward	4.6	9.0	3.6	5.8
Ashdale	2.4	4.5	3.6	5.8
Beechdale	2.3	5.4	2.9	7.9
Elmdale	2.3	3.7	3.6	5.8
Enfield Down	3.3	4.9	3.6	5.8
Lyndhurst	4.5	7.1	3.6	5.8
Ward 18	2.5	5.3	3.6	5.8
Ward 19 - Female	2.8	4.2	2.9	7.9
Ward 19 - Male	3.3	7.2	2.9	7.9
Appleton	4.6	6.9	3.5	7.5
Bronte	4.9	13.2	3.5	7.5
Chippendale	2.6	5.1	3.5	7.5
Hepworth	3.0	6.0	3.5	7.5
Gaskell	3.4	9.9	3.5	7.5
Newhaven	3.0	5.7	3.5	7.5
Priestley	2.1	3.0	3.5	7.5
Ryburn	3.4	3.5	3.5	7.5
Sandal	2.5	10.1	3.5	7.5
Thornhill	2.7	5.7	3.5	7.5

Waterton	2.5	5.5	3.5	7.5
Crofton	3.3	7.8	2.9	7.9
Horizon	8.2	40.1	6.5	20.3
Nostell	2.4	5.6	3.6	5.8
Poplars	3.9	16.4	2.9	7.9
Stanley	3.0	6.0	3.6	5.8
Walton PICU	6.4	18.0	5.7	16.8
All Wards				

CHPPD Key:	Within 10% of regional average
	More than 10% above regional average
	More than 10% below regional average

5 ANALYSIS OF FILL RATES April 2020 – September 2020

Following an establishment and skill mix review within Working Aged Adults the establishment templates have been changed since May 2020. Further reviews in Forensics and other individual wards are ongoing.

Overall Fill rates

Figure 4.
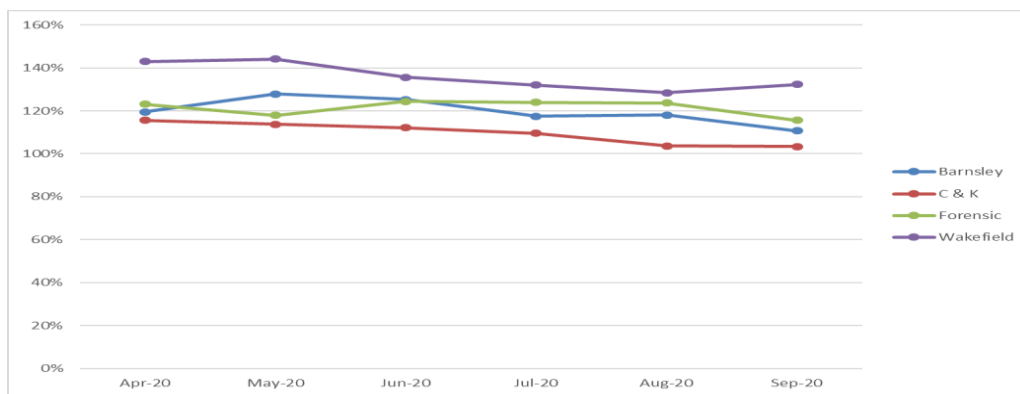
Figure 5.

Fill Rate	Month					
BDU	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**
Barnsley	120%	128%	125%	117%	118%	111%
C & K	116%	114%	112%	110%	104%	103%
Forensic	123%	118%	124%	124%	124%	116%
Wakefield	143%	144%	136%	132%	128%	132%
Grand Total	**124%**	**123%**	**123%**	**120%**	**118%**	**114%**

Fill Rate Key:	Within 20% of fill rate
	More than 20% abovefill rate
	More than 20% below fill rate

The Trust continues to reach its overall fill rate. This has been done with a high proportion of shifts (on average 3,500 per month) being covered by bank and agency as well as some registered shifts being taken by HCAs. We continue to produce these figures on a monthly basis (see Appendix 1)

and ask ward managers for an explanation of why the ward hasn't reached a particular threshold and what impact this had.

This is being addressed within inpatients by establishing the various roles including that of the Nursing Associate, whilst in training will be within the HCA numbers, Advance Nurse Practitioner and increasing the number of band 6 Team Leaders.

Overall days

Figure 6.

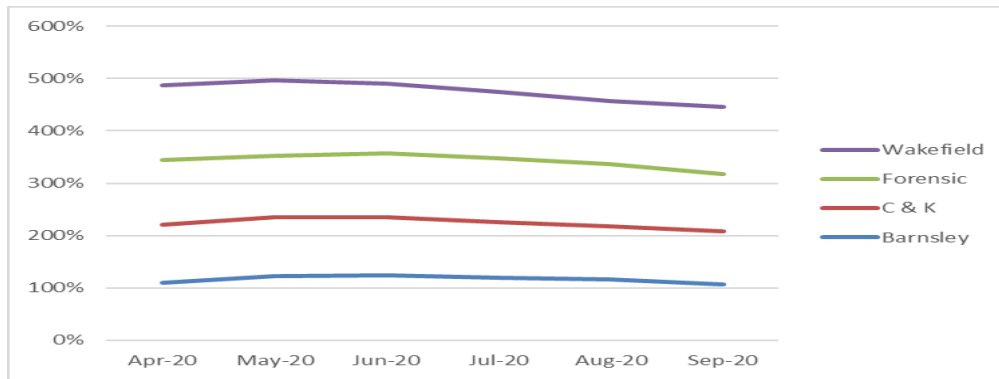There have been eight occasions, a decrease of three, where wards have fallen below this threshold with the majority being between 1% and 5% below. This was mitigated through local escalation plans to identify staff to cover. Seven were within the Forensic BDU due to vacancies, sickness, acuity and clinical decisions to safely manage incidents through reallocations.

Overall nights

Figure 7.
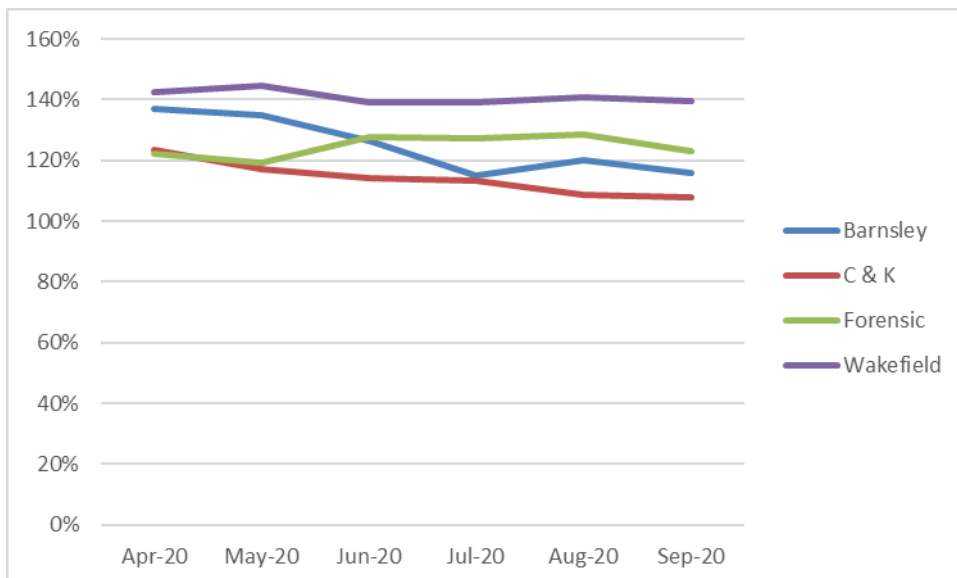
No ward has fallen below this threshold on nights. Indeed, due to clinical need/acuity and less clinical staff and activity, there tends to be a marked uplift in staffing. This has led to a significant number of wards appearing to be well over establishment. This will be addressed through the establishment review work. We are looking at the flexible deployment of team leaders through all shifts to ensure experienced staff are available.

Registered staff nights

Figure 8.
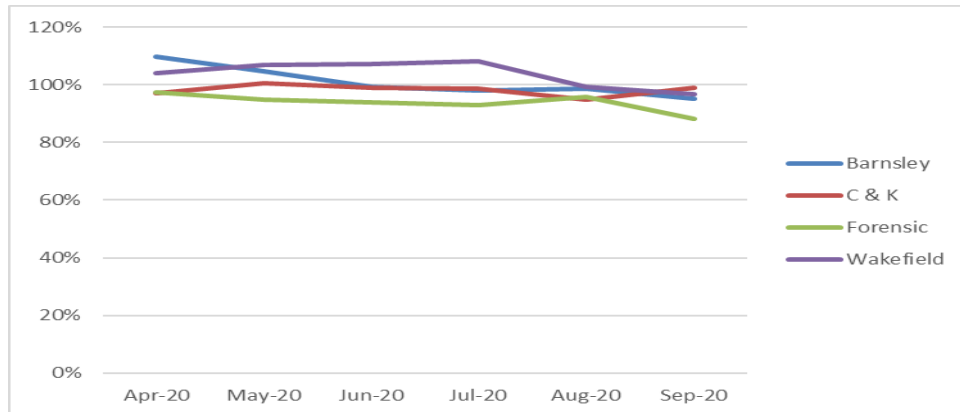
We have had 16 incidents where wards have fallen below the required 80% fill rate for registered staff on nights/ local continuity and escalation plans supported those areas with clinically based reallocations accounting for some of these. The rest have been as a result of vacancies and short-term sickness.

Registered staff days

Figure 9.
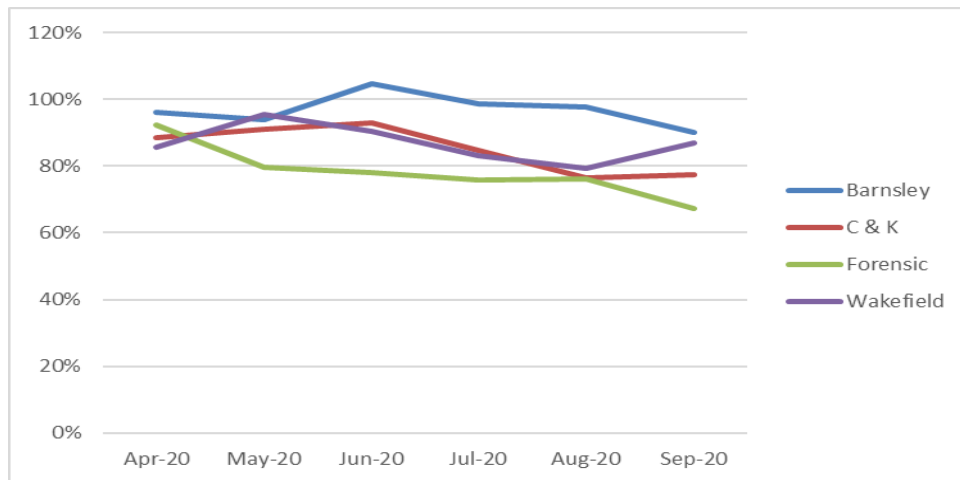
Registered staffing remains a significant pressure on the inpatient areas. We have introduced and embraced the Trainee Nurse Associate programme, which will increase our registered staffing resource when they complete their training programme. The Trust has also supported a clinical career pathway for nurses that include nurse practitioners, non-medical prescribers and advanced clinical practitioners in practice.

We continue to recruit band 5 nurses (58 have been recruited year to date) and attend recruitment fairs nationally, (see recruitment and retention section) and continue to provide ongoing central recruitment centres.

RN fill rate on days/nights

Figure 10.

Registered fill rate days

Unit	Aug-20	Sep-20	Oct-20
⊟ Barnsley	98%	90%	96%
Beamshaw	108%	103%	98%
Clark	93%	80%	90%
Melton Suite PICU	105%	90%	86%
Neuro Rehab Unit	101%	102%	103%
Stroke Rehab Unit	102%	92%	106%
Willow Ward	75%	70%	87%
⊟ C & K	76%	77%	79%
Ashdale	86%	88%	83%
Beechdale	69%	71%	73%
Elmdale	90%	94%	99%
Enfield Down	79%	84%	82%
Lyndhurst	88%	89%	93%
Ward 18	83%	77%	83%
Ward 19 - Female	61%	65%	71%
Ward 19 - Male	57%	51%	48%
⊟ Forensic	76%	67%	82%
Appleton	65%	56%	73%
Bronte	59%	58%	74%
Chippendale	59%	52%	65%
Hepworth	95%	61%	77%
Newhaven	66%	66%	90%
Priestley	58%	63%	79%
Ryburn	112%	102%	100%
Sandal	91%	71%	84%
Thornhill	88%	67%	74%
Waterton	63%	59%	68%
Horizon	126%	123%	160%
Gaskell	73%	67%	79%
⊟ Wakefield	79%	87%	92%
Poplars	57%	60%	79%
Stanley	102%	109%	105%
Nostell	82%	85%	95%
Crofton	63%	78%	79%
Walton PICU	83%	93%	95%
Overall Shift Fill Rate	**81%**	**78%**	**85%**

Registered fill rate nights

Unit	Aug-20	Sep-20	Oct-20
⊟ Barnsley	99%	95%	94%
Beamshaw	107%	98%	92%
Clark	96%	94%	78%
Melton Suite PICU	94%	87%	87%
Neuro Rehab Unit	100%	107%	129%
Stroke Rehab Unit	100%	93%	90%
Willow Ward	94%	93%	100%
⊟ C & K	95%	99%	101%
Ashdale	79%	80%	90%
Beechdale	100%	100%	111%
Elmdale	89%	92%	89%
Enfield Down	100%	98%	99%
Lyndhurst	102%	102%	101%
Ward 18	97%	112%	104%
Ward 19 - Female	108%	120%	130%
Ward 19 - Male	100%	100%	100%
⊟ Forensic	96%	88%	89%
Appleton	127%	118%	100%
Bronte	73%	67%	72%
Chippendale	113%	104%	113%
Hepworth	110%	73%	73%
Newhaven	88%	80%	81%
Priestley	106%	117%	116%
Ryburn	101%	97%	101%
Sandal	68%	75%	74%
Thornhill	85%	85%	77%
Waterton	126%	110%	122%
Horizon	100%	100%	100%
Gaskell	102%	90%	99%
⊟ Wakefield	99%	97%	102%
Poplars	100%	101%	113%
Stanley	93%	90%	99%
Nostell	105%	93%	102%
Crofton	100%	102%	100%
Walton PICU	99%	102%	100%
Overall Shift Fill Rate	**97%**	**94%**	**95%**

Various wards have consistently fallen below the 80% threshold as above. They are in the main within Forensics who have developed a local support process within the BDU to ensure the safety of both service users and staff.

Due to recruitment and retention measures this is an improving picture on days and is relatively stable on nights however, on days in particular this tends to fluctuate and mirror starting dates for newly qualified RNs.

Steps taken to ensure an RN presence on all wards at all times. This could be in the form of reallocations, ward manger cover or basing supernummery team leaders on the wards. Reasons for the shortfall are looked at and support offered. There are issues with correct recording within the health roster, which will account for some of this as ward managers are not always counted even though they are registered staff. This is being addressed.

All areas have business continuity plans in place as well as staffing escalation plans that have been, or will be in the next 2 weeks, reviewed with the safer staffing lead. This sets out what steps to take and in what order together with whose responsibility and accountability.

As we can see in Figure 11 the reduced fill rate for registered nurses is off set in the overall fill rate with the use of HCAs. Although this ensures safe number of staff on the wards it does lead to a dilution of the skill mix RN: HCA.

Among initiatives being looked at, is the introduction of ward based AHP's and RGN's as the second registered professional, as well as ensuring that our Nursing Associates have access to book second RN shifts as bank. Safecare will also allow for a more accurate picture of acuity and the available staff resources which will aid in the clinical decision-making process of staff deployment.

Figure 11.

Overall fill rates per ward

Ward Name	Apr-20 Average Fill Rate - All Staff (%)	May-20 Average Fill Rate - All Staff (%)	Jun-20 Average Fill Rate - All Staff (%)	Jul-20 Average Fill Rate - All Staff (%)	Aug-20 Average Fill Rate - All Staff (%)	Sep-20 Average Fill Rate - All Staff (%)
Beamshaw	107.1%	121.6%	120.5%	111.4%	100.8%	100.6%
Clark	95.5%	92.5%	99.3%	104.2%	122.7%	113.1%
Melton Suite PICU	128.5%	133.9%	149.2%	123.8%	119.2%	122.5%
Neuro Rehab Unit	121.1%	152.2%	142.9%	143.4%	148.3%	124.4%
Stroke Rehab Unit	113.1%	118.7%	122.2%	120.2%	115.2%	103.9%
Willow Ward	121.2%	114.9%	122.1%	105.9%	107.6%	101.8%
Ashdale	96.0%	104.7%	102.1%	105.0%	101.1%	99.0%
Beechdale	102.5%	116.4%	118.6%	153.7%	144.2%	131.7%
Elmdale	97.6%	107.5%	105.9%	102.7%	97.5%	97.7%
Enfield Down	102.5%	107.9%	100.7%	99.6%	97.7%	98.2%
Lyndhurst	103.9%	111.1%	116.8%	105.0%	99.0%	98.8%
Ward 18	107.3%	116.2%	130.4%	109.5%	102.5%	105.8%
Ward 19 - Female	117.3%	105.4%	110.0%	100.0%	94.7%	101.1%
Ward 19 - Male	103.8%	107.0%	116.2%	112.9%	101.1%	101.3%
Appleton	113.3%	103.0%	98.3%	98.5%	93.2%	87.3%
Bronte	133.4%	117.5%	136.2%	135.3%	129.0%	122.4%
Chippendale	95.7%	97.0%	100.0%	98.8%	100.5%	93.2%
Hepworth	110.0%	109.0%	168.2%	143.2%	162.6%	103.4%
Gaskell	173.1%	171.1%	170.4%	174.7%	175.1%	156.7%
Newhaven	106.6%	105.0%	108.3%	107.9%	91.9%	90.2%
Priestley	116.2%	102.6%	98.8%	96.0%	92.2%	89.0%
Ryburn	117.3%	106.7%	109.5%	104.0%	107.6%	100.8%
Sandal	131.0%	121.9%	136.9%	143.8%	129.1%	128.4%
Thornhill	114.1%	106.9%	107.3%	114.9%	123.3%	107.9%
Waterton	129.2%	133.9%	126.9%	123.2%	121.8%	112.8%
Crofton	136.4%	119.8%	122.1%	108.7%	105.5%	116.9%
Horizon	120.8%	119.6%	110.4%	116.5%	128.1%	152.2%
Nostell	126.5%	141.1%	134.5%	127.2%	124.1%	122.3%
Poplars	143.3%	154.8%	156.3%	144.0%	131.8%	153.7%
Stanley	109.8%	137.0%	149.3%	152.3%	136.5%	135.7%
Walton PICU	101.4%	124.2%	122.4%	127.0%	136.5%	134.8%
All Wards	115.1%	119.4%	123.3%	120.3%	118.0%	114.4%

Fill Rate Key for All Staff:	Less than 90% fill rate
	Greater than or equal to 120% fill rate

We have continued to face challenges with our registered fill rate, however, the expected impact on both the first and current increase in infection rates of COVID-19, has not unduly affected the overall fill rates. This is a fluid and everchanging presentation which requires a flexible and pragmatic approach, ensuring our focus is maintained.

6   ANALYSIS OF DATIX INCIDENTS RELATED TO STAFFING

<u>**Figure 12.**</u> **Datix Incidents recorded for staffing issue**
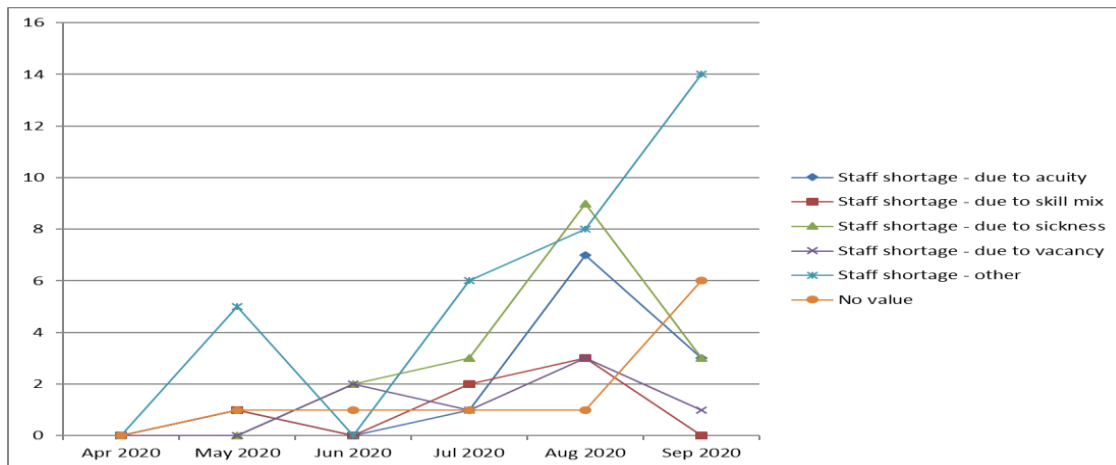

<u>**Figure 13.**</u> **Datix incidents where staffing listed as a contributory factor**
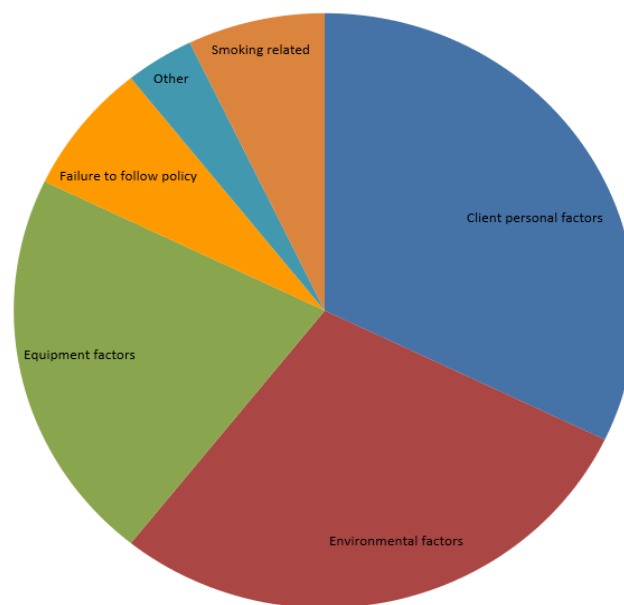
In the 6 months leading up to the 30th September 2020, there were 85 Datix incident reports highlighting staffing issues. This is a slight decrease from the previous report and a further reminder that Safecare should prompt a more realistic reporting of staffing incidents.

As we can see from figure 12, since June there has been a steady increase in the number of staff shortages due to acuity reports, however staff are suggesting this figure is much higher and we are encouraging reporting of incidents. This increase is largely due to a better understanding amongst staff of need to report following discussion at the safer staffing meetings.

We utilise Datix information to identify "hotspots" and work closely with the ward teams and managers to resolve any issues and ensure safety is maintained.

7 **RECRUITMENT AND RETENTION**

The Trust has continued a values-based centralised recruitment process for both registered and non-registered nursing staff within inpatient areas. Since September 2016 the Trust has held monthly assessment centers to recruit Band 5 nurses. These have allowed us to remain proactive with our band 5 vacancies, keeping them as low as possible. We are also engaging both community teams, Allied Health Professions and other professions. The Trust continues to focus on recruitment and retention as a key workforce objective and is now delivering on its second year of having a Recruitment & Retention Strategy in place. The Trust also has in place an R&R steering group whose purpose is to identify and implement key objectives for the next 12 months and gain sign off at Board level for agreement on several objectives and work streams. Due to COVID-19 however at this time the group is temporarily suspended.

7.1 Retention Strategy

Work ongoing and current status includes:

- Increased internal and external marketing of available roles across SWYPFT. The Trust is now fully utilising NHS Yorkshire jobs Facebook feed. All new posts entered on NHS Jobs are now uploaded to Trust Facebook feed and NHS Yorkshire jobs feed. All posts are boosted by the Recruitment Marketing Advisor on a daily basis to appropriate FB groups and LinkedIn networks. LinkedIn networking has increased by over 800% in the last months and the Trust now has a dedicated Linked in Recruitment account able to use wider engagement techniques. Increases in applications to senior clinical posts has been seen since this has improved, in particular clinical psychology and secure CAMHS roles. Where appropriate posts are also uploaded onto local and national University and FE colleges websites to encourage applications and interactions, especially to increase Trust awareness in the sector.

- Localised recruitment and retention task groups in place with actions plans for delivery in both Forensics and Secure CAMHS to meet staffing issues, particularly within Adel Beck and Wetherby YOI. This work is ongoing. The ward areas within Forensics currently see a large number of nurse vacancies (27 wte). Targeted recruitment fairs have been signed up to and earmarked to drive candidates to roles within forensics such as the British Forces Resettlement Services which occurs in November 2020 and April 2021.

- Implementation of a Trust onboarding & management portal system was agreed in September 2019. Procurement and tender exercises were completed, and implementation plans are now underway to deliver onboarding system into Trust by April 2021. This has been delayed due to the COVID pandemic this year, but design and implementation has now re-started.

- Development of career pathways in professions. Nursing, AHP and Psychology leads developing career structure pathways. Plan to develop more visual progress opportunity for staff both within intranet and at job application, job advert/NHS Jobs E.g. ACP developments.

- Trust recruitment fair attendance. The Trust committed to an extensive programme of events to market its job opportunities and vacancies which began in February following extensive work to ensure we were business ready (marketing, stand equipment, volunteer availability, transport and planning etc.). The programme of attendance has been severely hit by COVID-19 however with all physical events being cancelled or moved to a virtual platform. This includes 5 of the 7 Royal College of Nursing events across the UK and Ireland, 2 Health Sector Talent events in London and Dublin, dozens of JobsFair UK events across the UK and various localised events at all the neighbouring Universities and colleges. In total approximately 30 events have been affected in this time that SWYPFT were targeting. The Trust had physically attended 2 RCN events, 1 Health Sector Talent event and 1 Wakefield College collaborative event prior to the pandemic with good success from them on the whole.

The Trust has since virtually attended 2 further fairs; 1 RCN event and 1 Huddersfield University event. Attendance and ROI has been poor however, due to a new way of delivering these events digitally by event hosts, not due to a lack of SWYPFT preparedness or participation. Further events being assessed for ROI currently.

- Staff ending employment procedure to be re-designed via SurveyMonkey platform to allow for greater response rates and ease of use for staff. Current process antiquated and heavily narrative driven. Work ongoing

- A Trustwide 'internal' transfer window has been in place since January 2020 following initial marketing campaign with communications on the intranet and headlines to pique interest. This continues to increase in success. Approximately 20 internal moves have occurred since implementation which have all been staff who were considering or actively looking for work outside the Trust due to work-life balance issues. Approximately half of these have been nurses.

- Recruitment of TNA and nursing apprenticeships is a constant process across the Trust. 25 TNA vacancies across our re-modelled inpatient services have been completed and the Trust has implemented these roles into wards across Wakefield and Barnsley.

- Annual workforce planning workshops are being planned for January 2021. This will focus on identification of numbers for development roles in teams for wider workforce TNA's, nurse associates, ACP roles, physician associates, pharmacy support development and other potential expansion roles. Several new role opportunities are currently being assessed and scoped within the Trust following external funding support from HEE, NHE and NHSi to deliver on the NHS Long Term Plan and the Mental Health Investment Standard.

- Establishment of Workforce Strategy Group (Dec 2020). This will replace the Agency Project Group and will report to the Workforce & Remuneration Group. Chaired by 177 Director's of HR, OD and Estates. There will be 4 key strategy groups under this over WSG;

  - **Flexible Workforce Model**

    - Develop the flexibility of the core substantive workforce

    - Reduce agency spend including a focus on unregistered roles

    - Ensure an engaged Staff Bank of an optimal size

    - Promote the development of new roles and skill mix

    - Ensure that there is effective rostering

  - **Health and Wellbeing**

    - To ensure that the Trust effectively supports and promotes positive staff health and wellbeing

    - To develop an annual health and wellbeing plan linked to NHS Staff Survey and the Trust's health and wellbeing survey

    - To reduce sickness absence

    - Increase staff engagement

  - **Workforce Planning and Development**

    - To develop a strategic workforce plan which is aligned to the Trust's service and financial plans

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- ▪ To develop robust Recruitment and retention plan

- ▪ To reduce turnover

- **Leadership and Management Development**

    - ▪ To ensure that the Trust has a clear leadership and management development pathway

    - ▪ To positively promote and support diverse and representative leadership and management development

    - ▪ To enable staff to reach their potential through a talent management strategy and plan

- International Nurse Recruitment. As part of the NHS Long Term Plan NHS England have invited Trusts to put forward plans for international nurse recruitment over the next 12 months (Dec 20-Nov21). This will be partially supported financially by NHS England in its drive to increase nurses across the health sector nationally. Following consolation with neighbouring WY MH Trusts, SWYPFT have agreed to be lead partner with Leeds & York Foundation Trust and Bradford District Care Trust on a collaborative workforce plan to recruit a total of 70 mental health nurses. SWYPFT have committed to recruiting 40 of these 70; primarily from India and the Philippines over the next 14 months. The proposed bid for support funding is still awaiting ratification from NHS England and once agreed the three MH Trusts will work together on delivery with university support and placement support etc.

- Medical recruitment plan, including potential for relocation and onboarding support for all medics underway. This includes a revised and standardised relocation package currently being reviewed.

Ongoing and constant nurse recruitment within the Trust along with a greater presence in the social media advertising arena and recruitment fair attendance is now seeing improvements in our overall nurse staff in post position.

Nursing turnover (adjacent) continues to reduce. This has been affected due to COVID since March where overall recruitment movement has reduced across the health sector as a whole. Projected nurse turnover for 2020-21 is expected to be reduced to 10.2% by March 2021.

The graph below shows our nursing staff in post numbers for the past 18 months. We see that the trend has been steadily rising since a Trustwide low in August 2019. In the last 18 months the Trust has seen a 6.42% increase in nursing staff in post (FTE).
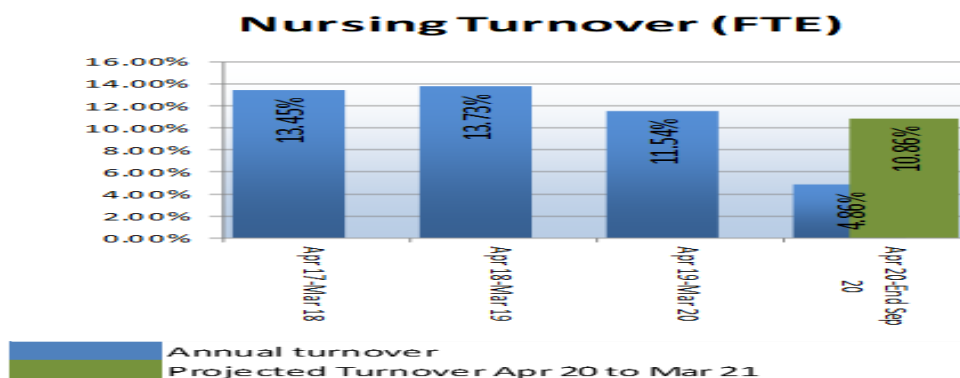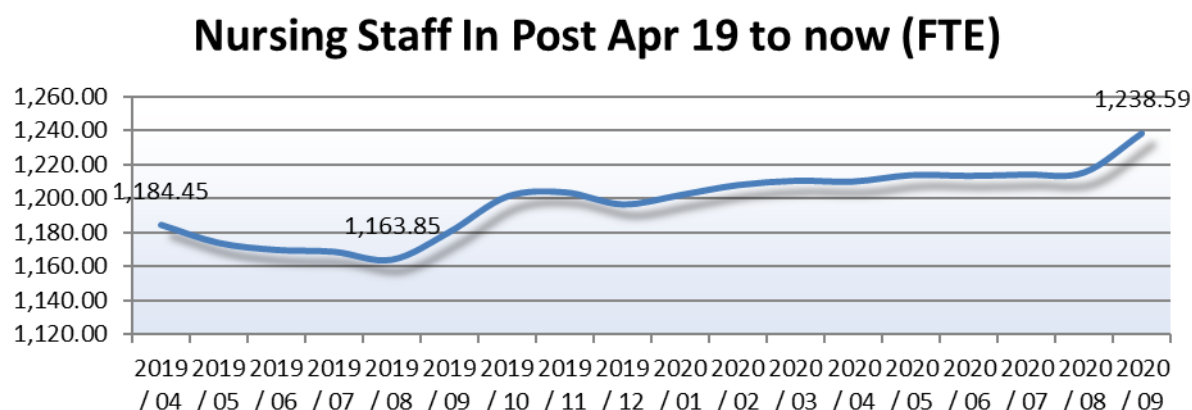
Figure 12.

Figure 13.

Nursing Staff In Post Apr 19 to now (FTE)

8   INPATIENT REGISTERED AND NON-REGISTERED BANK AND AGENCY

The Trust continues to engage with the National Performance Advisory Group for Safer Staffing.

As discussed earlier within the report, we are also engaging in work on collaborative banks. This is in line with our regional partners.

We have continued to concentrate the bank recruitment on Health Care Assistants and Registered staff with some success. We have also embarked on a programme of transition from bank to substantive posts or temporary contracts. This shows a slightly distorted picture as staff on temporary contracts are not counted in the staff only numbers.

We continue also to recruit all care professional students onto the bank following a shortened interview process as well as transitioning, after engaging them, more agency staff onto bank than previously.

This has resulted in a marked increase in active registrants and HCAs on the bank thus increasing our ability to react to staffing requirements.

Figure 14

Staffing on the bank September 2019, March 2020 and Sept 2020

Staff Group	Bank Only Sept 2019	Mar 2020	Sept 2020
Additional Clinical Services	284	289	365
Administrative and Clerical	99	93	86
Allied Health Professionals	43	33	23
Estates and Ancillary	10	10	5
Medical and Dental	66	47	69
Nursing and Midwifery Registered	151	172	135
Grand Total	**653**	**644**	**683**

During September 2020 bank and agency staff worked 636 RN shifts and 2723 HCA shifts on inpatient wards. This has a financial impact on the Trust's direction of travel regarding recruitment and budgetary planning.

Financial challenges remain in regard to both bank and agency spending. There is an understanding nationally that the flexible staffing workforce is an integral part of the modern workforce. However, the drive should remain to reduce the spending on these groups, agency in particular.

Figure 15.

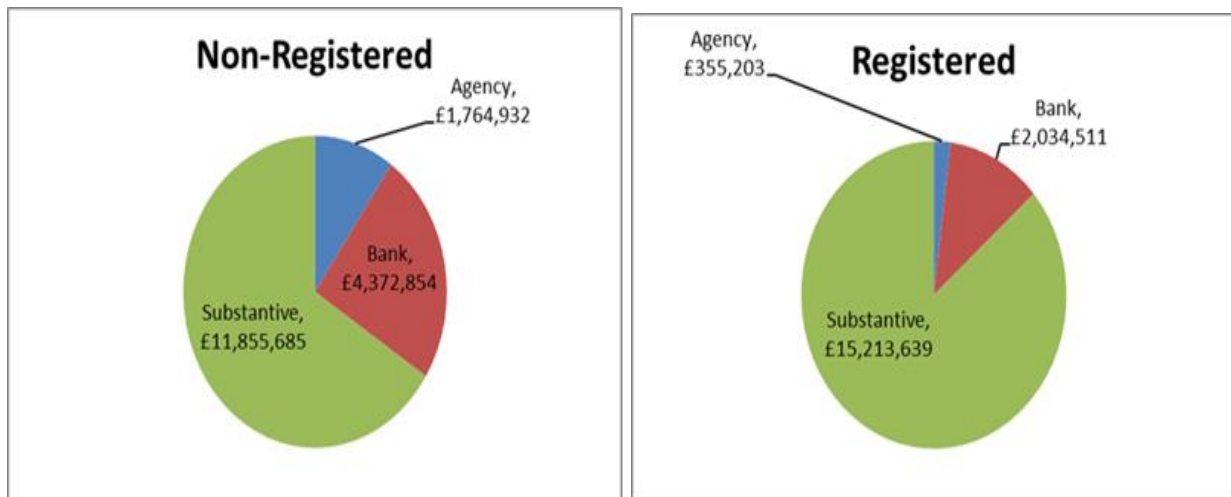**Figure 16.**
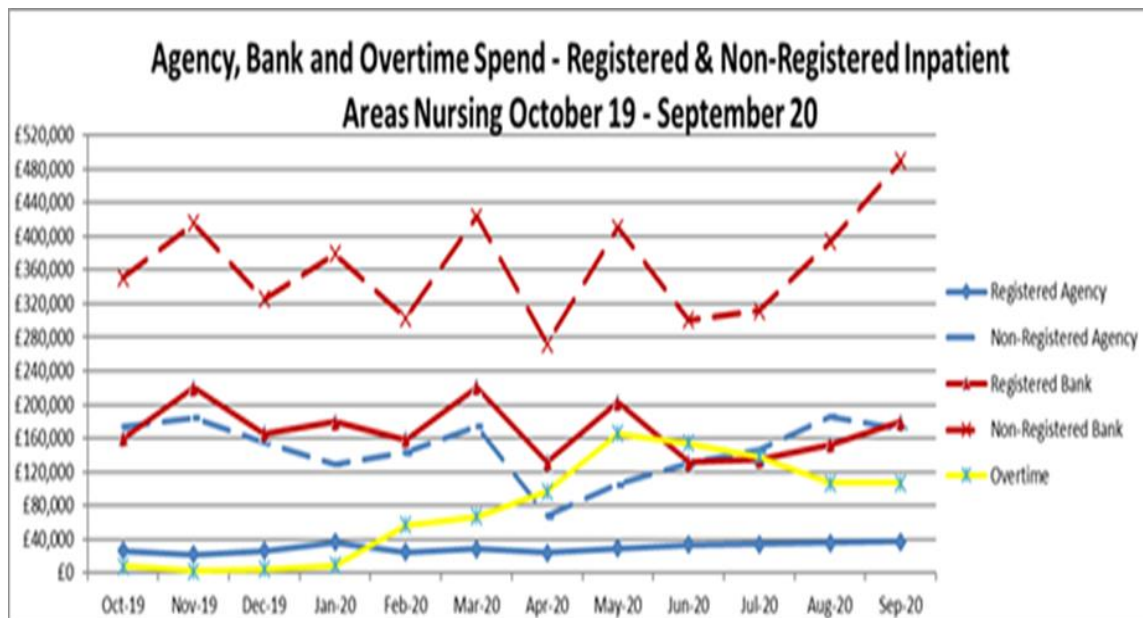
Figure 16 shows that agency spend for both registered nurses and non-registered staff has remained reasonable consistent over time although there has been some fluctuations between months.

Bank spend shows similar fluctuations but there has been a marked increase in these costs in September. This is partly due to a change in accounting periods for supplementary payroll as the

Trust migrates from Agresso to Oracle ledger systems (the supplementary payroll will fall in the month to which it relates).

In 19/20, overtime payments were incurred by Forensic services, these were typically £5k per month until Feb 20 when costs increased to typically £70k per month. Further to this, other areas are also started to incur overtime costs from April, total overtime costs are typically £106k per month.

Figure 17
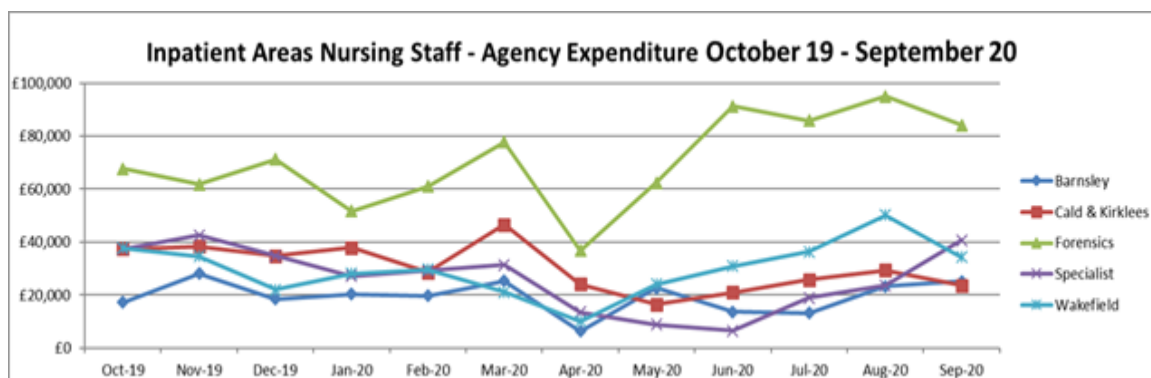
Figure 17 shows that agency spend on inpatient wards is highest in forensic services. All areas saw a reduction in agency use in April 20 (the first few weeks of lockdown) and although this has continued in Calderdale and Kirklees, other areas are using agency staff as they did prior in 19/20, the exception is forensic services where agency costs have increased by approx. £35k per month since June.

Figure 18.

Bank, Overtime and Agency use

Figure 18 illustrates that, despite the drive continuing to temporary staffing spend, we maintain the trend of reducing or stabilising agency whilst increasing the use of our own temporary workforce. This should increase quality through consistency and bank workers identifying themselves more with the organisation as stated often in the bank forums.

Figure 19.

Bank/Agency/Overtime Hours on Inpatient Wards by Year

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	25,920	25,472	30,487	31,797	32,523	30,471	28,919	28,333	26,678	31,834	30,313	30,789
2017-18	23,335	24,807	23,979	29,728	30,026	29,790	29,088	26,995	28,890	33,650	35,871	40,148
2018-19	32,629	35,137	33,772	35,835	36,357	35,551	34,177	35,376	34,865	36,273	33,533	42,642
2019-20	35,706	37,167	39,747	40,090	42,937	40,851	40,102	39,394	37,382	36,744	39,851	48,515
2020-21	39,617	38,522	37,936	39,369	43,647	44,151						

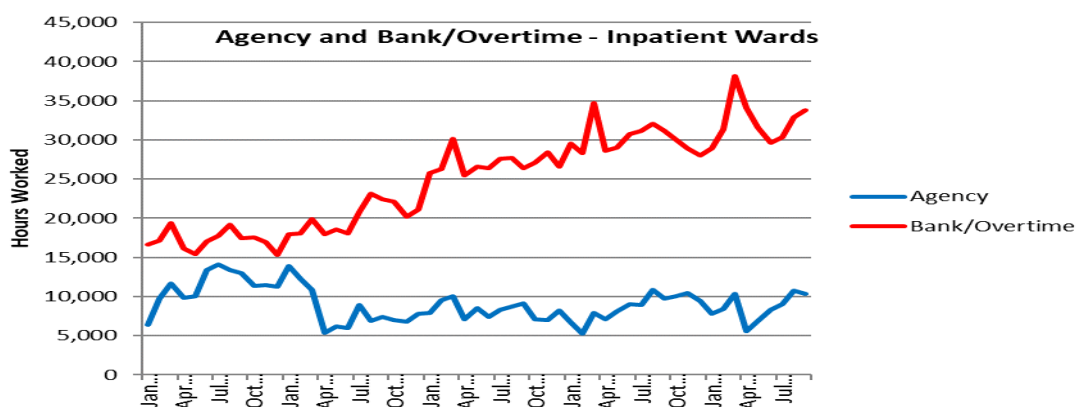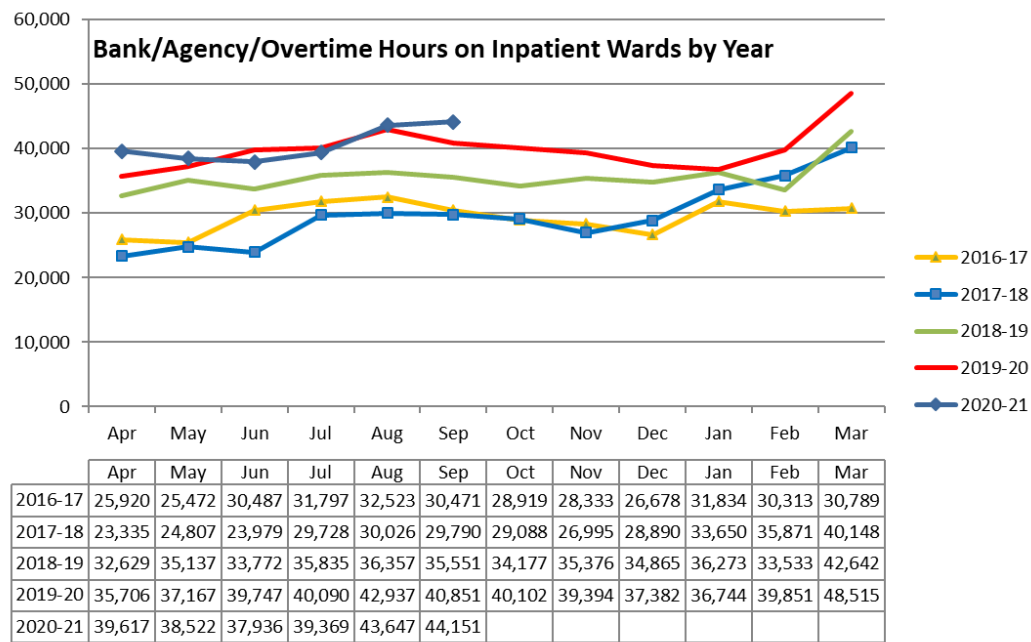Figure 19 gives a month on month yearly trend of spend on bank, agency and overtime. As   can be seen the comparison shows an upward trend the last 2 months. This is reflective of vacancies, acuity and losing the paid placements of the student nurses.

Below figure 20 shows the trend over the last 18 months. As the full effects of the pandemic struck, we saw a reduction in the deployment of our flexible staffing workforce. This was due to reasons already cited however we are now at the highest level of HCA hours, usually covering increased staffing due to acuity and sickness, on the bank than in the last 18 months.

Figure 20.

Agency and Bank/OT/Excess Hours - Inpatient Wards

	Mar (2019)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan (2020)	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Agency - HCA	6,177	5,826	6,882	7,700	7,769	9,638	8,686	9,138	9,563	8,418	6,949	7,515	9,401	4,598	5,973	7,161	7,756	9,533	9,088
Agency - RN	1,529	1,231	1,218	1,283	1,202	1,216	1,021	904	932	971	860	933	989	958	949	1,140	1,248	1,224	1,225
Bank/OT/Excess - HCA	25,039	21,604	21,386	22,865	23,262	25,043	23,853	22,331	20,996	21,414	20,846	22,711	28,110	24,749	23,162	21,651	23,037	24,887	26,166
Bank/OT/Excess - RN	8,696	7,045	7,682	7,898	7,858	7,040	7,291	7,729	7,902	6,578	8,089	8,693	10,016	9,312	8,438	7,985	7,328	8,002	7,671

22

Figure 21.

Inpatient Ward - Vacancies - 31 October 2020

BDU	Ward	HCA/TNA/NA	RN	Grand Total
Barnsley Total		10.37	7.00	17.38
C & K Total		15.86	28.88	44.74
Forensic Total		1.00	37.43	38.43
Specialist Total		14.99	0.07	15.06
Wakefield Total		2.64	10.97	13.61
Grand Total		44.87	84.35	129.22

These figures are taken from Health roster and contain band 5 new starters within the HCA numbers as they have not received their PIN numbers to date. At the end of November, we will have a more accurate picture and we have other new band 5 starters coming through up until February as well as band 2 starters throughout November.

Shortfalls due to vacancies are mitigated by measures to increase additional hours including, bank and over-time, agency staff and new initiatives introduced as part of response to COVID-19 including return to practice, retire and return and voluntary postponement of annual leave.

9   SAFER STAFFING IN THE COMMUNITY

We continue to assess when it would be practicable to deploy the staffing measurement tool within our community teams. The project was postponed due to the COVID-19 outbreak from April until October. With the upcoming upgrade of the health roster, and subsequent migration of community teams onto the electronic roster, this will make the deployment of this measurement tool easier. We will be utilising the recent caseload benchmarking data and will be looking to roll this out at the end of February following the community teams going onto the health roster.

We will, in the meantime, continue to:

- Offer support where staffing shortages have been identified.
- recruit bank specialists to support the services
- Support the AHP tender process to help secure a broader resource for the community teams

10   COVID-19 RESPONSE

As we are all aware the health system is being severely challenged with the outbreak of the COVID-19 virus. This has impacted greatly on several of the interventions that Safer Staffing have had planned for this year.

Figure 22 below shows the extent of absenteeism due to staff isolation arising from symptoms (7 days), household symptoms (14 days) and shielding (12 weeks).

At present 148 staff are either absent or working from home due to COVID-19.
This is a 62.6% increase from last week (91), 80 of these are absent and 68 working from home.

The 2278 absences recorded since 16th March is made up of 1772 individuals, with 368 people having 2 or more periods of absence.
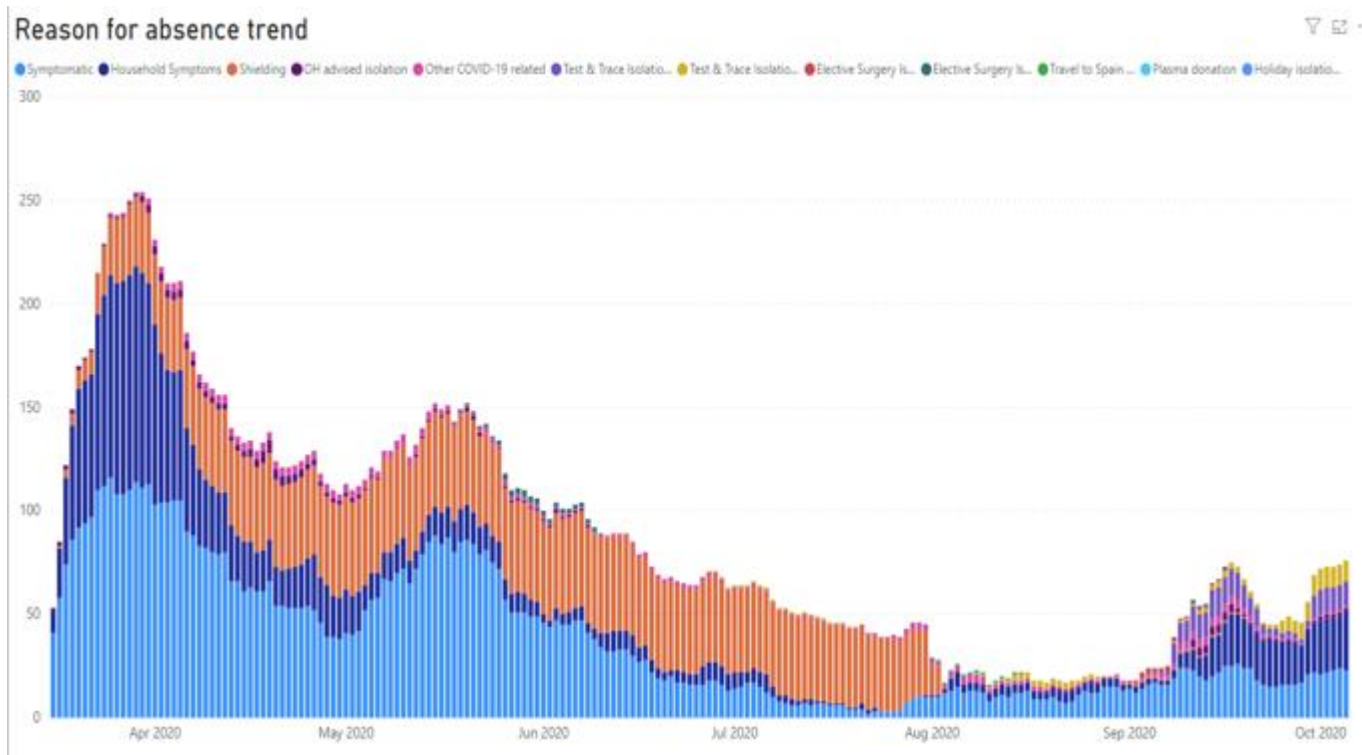
There are many different examples of multiple periods of absence, eg where someone was off because of household symptoms, then became symptomatic themselves.

Since 07/09/20, the number of people absent due to COVID-19 has been increasing by an average of 27 per week

We continue to work with both inpatient and community teams to identify hotspots that require priority support as well as informing the flexible staffing resources of all relevant information. We are also engaging with further agencies as the increase in demand is increasing.

We are encouraging bank staff to work in one area rather than multiple to reduce the risk of cross infection. This is proving challenging as staff have always moved around the trust and perhaps a uniformed approach has to be considered.

Figure 22   Absenteeism due to staff isolating or shielding

Reason for absence trend

Reason for absence trend

Staff Absence by BDU

BDU ● Adult ADHD/ASD ● Barnsley ● Barnsley General Ops ● Calderdale and Kirklees ● CAMHS ● Forensic ● LD ● Support Services ● Trust Bank/Pastoral Care ● Wakefield

Staff Absence by BDU

BDU
- ● Adult ADHD/ASD
- ● Barnsley
- ● Barnsley General Ops
- ● Calderdale and Kirklees
- ● CAMHS
- ● Forensic
- ● LD
- ● Support Services
- ● Trust Bank/Pastoral Care
- ● Wakefield
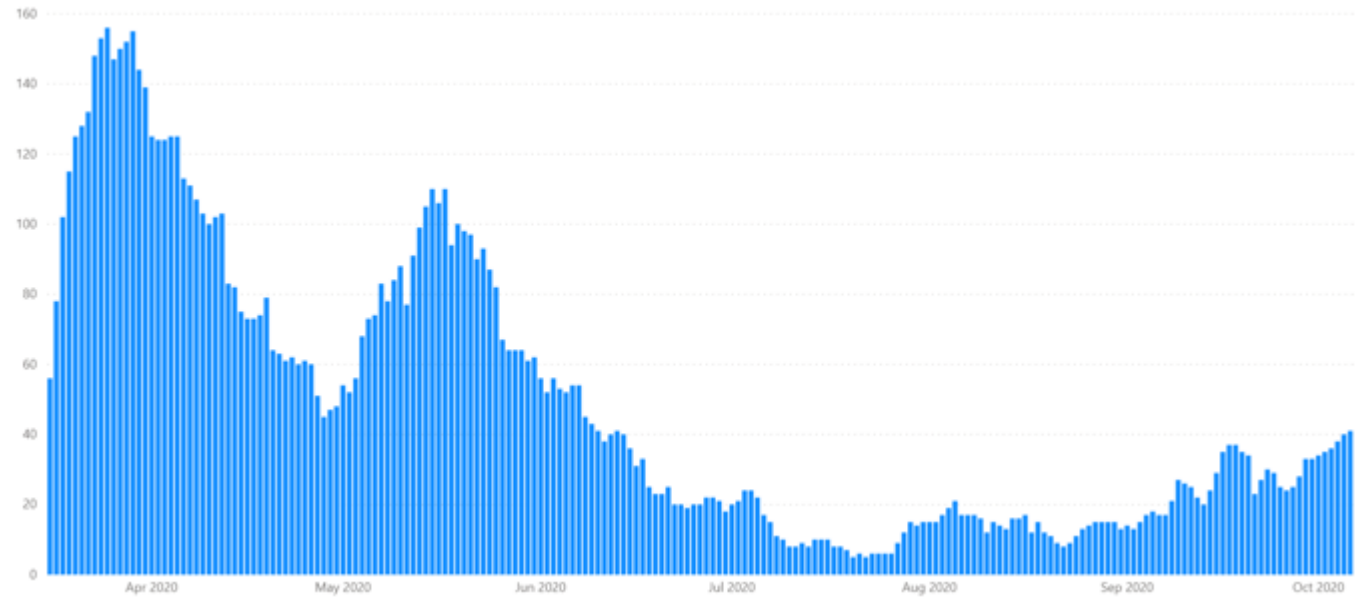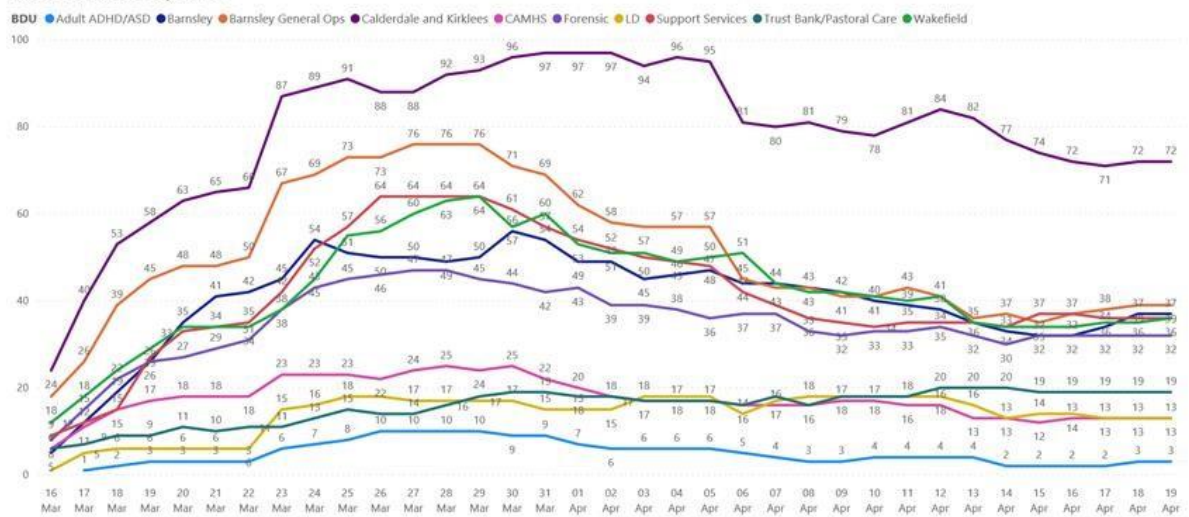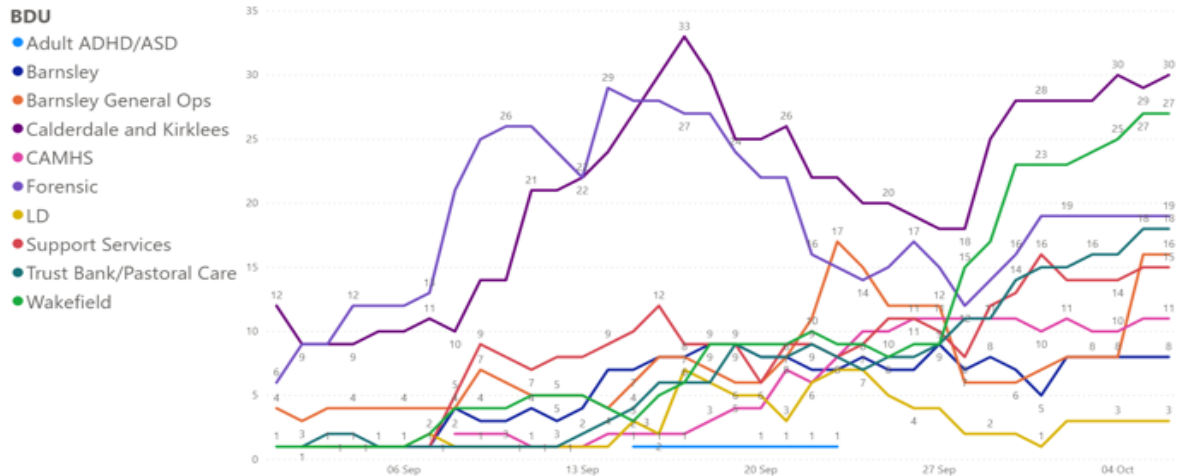
In summary, we have

- Tested our business continuity and escalation plans (see Appendix 2)
- Participated in discussions about ways forward in groups at all levels.
- Participated fully in the trust command structures.
- Accelerated recruitment onto the staff bank.
- Supported return to practice for registered staff.
- Accelerated recruitment onto staff bank.
- Supported the development of induction plans for new starters.
- Supported the development of induction and updating of skills for non-clinical registrants.
- Sourced specialist skills as they were requested.
- Ensured that bank and agency staff remain informed and engaged in supporting our teams.
- Fast tracked bank contracts for permanent staff.
- Continue to offer specialist advice for staffing issues.
- Supported hotspot areas when staffing has become an issue due to cancellations.

We are involved in the outbreak meetings and offer support to the teams involved.

11 SUMMARY

There is a continued and sustained focus on the safer staffing agenda nationally, regionally and locally. This is despite the added pressures from the COVID pandemic and the oncoming winter pressures. SWYPFT have maintained a level of recruitment that have shielded us from a lot of the issues of other Trust's similar in size. However, more needs to be done. As stated above we are looking at increasing the bank resources, have completed the master vendor processes, are looking at international recruitment and bespoke recruitment campaigns.

Despite all the above, we continue to experience challenges in staffing inpatient registered posts, therefore, we must ensure that we retain a flexible and adaptable approach. One initiative is the introduction of safety huddles in WAA inpatient areas by the Matrons, in line with one of the objectives of the Nursing Strategy. Workforce planning, which is due to restart in November, and other interventions continue to support the safer staffing agenda. The roll out of SafeCare, in addition to community teams being included on the health roster, must remain a priority to ensure we have a contemporary, up-to date picture of staffing resources and acuity across the Trust.

The numbers of registered nurses and HCAs on the staff bank continue to increase and we are looking at targeted recruitment to increase the active resources within other disciplines. The incorporation of our flexible workforce into workforce planning is a positive, and necessary step, however we are looking to complete our bank staff survey to understand the migration of a large group of staff from substantive to bank posts. The flexibility that bank offers could be reflected in annualised hours or peripatetic working and will be explored following the results of the survey.

We are looking at the next stage is ensuring regular establishment reviews for all inpatient areas, as recommended nationally, are carried out in a safe and productive manner utilising the MHOST.

Recruitment and retention plans remain in progress with more initiatives planned for the remainder of 2020/21.

As a recruiter, the Trust must continue to show flexibility, innovation and adaptability in today's recruitment market.

12   NEXT STEPS

We will continue:

- To build upon and improve data in exception reports including;
    • Triangulation of DATIX, exception reporting and HR information
    • Extend the narrative and analysis of the information
    • Weekly roster analysis including unfilled shifts, acuity and bed occupancy
    • Understanding any significant increase in staffing fill rates

- Continue to provide effective and efficient support to meet establishment templates
- Continue to work within areas of high acuity where there is pressure on meeting staffing numbers
- Continue to support the development of the NHSI led acuity tool within community teams
- Continue to develop, manage and deploy the peripatetic workforce
- Continue with the Safer Staffing Group, and monitor the action plan and new initiatives
- Build on work with Quality Leads to review Safer Staffing in the community and improve understanding and monitoring of direct care contact time
- Continue recruitment onto staff bank
- Aligning Safer Staffing initiatives with Workforce Strategy
- Making effective use of the awarded agency master vendor contract for both Nursing and AHPs

New plans for Quarters 3 and 4 2020/21 include:

- Prioritise staffing in response to COVID-19 challenges
- Ensure that community staff teams are brought onto health roster in line with the rest of the trust, utilising the awarded funding for this project. (End of Jan 2021)
- Develop the proposal for a Preceptorship Academy to support the retention of newly qualified staff. (March 2021)
- Relaunch the pilot implementation of staffing judgement tool within community teams
- Finalise the Forensic BDUs establishment and skill mix review (End of November 2020)
- Embed the MHOST within our inpatient wide establishment review (March 2021)
- Participate and support the collaborative bank project
- Ensure establishment of SLAs with our neighbouring acute trust banks to provide reciprocal specialist support (Dec 2020)
- Continue with the Staff Bank forums to better understand why staff remain on the bank.
- 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 (Jan 2020)
- 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

13 APPENDICES

Appendix 1 FILL RATES: Actual and Planned Staffing Hours, September 2020

Ward Name	Area	Day		Night		Average Fill Rate - All Staff (%)	Care Hours Per Patient Day (CHPPD)			
							Trust		Regional Average	
		Average fill rate - Registered Nurses (%)	Average fill rate - Health Care Assistants (%)	Average fill rate - Registered Nurses (%)	Average fill rate - Health Care Assistants (%)		Registered Nurses	HCA	Registered Nurses	HCA
Beamshaw	Barnsley	103.2%	97.0%	98.3%	104.0%	100.6%	3.0	4.4	3.6	5.8
Clark	Barnsley	80.2%	128.6%	94.0%	135.8%	113.1%	3.3	7.0	3.6	5.8
Melton Suite PICU	Barnsley	89.6%	137.4%	86.7%	154.4%	122.5%	6.7	16.2	5.7	16.8
Neuro Rehab Unit	Barnsley	102.3%	126.9%	106.8%	268.8%	124.4%	6.4	8.0	3.4	5.3
Stroke Rehab Unit	Barnsley	92.2%	115.2%	93.5%	100.0%	103.9%	13.0	21.9	3.4	5.3
Willow Ward	Barnsley	70.5%	120.3%	93.3%	121.3%	101.8%	4.6	9.0	3.6	5.8
Ashdale	C & K	88.0%	98.9%	80.0%	123.4%	99.0%	2.4	4.5	3.6	5.8
Beechdale	C & K	70.7%	209.4%	100.0%	168.3%	131.7%	2.3	5.4	2.9	7.9
Elmdale	C & K	94.4%	94.7%	91.7%	109.9%	97.7%	2.3	3.7	3.6	5.8
Enfield Down	C & K	83.5%	109.0%	98.3%	101.1%	98.2%	3.3	4.9	3.6	5.8
Lyndhurst	C & K	88.5%	105.6%	101.9%	99.9%	98.8%	4.5	7.1	3.6	5.8
Ward 18	C & K	77.5%	124.7%	111.7%	103.4%	105.8%	2.5	5.3	3.6	5.8
Ward 19 - Female	C & K	65.4%	143.5%	120.4%	104.7%	101.1%	2.8	4.2	2.9	7.9
Ward 19 - Male	C & K	51.0%	175.9%	100.0%	105.0%	101.3%	3.3	7.2	2.9	7.9
Appleton	Forensic	55.9%	114.4%	118.4%	86.9%	87.3%	4.6	6.9	3.5	7.5
Bronte	Forensic	57.6%	206.2%	66.6%	178.2%	122.4%	4.9	13.2	3.5	7.5
Chippendale	Forensic	51.7%	133.0%	103.5%	102.0%	93.2%	2.6	5.1	3.5	7.5
Hepworth	Forensic	61.5%	151.1%	73.4%	135.0%	103.4%	3.0	6.0	3.5	7.5
Gaskell	Forensic	67.5%	226.0%	89.8%	282.5%	156.7%	3.4	9.9	3.5	7.5
Newhaven	Forensic	66.2%	100.0%	80.0%	110.0%	90.2%	3.0	5.7	3.5	7.5
Priestley	Forensic	62.6%	113.7%	116.9%	84.8%	89.0%	2.1	3.0	3.5	7.5
Ryburn	Forensic	102.2%	99.4%	97.3%	104.4%	100.8%	3.4	3.5	3.5	7.5
Sandal	Forensic	70.7%	141.0%	75.2%	182.9%	128.4%	2.5	10.1	3.5	7.5
Thornhill	Forensic	67.0%	125.1%	85.1%	153.9%	107.9%	2.7	5.7	3.5	7.5
Waterton	Forensic	59.2%	153.9%	110.0%	143.3%	112.8%	2.5	5.5	3.5	7.5
Crofton	Wakefield	78.1%	182.7%	102.2%	109.6%	116.9%	3.3	7.8	2.9	7.9
Horizon	Wakefield	122.6%	185.6%	100.0%	144.5%	152.2%	8.2	40.1	6.5	20.3
Nostell	Wakefield	85.4%	135.6%	93.3%	160.8%	122.3%	2.4	5.6	3.6	5.8
Poplars	Wakefield	60.3%	211.7%	100.6%	210.0%	153.7%	3.9	16.4	2.9	7.9
Stanley	Wakefield	108.7%	152.1%	90.0%	175.9%	135.7%	3.0	6.0	3.6	5.8
Walton PICU	Wakefield	92.8%	152.5%	101.8%	162.4%	134.8%	6.4	18.0	5.7	16.8
All Wards		77.7%	138.0%	93.6%	137.6%	114.4%				

Fill Rate Key for RNs and All Staff:	RNs - Less than 80% fill rate; All staff - Less than 90% fill rate
	Greater than or equal to 120% fill rate

CHPPD Key:	Within 10% of regional average
	More than 10% above regional average
	More than 10% below regional average

Appendix 2   Escalation and Continuity Plan for Unity Centre – November 2020

Stages	Who does this involve	Detail of step	Names	Responsibility
Across the wards	**Stanley, Nostell, Poplars, Crofton, Walton**	**Check excess staff including office days.**	**Ward staff**	**Ward Manager/Matrons/On call manager/ Senior Nurse**
Additional hours to existing staff	**Ward and Unit staff**	**Offer alternative days off etc. to staff.**	**Ward staff**	**Ward Manager/ On call Manager/Matrons**
Bank Staff	**SWYT bank office**	**Send through health roster.**	**Bank staff**	**Ward Manager/Nurse in Charge/On call manager/ Matrons**
Overtime offered	**Trust Staff**	**Overtime is available to cover vacant shifts.**	**Substantive staff**	**Matrons/ General Manager**
Agency Staff	**SWYT bank office/ out of hours direct to agency**	**Send through health roster/ call direct.**	**Agency Staff**	**Ward Manager/ on call manager/ Matrons**
Review seconded staff	**Ward Staff**	**Review all staff secondments.**	**Ward Staff**	**Matrons/ General Manager**
Review staff on sick (incl. long term) regarding temporary alternative duties to support services and return to work.	**Staff on Sick**	**Review alternative duties for appropriate staff currently off sick.**	**Substantive staff**	**Ward Managers & Matrons/ General Manager**

Review alternative roles for staff who are working from home due to being classed as extremely clinically vulnerable due to COVID-19 or other pandemics	Staff judged to be clinically extremely vulnerable	Review of staff in this group to redeploy into appropriate alternative roles.	Substantive staff Bank Staff	Ward Managers & Matrons/ General Manager/ Safer Staffing lead
Review staff leave and offer carry forward to next year if necessary	Ward Staff	Look at flexibility within planned annual leave.	Substantive staff	General Manager
Check registered nursing staff availability from other services	Psychiatric liaison team, CMHT, IHBT, EIS. On Wakefield site: Forensic services via Newton Lodge and Horizon Centre. Across the Trust: Barnsley then C&K.	Assess whether other areas can support the inpatients safely. Ensure that staff have the correct skill set and adjust interventions accordingly.	Staff who have the appropriate training and knowledge. All registrants.	General Manager for AWA General Manager for Community teams. Deputy Director
Identify non-clinical registered nursing staff (e.g. managers, PGC, nurse consultants) who can cover shifts or parts of shifts or carry out tasks within their capabilities i.e. audits, supervision	Within BDU. Across the Trust: Nursing and Professions Directorate, L&D, EMT.	Access support from non-clinically based registrants	Can be provided by Safer Staffing Office or Workforce Information	General Manager

Temporarily Redeploy community/non-ward clinical staff from within BDU on secondment	**Any Professional registrant who is on an external secondment**	**Review all secondments external to the BDU and evaluate whether they can be temporarily stopped.**	**General Managers** **Workforce Information**	**General Manager** **Deputy Director**
Temporarily Redeploy registered nursing staff from other areas on secondment	**Any Professional registrant who is on an external secondment**	**Review all secondments external to the BDU and evaluate whether they can be temporarily stopped.**	**General Managers** **Workforce Information**	**General Manager** **Deputy Director**

Appendix 3

Trust Board Safer Staffing Checklist

1. Do Boards fully understand the specific characteristics of Mental Health that will have an impact on the approach to capacity and capability? Do they have a clear vision and values around quality and safety and how it is defined differently in a Mental Health setting?
   Board receives regular presentations on staffing (e.g. IPR reports, regular assurance visits from Board members to the wards/departments in order to learn about and understand the services better (e.g. Quality and Exec Trio visits).

2. Are their processes for escalating issues identified by staff, patients or relatives or responsive to the quickly changing acuity and unpredictability of Mental Health services? *Acuity is regularly and routinely monitored on wards including need for 1:1 observations. On call arrangements mean staffing issues can be escalated quickly and senior managerial support sought. Staffing issues are captured via Datix system and regular reporting to safer staffing group.*

3. Is there a clear methodology for the planning and deployment of staffing that is firmly rooted in an evidence based approach? How can the calculator tools be best deployed in delivering this?
   Originally the Trust has developed a bespoke decision support tool which was utilised to decide on the original staffing templates. We have moved to utilising the most up to date evidence tool available which has been utilised in staff reviews to date and will be for the trust wide inpatient establishment review. E-rostering extrapolates where fill rates fall below optimum levels and managers are asked for exception reports on why, mitigation and actions to prevent recurrence.

4. What practical steps are being taken to develop sound skills in professional judgement because of the less predictable nature of Mental Health services?
   Managers are empowered to use a range of interventions (e.g. use of bank/agency etc.) to ensure safer staffing where unexpected demand is encountered. Widespread roll out of dashboards and benchmarking across the organisation continues to improve data fields available to support professional judgement. Specialist Advisor for safer staffing is available to offer advice and support as required.

5. How are the needs of Mental Health service users incorporated in staffing?
   Services are planned and designed in consultation with service users and carers. Transformation of care pathways ensures that they are contemporary and relevant.

6. What evidence is there that a multi-professional approach to staffing is being deployed across the organisations? How is the need to spend time simply engaging with and talking to the patients built into workload calculation?
   Service user and carer engagement and satisfaction tools assure us that service users and carers are largely satisfied with the care and treatment they receive. Where this is not the case, services and customer services respond promptly to try and resolve the issue as quickly as possible.

7. As well as staffing measures outlined by the NQB are there measures of improvement or performance that reflect some of the unique characteristics of Mental Health services and specific clinical drivers?
   Complex benchmarking and performance data is widely available throughout the organisation and drills down to team level. Clinical metrics in relation to incidents such as violence and aggression are also available and reviewed regularly.

8. How this ward staffing information might be presented differently within a Mental Health setting where the ward based team is not the only important resource available? *Monthly reporting on Trust website and safer staffing exception report shared with all services monthly and summary information provided in IPR*

9. How are the challenges of filling specific Mental Health roles handled? E.g. recruitment training etc.?
    We have very good relationships with providers of undergraduate education and have recently invested in improvements to the Practice Placement Quality Team to ensure we remain the local employer of choice. We attend national recruitment events and are lead provider in a regional collaboration looking at international recruitment. Training Needs are reviewed across the organisation each year and training programmes commissioned to support. Supervision and appraisal also support identification of training/learning needs.

10. How is the commissioner kept informed about best practice in Mental Health such that informed commissioning decisions are made?
    Local CCG Quality Boards receive updates on how the organisation is performing in relation to safer staffing.

Trust Board 1 December 2020
Agenda item 11.3

Title:	**Sustainability Strategy Update**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper updates the Board on the next steps for the development of its sustainability strategy (Green Plan) for 2021-2026.
Mission/values:	The Sustainable Strategy is a mechanism for the Trust to take a coordinated, strategic and action-orientated approach to being a good corporate citizen with strong social values.
Any background papers/ previously considered by:	Sustainability Strategy 2015-2020 and environmental reporting within the Annual Reports. The production of a Sustainability Strategy pre-covid was a mandated requirement under the NHS standard contract and a Board approved plan is considered a good measure of a well led organisation by NHSI and NHSE.
Executive summary:	This paper is designed to provide the Board with an update on the timetable and framework for the development of a sustainability strategy for 2021-2025.
	Originally it was planned that the Trust would develop and agree a Sustainable Development Management Plan for 2020-2025 in line with national requirements. However, this was paused due to the pandemic. The impact of the coronavirus on the whole world has served to highlight the importance of climate change on health inequalities and brought the sustainability/green agenda into sharper focus.
	The Trust remains fully committed to the development of its sustainability agenda through an ambitious Green Plan. The Green Plan which replaces the Sustainable Strategy will align the Trust with the ambitions of the wider systems as well as reflecting its responsibility as an organisation who aims to enable people to live well in their communities. The Green Plan will also aim to make a significant economic contribution both as an employer and as a purchaser.
	In order to continue to progress this key agenda whilst dealing with significant service pressures, the Trust has appointed WRM to support the development of the Green Plan. WRM is a Yorkshire-based specialist sustainability consultancy with a technical team of environmental management and sustainability

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	professionals who provide strategic and operational advice and support across a range of industrial and service-based sectors including considerable experience within the NHS. The timetable to produce the Green Plan is proposed as follows: 1st December 2020: Update to Board 15th December 2020: WRM presentation to Strategic Board 23rd February 2021: Draft Green Plan to Strategic Board 30th March 2021: Green Plan formal sign off by Board This paper also includes an update on the Trust's Carbon Footprint for 2019-20. **Risk Appetite** The adoption of a sustainability strategy is in line with the risk strategy adopted by the Trust and its ambition in regard to the sustainability agenda.
Recommendation:	**The Trust Board is asked to NOTE and COMMENT on the content of the update.**
Private session:	Not applicable

Trust Board 1 December 2020

Sustainability Strategy Update and Trust Carbon Footprint 2019 -20

Introduction

The development of the 2020 – 2025 Sustainable Development Management Plan was put on hold as a global health emergency was declared in January and the rest of the year has been dominated by the COVID-19 virus. However, there is a recognition that climate change and the inequalities which exist in society are themselves a health emergency which if unabated will impact on our and future generations health and how we lead our lives.

The Trust is committed to continue the development of its sustainability agenda in the form of an ambitious Green Plan. The Green Plan which replaces the Sustainable Development Management Plan (SDMP) will align the Trust with the ambitions of the wider systems of which it is a core partner as well as reflecting its responsibility as an anchor organisation across the local communities from which it deliver services and makes a significant economic contribution both as an employer and as a purchaser.

This update provides a framework for the production of the delayed strategy (Green Plan) including the use of external consultants and also reports the Trust's Carbon Footprint for 2019-20.

The Green Plan

The Trust approved the Sustainability Strategy 2015-2020 in June 2015 which provided a framework and vision as to how the Trust would integrate sustainability into its operations and its engagement with staff, service users and the communities we serve. There has been significant achievement since 2015 especially in relation to the reduction of carbon emissions, elimination of waste to landfill and development of partnerships and networks including Creative Minds and our volunteers.

A draft SDMP was prepared for review at the start of the year to replace the strategy however the management of COVID-19 pressures shifted the emphasis and focus of the Trust and this work was subsequently delayed. Owing to the resources required to recommence and deliver the Trust's SDMP at a time when focus is still concentrated on COVID-19 management and recovery, external consultants WRM have been appointed to lead on the work. WRM is a Yorkshire-based specialist sustainability consultancy with a technical team of environmental management and sustainability professionals who provide strategic and operational advice and support across a range of industrial and service-based sectors including considerable experience within the NHS.

The SDMP which is now known as a Green Plan following the publication of 'For a Greener NHS' in January 2020 is a mandated requirement for the Trust and alongside the Climate Change Act (2008) and 'Delivering a Net Zero NHS' will shape how the NHS delivers its services and manages its resources.

The Green Plan will identify proposed interventions and suggested savings (both carbon and financial). The list will be broken down into modules aligned to the NHS Sustainable Development Unit (SDU) Sustainable Development Assessment Tool (SDAT). These 10 key areas are:

• Corporate Approach
• Asset Management and Utilities
• Travel and Logistics
• Adaptation
• Capital Projects
• Green Space and Biodiversity
• Sustainable Care Models
• Our People
• Sustainable Use of Resources
• Carbon and Greenhouse Gases

The SDAT ensures the Trust's actions are linked to, and measured against, the United Nations Sustainable Development Goals. The goals recognise that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality and spur economic growth whilst tackling climate change and working to preserve our natural resources.

The timetable to produce the Green Plan is proposed as follows –

1st December 2020:   Update to Board
15th December 2020:   WRM presentation to Strategic Board
23rd February 2021:   Draft Green Plan to Strategic Board
30th March 2021:   Green Plan formal sign off by Board

Meetings with various heads of department (including staff side) will take place week commencing 30th November to discuss sustainability in the context of each department with a view to assigning responsibility for individual sections of the Green Plan to different areas of the Trust. The intention is that the Green Plan becomes an organisational priority instead of purely Estates and Facilities.

Carbon Footprint 2019 -20

The Government has committed the UK to cut greenhouse gas emissions to virtually zero by 2050 (Climate Change Act 2008). There is a growing view that in order to prevent irreversible damage to the planet this date needs to be more ambitious which has led the NHS to commit to being carbon net zero by 2040 for emissions it has direct control over (utilities, waste, Trust fleet and leased vehicles) and 2045 for those it has indirect control / influence over. Further to this there is a target of an

80% reduction in direct emissions between 2028 – 2032. A number of organisations have set themselves an even more ambitious target of 2030 including Wakefield Council.

The Trust's carbon footprint for 2019-20 is detailed in appendix 1. As shown the figure of 5,832 tonnes CO_2e continues the trend of a declining carbon footprint and is a reduction of 45% on the baseline of 2011-12. When considering that the NHS targets are based on a 1990 baseline this is a significant achievement which exceeds the Climate change Act target of 34% by 2020.

However, it should be recognised that the Trust has significantly reduced its estate during this period and where replacement buildings have been developed these are much more efficient. In addition, we are seeing benefits in our emissions from cleaner energy with a greater proportion of renewables feeding into the national grid as can be seen in the table below.

Source	CO_2e	Consumption
Electricity	-62%	-24%
Gas	-28%	-20%
Water	-22%	-22%

The period of estate rationalisation has largely passed and therefore the challenge going forward is to maintain the reductions from a stable estate which will involve proactive management, behaviour changes and investment in green infrastructure.

The Trust has committed funds to Green Initiatives within its minor capital plan for 2020-21 (with proposed commitments for 2021-22 subject to approval) and is working on solar panel schemes at Laura Mitchell and Baghill House as well as EV charging points for Fieldhead and Kendray Hospitals and continuing the installation of LED lighting Trust wide. In addition, it is to submit a bid for SALIX funding for decarbonisation projects.
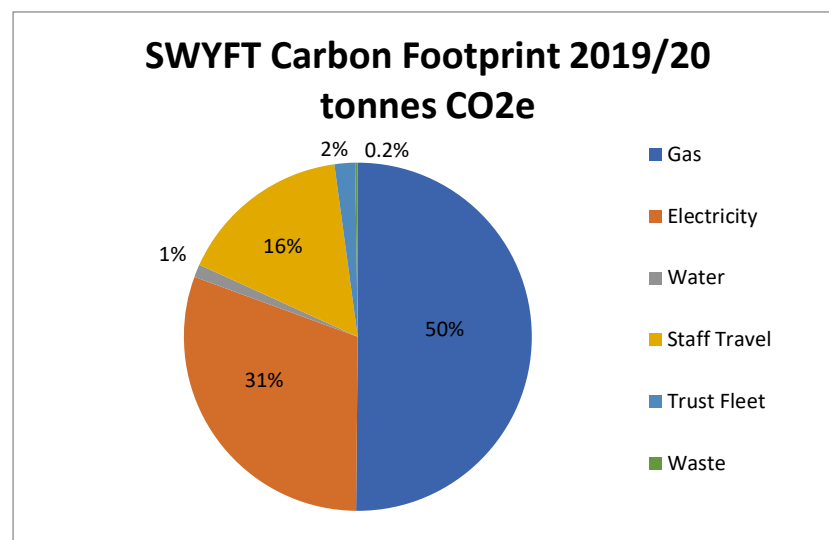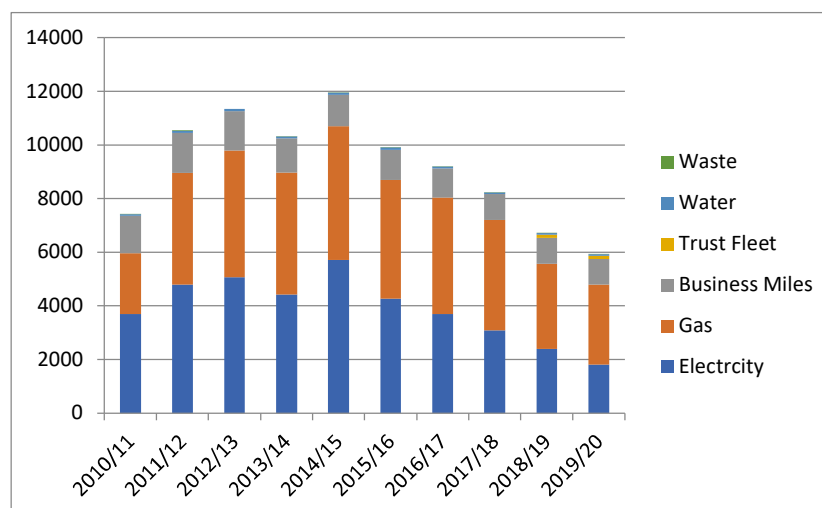
Recommendation

Trust Board is recommended to

1. Support the revised process and timescale for delivering a Green Plan
2. Note the Trust's 2019-20 Carbon Footprint results

TRUST CARBON FOOTPRINT 2019 -2020 (Tonnes of CO$_2$e)

Source	2010/11	Baseline 2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Electricity	3,693	**4,793**	5,067	4,416	5,710	4,270	3,697	3,083	2,396	1,809
Gas	2,267	**4,157**	4,733	4,549	4,992	4,418	4,344	4,115	3,171	2,983
Business Miles	1404	**1496**	1460	1274	1167	1127	1086	970	967	956
Trust Fleet		**n/a**	n/a	n/a	n/a	n/a	n/a	n/a	114	114*
Water	47	**90**	78	77	90	97	71	62	69	70
Waste	18	**20**	12	17	12	18	15	15	11	14
Total	7,428	**10,556**	11,350	10,333	11,971	9,930	9,212	8,245	6,727	5,832
% Change		**0%**	8%	-2%	13%	-6%	-13%	-22%	-36%	-45%

* Data not currently available so prev year used

SWYFT Carbon Footprint 2019/20 tonnes CO2e

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 1 December 2020
Agenda item 12 – Assurance from Trust Board Committees & Members' Council

Clinical Governance & Clinical Safety Committee

Date	10 November 2020
Presented by	Charlotte Dyson, Deputy Chair (Chair of Committee)
Key items to raise at Trust Board	Improvements • Quality Monitoring Visits – New proposal agreed. • Patient Safety Strategy – Progress and Next steps noted. • Learning Journey Report – Reports received and many examples of learning from incidents across the Trust noted. Focus on Outcomes going forward. Clinical Risks • Clinical Risks – Covid-19 focus on patient safety / delivery of clinical services / testing /outbreak management / Staff wellbeing. In depth discussion on Barnsley Community Services and supporting staff in Barnsley. • Clinical Supervision – Discussed issues in Barnsley Community and how these could be addressed. Assurance • Safer Staffing Report – additions to report requested around CHPPD and ward cross cover assurance, to be discussed at CGCS. • Ligature Report – Discussed and significant next steps noted. • Serious Incidents Report Q2 – Report received discussed SI's; themes; assurance. • Infection Prevention & Control Report – Updates received through TAG. • Mandatory Training Report – Significant work noted and received (Food Safety).
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 15 September 2020 attached.

Finance, Investment & Performance Committee

Date	24 November 2020
Presented by	Chris Jones, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Received assurance on the explanation around extra 200 whole time equivalent staff. • No further update on particular risks but noted some challenges around lead provider project and the acceptance of the risk share process. • Received first set of finance reports from new SBS system and noted the inevitable challenges that come with the first month, but we are pleased that we have been able to produce a set of accounts, and based on that one month we seem to be on target to at least achieve if not exceed our control total.

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	• Received a benchmarking response around Covid that EMT will consider how best to use.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 22 September 2020 and 26 October 2020 attached.

Mental Health Act Committee

Date	3 November 2020
Presented by	Kate Quail, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Service user engagement work. • Excellent input from MHA admin team. • CQC feedback. • All age liaison service. • Generally positive strong relationships with acute trusts and AMHPs. • Performance report working well.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 25 August 2020 attached.

Workforce & Remuneration Committee

Date	12 November 2020
Presented by	Sam Young, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Integrated Workforce Performance Report – impact on staff health and wellbeing and absence. • Staff Wellbeing – update on Robertson-Cooper survey and actions in response to staff feedback. • Development of Workforce and OD Strategy – Deferred to January due to Covid-19. • Board Succession Planning – Paper to go to private session of the Trust Board. • Workforce Risk Register – EMT to review workforce risks in light of Covid-19 second wave. • Annual Work Programme – SY and AGD to review in light of Covid-19.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 13 October 2020 attached.

Members' Council

Date	30 October 2020
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	• N/A
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 31 July 2020 attached.

Note: assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

**Minutes of Clinical Governance and Clinical Safety Committee held on
15 September 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)
	Kate Quail (KQ)	Non-Executive Director (*part apologies for the meeting*)
	Dr Subha Thiyagesh (SThi)	Medical Director
Apologies:	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Carol Harris (CH)	Director of Operations
In attendance:	Mike Doyle (MD)	Deputy Director of Nursing and Quality
	Sarah Harrison (SH)	PA to Director of Nursing and Quality (author)
	Sue Barton (SB)	Deputy Director of Strategy and Change
	Yvonne French (YF)	Assistant Director of Legal Services
	Dave Ramsay (DR)	Deputy Director of Operations (attending for CH)
	Chris Lennox (CL)	Deputy Director of Operations (attending for CH)
	Andrew Broadhead (AB)	Head of Learning and Development (attending for AGD)
	Louise Horsley (LH)	Greater Huddersfield CCG (Observer) Quality Manager
	Estelle Myers (EM)	Freedom to Speak up Guardian (item 14)

CG/20/84 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting, and informed the meeting that due to the pandemic the meeting would continue to be on Microsoft Teams until further notice. The revised agenda was also acknowledged due to Covid-19. It was noted that the meeting was quorate and that it would be recorded for note taking purposes. The Committee agreed. CD welcomed Louise Horsley (LH), Quality Manager from Great Huddersfield CCG who would be observing the meeting in relation the Quality Board and how it links with the Clinical Governance and Clinical Safety Committee (CGCS) to enable a more productive way of working and conducting the meeting. The Committee gave introductions to LH. It was noted that Kate Quail (KQ) was not able to join the full meeting and that Estelle Myers (EM) would be joining for item 14.

CG/20/85 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.

With **all of us** in mind.

CG/20/86   Minutes of previous meeting held on 9 June 2020 (agenda item 3)

CD asked the Committee for any comments in relation to the minutes regarding accuracy. Angela Monaghan (AM) raised a query on page 16 and whether the verbal update on serious incidents was appropriate for the public minutes or should be redacted. Tim Breedon (TB) confirmed that it was suitable for the public domain as there were no patient identifiable information.

The Committee also reiterated the need to ensure the minutes are suitable for public scrutiny in relation to acronyms and to ensure the action points are clear. CD and TB to discuss.

Action: CD/TB

It was RESOLVED to APPROVE the minutes of the meeting held on 9 June 2020

CG/20/87   Matters Arising (agenda item 4)

The Committee discussed and noted the complete actions.

CG/20/54 Risk 1524 – This item was discussed at the last meeting and it was agreed that there were two separate elements, workforce and personal protective equipment (PPE). TB stated that the PPE resourcing risk had been reworded however this is not reflected in the paper. This will go to Board at the end of the month and TB confirmed that Alan Davis (AD) had taken the staff morale risk through Workforce & Remuneration (WRC) which will also go to Board. Complete

CG/20/54 Risk ID 1528 New models of care arising from Covid-19 being adequately tested. This will be covered at item 20 on the agenda. Complete

CG/20/61 CQC Improvement Plan – Updated improvement plan will be discussed at agenda item 7. Complete

CG/20/63 – Patient Experience Report Mike Doyle (MD) confirmed that the complaints survey had been discussed with the team. Complete

CG/20/64 Update on Covid-19 / national issues / guidance. MD confirmed that the guidance for face coverings and masks had been circulated. Complete

CG/20/67 Delivery of Clinical Services. Improving access to psychological therapies (IAPT) waiting times. This will be covered at item 30. Complete

CG/20/71 Serious Incident Quarterly Report Q4. AM confirmed all the information had been received. Complete

CG/20/42 Physical Health Strategy. This has now been circulated. Complete

CG/19/139 Child and Adolescent Mental Health (CAMHS). The Trust wide transition meeting has now taken place and actions have been shared.   Once a review meeting has been scheduled an update will be included within the CAMHS update. Complete

CG/20/88   Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance and Clinical Safety Committee (agenda item 5)

The Committee agreed that the key items had already been discussed at Trust Board on 28 July 2020 and noted the following risks aligned with the CGCS.

TB informed the Committee that this is the standard report which was completed during July and was reviewed regularly by the Executive Management Team (EMT) and will be received by Trust Board at the end of the month.

TB noted that all the risks have been reviewed in light of Covid-19 and also that additional risks have been assigned to the Committee via Trust Board that were previously held by Board.

TB stated that the existing risk 1424 (patient safety) has been updated to include Covid-19. Risk ID 1169 which related to open referrals has been closed off since the last Committee meeting.

All risks in relation to Covid-19 have been updated in the context of action plans and controls and the Trio are regularly reviewing this on a regular basis.

All Covid-19 risks have been updated and will be going into Board at the end of September.

AM noted the update and queried if there were any emerging risks that have not yet formulated. TB informed that there is nothing emerging but noted a change in intensity, relating to items below 15, especially around access to testing for the workforce and the scoring could increase in light of recent events.

AM raised a query around staff compliance in relation to physical distancing as people become increasingly weary both inside and outside of work. TB noted that this could be considered under RISK ID 1524. TB and MD will be discussing compliance with the team.

Action: TB/MD

It was agreed that the agenda today reflected the risk assigned to CGCs Committee.

CD confirmed that RISK ID 1169 could be removed from the register and TB confirmed that this will be agreed at Board.

CD raised a query in relation to RISK ID 1151 – Qualified staff. CD noted that the action plan had nothing in relation to the people plan and whether this should be included. TB informed the Committee that a letter had been received from Ruth May outlining key pieces of work that will be strengthening the workforce.

TB noted that actions and controls would be changing quickly for the Committee and EMT are constantly reviewing the corporate risk register. AM queried whether the members of the Committee / Non Executive Directors (NEDs) could be notified early if a risk goes above 15. TB asked if this could be highlighted in the NED briefings and it was agreed if any risk does alter, after being discussed at EMT, TB will inform the members and the NEDs.

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 Covid-19 risks.

CG/20/89   Quality Accounts (agenda item 6)

The Quality Account report has been produced in line with updated national guidance 'reducing governance burden'. In this context the report is less comprehensive than previous versions, however, as previously agreed, a respectable version has been produced and meets governance requirements and includes stakeholder comments. Our Members Council Quality Group have also been engaged in the process.

A national deadline had been set for the end of the year however the account will be finalised for the end of September.

To date the report has been commented on by the Members Council Quality Group and is currently out with stakeholder partners, with comments due to be returned, in advance of September Trust Board (private session).

The Committee received the Quality Account prior to the meeting to provide any comments and these will be incorporated into the account via Karen Batty and will be provided to Trust Board for final approval.

Karen Batty will be replying to comments that have been received.

The Committee RECEIVED and APPROVED the Quality Account report.

CG/20/90   Care Quality Commission Improvement Plan update (agenda item 7)

Monthly Care Quality Commission (CQC) Improvement plan updates re-commenced in July 2020 after they had previously been stood down between March and June 2020 due to the impact of COVID-19. The August monthly updates showed that 100% of 'must do' actions are either completed or on track. 97% of 'should do' actions are complete or on track. It was also noted that the number of completed actions had increased by 3% since the previous updates.

A number of ongoing quality initiatives have been stood back up to address some of the outstanding 'must' and 'should' do actions. Again these were paused during April and May due to the pandemic. These have focused on key areas such as risk assessment, care plans, record keeping and safe medicines along with other improvement work to look at reducing violence against staff and dignity and respect.

The CQC have not undertaken any routine inspections of our core services in line with their regulatory approach during the pandemic. However, they have made it clear that they could visit a service at any time if they had concerns. It is anticipated that the number of routine inspections will increase as the year progresses.

The quarterly CQC engagement meetings have continued via Microsoft Teams. This meeting provides the CQC with the opportunity to provide any feedback about our organisation and to discuss any issues they may have to seek clarification on. The meeting is also helpful in enabling our CQC inspection team to hear about all of our good practices and quality improvement initiatives and to gain a better understanding of how we work and our services.

As a result of Covid-19 the CQC have established a new approach to monitoring visits using "provider collaboration reviews" which are themed pathway based reviews. Older peoples

services has been the first one with a focus on inequalities and BAME etc. MD informed that mental health is on the list and the Trust should be notified towards the end of the year.

TB highlighted that staff have continued to progress work on this despite it being on hold and noted the positive approach to this. TB also noted how fundamental the risk assessment work is to the improvement plan and MD noted that the formulation informed risk management (FIRM) assessments are implemented. Support is being provided.

The Committee asked to be kept up to date on any pressures that may be a concern.

Action: MD

Yvonne French (YF) informed the Committee that since the Covid-19 outbreak there had been 10 Mental Health Act CQC remote visits. The feedback from both parties was that it worked very well. Positive feedback has been received via interactive sessions The CQC also informed that visits to services and wards may be restarted but would be undertaken by exception. They have also enquired about remote access to patient records as with remote visits the documentation is not available. This is being considered. There are still some hot spots around care planning and service users receiving copies of care plans however Karen Batty is leading some work on this. It was noted that Section132 has improved and the Mental Health Act Committee has received a report on this in August 2020 and a more in depth discussion will be had in relation to advocacy.

AM reiterated the importance of the Trust's quality monitoring visits (QMV) and queried how, if the visits are now being reinstated, the NEDs and Governors could remain involved whilst being unable to visit services. MD confirmed that this is being discussed at the Clinical Governance Group tomorrow 16th September and a decision will be taken on how the visits can be undertaken remotely so as not to increase the footfall within the Trust. MD to provide an update at the next Committee meeting.

Action: MD

CG/20/91 Care Quality Commission Impatient and Community Surveys (agenda item 8) (deferred)

CG/20/92 Trust Achievements (deferred) (agenda item 9)

CG/20/93 Waiting List Improvement Plans (agenda item 10)

Chris Lennox (CL) informed the Committee that items 10 and 30 will be covered together here.

CL advised that the waiting lists paper covered an update summary table for each area including:
- brief description of the waiting list
- average length of wait
- number of people on the list
- trajectory for elimination
- any other information or comment

The reports provided a position statement to the Committee for Improving Access to Psychological Therapies (IAPT) in Calderdale and Kirklees and Barnsley. Key issues include:

- Impact of Covid 19 and the service plan
- Secondary waits relating to specific therapy pathways
- Challenges in relation to access and recovery performance measures
- Changes to virtual delivery well as face to face
- Support available to service users during waiting

It was noted that new performance reports have been developed in relation to monitoring ethnicity to ensure that no group is adversely affected by waits.

CL noted that there were concerns within IAPT, core pathways and psychology services around waiting times although support is available for people who are waiting. Discussions with Commissioners are also underway. Inevitably with the reduction in face to face contact and groups of people being unable to meet, the waits have increased.

It was noted that it is a challenging picture and services are working hard to use digital solutions and work closely with partners to provide service users and carers with as much support as possible whilst maintaining services within the parameters.

CL also noted a new demand around IAPT, long term condition pathways and post support for Covid patients from ICU.

It was recognised that the situation is a difficult and challenging one. The committee discussed the paper and queried whether a high level summary of the actions would be beneficial and AM also enquired whether people are being offered access to helplines whilst waiting for an appointment and how expectations are being managed. It was noted that the volume of data supplied was complex and it was queried if there could be a more simplistic way for this to be displayed. CL confirmed that what had been provided was a summary update however confirmed each area have their own action plans and will work with Performance and Information to provide a better way of presenting the information.

Action: CL

CL confirmed that people are offered access to helplines at the initial contact however that managing their expectations does need to be considered. CL noted that Calderdale are working well to time frames and providing a rapid service, however some people are choosing to wait as the preference is for a face to face meeting rather than the digital service offered with the IAPT service.

CD confirmed the actions and noted the huge amount of work that was being done and information that had been provided and that continuing to look at data presentation could aid understanding.

It was also noted that there could be duplication of the data and conversation with Finance, Investment and Performance Committee (FIP) around waiting lists. TB will discuss with CL and Carol Harris (CH).

Action: TB and CL

The Committee RECEIVED and NOTED the update and actions.

CG/20/94   Patient Safety Strategy update (deferred) (agenda item 11)

CG/20/95   Update on Covid-19 Response (agenda item 12)
12.1 National Issues / Phase 3 Letter / NHS Providers Briefing
It was noted that the Committee have already received a brief.

TB informed the Committee that the Phase 3 work is now sitting with the restoration and recovery team and the work that is described regarding workforce has been reprofiled in terms of the integrated performance report (IPR) and Board can then put to the Committee.

CD and the Committee felt well briefed on this and noted that it is helpful to have the information in the Committee.

12.2 Updated Command and Control Structures
The command structure was noted for information and is reviewed on a regular basis as it is ever changing.

The Committee NOTED the update.

CG/20/96   Workforce Update with response to Covid-19 (agenda item 13)
13.1 Safer Staffing
MD provided a brief overview to the Committee and informed that BDU and team business continuity plans have remained resilient in the face of significant challenges. Staff have been returning to their substantive roles and the continuation of their responsibilities. The use of the temporary staffing workforce as well as overtime and time owing to cover our inpatient areas was continuing. As of 30th June we have 611 bank staff of which 365 have been active in the last 6 weeks.

The Trust has 33 staff absent or working from home due to Covid-19. This makes up 0.65% of the workforce relating to testing, symptoms and holiday isolations etc. There has been a timely response to this and business continuity plans have stood up well.

Several areas have experienced significant pressure and demand on staffing. Lyndhurst Ward, Stanley Ward and the Medium secure service as a whole have noted increased pressure, mainly due to vacancies and sickness.

Next steps

- Prioritise staffing in response to Covid-19 and acuity challenges
- Ensure establishment of service level agreements with our neighbouring acute trust banks to provide reciprocal specialist support
- Continue with our recruitment and retention plans, hosting central recruitment centres and attend national recruitment fairs.
- Roll out of SafeCare to ensure an effective use of the staffing resource available
- Ensure the preceptorship plus is embedded for the influx of new band 5s

- Look at the financial breakdown for locum Registered Nurses (RNs) and readjust costings, staying within contractual obligations, to increase engagement with RN locums
- Reintroduce Safer Staffing group to focus on community settings
- We have identified 24 new starters all band 5 to start in forensic services from September 2020
- A bespoke advert for forensic services is now used
- Forensic establishment review near completion
- If SafeCare is successful in adult acute mental health wards, next area will be forensic services.

CD noted a concern relating to the resilience of the workforce as Covid-19 seems to be increasing once again and also noted the pressure points in staffing levels in community staffing and suggested that more information is needed on community staffing. MD informed that plans had been in place to use an evidence based tool within the Community pre Covid-19 however this had been stood down. Discussions are now taking place with a view to reinstating this to look at the caseload.

MD informed the Committee that the Forensic Establishment Review is almost complete and noted that 24 new staff members will be starting in Forensics from next month to help alleviate pressures.

CL informed the Committee that the Older Peoples Services (OPS) inpatient workforce review is underway as well which will be updated within the next safer staffing report.

The Committee NOTED the update report.

13.2 Testing / Outbreak Management
MD gave an update to the Committee on how patients are tested and the guidelines that need to be followed and from this it was noted that in a recent audit some learning had been identified in terms of recording. MD also informed that the antibody testing had stopped for the time being. In terms of assurance MD highlighted that the positive rates are very low but are starting to increase slightly and an increase in sickness and absence have also been noted. There has been difficulty in accessing pillar 2 so the Trust have stood up some tests for our own staff which has been worthwhile.

MD advised that there had been an outbreak on Bronte ward and also Ashdale ward last week and highlighted that the guidance had been reinforced in these areas and across the Trust.

CD raised the query that if people are not following PPE and social distance guidance what measures were being taken. AM also noted how well the Trust had previously done doing during the pandemic and queried what measures have been taken in relation to breaches.

MD reported that in the first instance a blue light alert was sent and it was highlighted that not following the guidance would be a breach of health and safety. What has been found is that staff have engagement fatigue, they have been heroes in terms of standards of care and this is a wake up call and lessons are to be learnt from this.

CL reported the need to acknowledge the impact of 12 hours shifts and breaks for staff however this asked it was not excusing the behavior reported that more conversations were needed and work is underway with matrons on this topic.

MD informed the Committee that letters have been sent to staff regarding the consequences of not following the guidance and now a stronger sense of cooperation has been seen and reinforcement work on the ground is underway. The Committee felt reassured to hear this as it is not a time to discipline staff and support for staff should continue.

Andrew Broadhead (AB) noted this is not a zero tolerance approach like bullying and harassment and that a holistic approach would be more appropriate.

MD clarified the next steps:-
- To continue with staff and patient testing through the national testing route or where necessary using the local SWYPFT resources with the Nursing Directorate and Infection Prevention and Control (IPC)
- For the IPC team and Performance and Information to continue to monitor surveillance data (using internal mechanisms or via the test and trace) and identify early possible outbreaks
- For the IPC team to continue to work with the Emergency Planning team for the identification of new national guidance, ensuring timely and responsive interpretation into local Policy to ensure patient and staff safety
- To continue to share the learning from outbreaks across the Trust
- Arrange personal issue of scrubs.

The Committee NOTED and RECEIVED the update and progress.

13.3 Volunteers
Sue Barton (SB) gave a brief overview to the Committee:-

It was noted that:

➢ The central volunteer service provides advice and guidance to all Trust volunteers and the managers who support them. This includes regular contact and Covid-19 updates
➢ Most of the volunteers are medium/high risk. Support is provided by the managers and occupational health advice is available if required
➢ At the moment most volunteers do not want to return
➢ Any volunteers who wish to return are completing risk assessments with the support of managers. This includes people who are volunteering from home. Plans are developed to make sure we re-engage volunteers back into the Trust safely
➢ Volunteers have been involved in the virtual visitor project on ward areas across the Trust. This work connects people with their family and friends using a tablet device
➢ The service will be sending the annual volunteer survey out in the next two weeks
➢ The central volunteer service is undertaking a variety of developments during this time, these include:
　○ Specific work to look at increasing the diversity of our volunteers and how to better engage our communities
　○ Work to put volunteers on to the Electronic Staff Record (ESR) system
　○ Work with Barnsley Community and Voluntary Sector to introduce virtual groups in the Barnsley community for isolated groups. This has included the provision of six tablet devices to start the project
　○ Work to scope a volunteer strategy

o   Making connections with partners in relation to NHS Responders

CD thanked the committee for all the work on this and noted the importance of keeping the volunteers engaged and that support is in place for them as well.

AM went on to note that the Trust Governors are also volunteers and that they feel well engaged and informed.

The Committee RECEIVED and NOTED the update on Trust volunteers.

CG/20/97   Staff Wellbeing (agenda item 14)
14.1 Overview of staff support arrangements
AB informed that Alan Davis will give a verbal update to the next meeting.

14.2 Brief update from Freedom to Speak up Guardians
AB addressed the action points raised previously in relation to Freedom to Speak up Guardians (FTSUG). CG/20/66

  ➢ Training - This was put on hold and still in progress - updated.
  ➢ Language in the report relating to Governors - this will now be changed.
  ➢ Action plan - Estelle Myers (EM) informed the Committee that the action plan for FTSUG is still in draft however will need a further update due to Covid-19. EM has some objectives that she is working on however these will also need to be updated. It was agreed that this will come back in February.

Action: AD

EM informed the Committee that a new update in regard to how the Trust is benchmarked (Insight Report) is being discussed with Alan Davis and will be brought back to the Committee.

Action: AD

The Committee is keen to get the right message, communication and engagement out to the Trust in relation FTSUG.

AM raised a query in relation to a Governor that wanted to access the training in 2019 and still has been unable to access this and queried if this can be done remotely and that a guardian is due to leave and therefore remote training could alleviate any gaps.

AB informed that there is difficulty around this as the places are in London. EM to look into this issue

Action: EM/AD

The Committee would like the following addressed at the February meeting:

  ➢ Training
  ➢ Governor involvement
  ➢ Insight report
  ➢ Action plan
  ➢ Recovery and Reset
  ➢ Organisation engagement

Action: AD

AM highlighted the enormous amount of work around engagement of staff and the increasing opportunities for listening. The Board have become involved and have had direct conversations with the Black, Asian, minority and ethnic (BAME) network and will continue to do the same with other protected characteristics groups which will give staff more opportunities to raise issues directly.

The Committee NOTED the update from the Freedom to Speak Up Guardians.

CG/20/98 Delivery of Clinical Services. Impact of all clinical areas (agenda item 15)
The Committee received and read the update in terms of how clinical services are operating.

The Committee asked if there were any specific comments on the slides.

One comment was noted on the learning disability (LD) slide from CD regarding the closure of an assessment and treatment unit and what the impact had been. CL reported on the impact of the closure of the Leeds unit on the Bradford and Wakefield systems. TB informed that this was done at pace which SWYPFT supported by allowing 1 patient to use a place in our services.

AM noted that the Committees in Common have oversight of Assessment and Treatment Unit (ATU) processes.

AM noted that it was very good to see the positive progress in child and adolescent mental health services (CAMHS) and attention deficit hyperactivity disorder (ADHD) which was noted by Jo Webster, Wakefield CCG) in a system wide meeting.

The Committee agreed that the slides and the format were helpful and supported the approach.

The Committee NOTED the update.

CG/20/99   Patient Safety (agenda item 16)
16.1 Introduction of Covid-19 Pathway
The Committee received and noted the Covid-19 pathway.

The Committee RECEIVED and NOTED the update.

16.2 Incident Trends
TB provided a brief overview of the report as these are areas of concern for the Trust. The report provided information on the work that had been happening to monitor suicides and self-harm incidents on a weekly basis to ensure early identification of peaks and trends. Between 5/1/2020 and 29/8/2020 there were 734 incidents reported. This compares with 485 in the equivalent period in 2019. There are fluctuations in reporting rates and where this is outside the normal variation, further analysis has taken place to explore peaks.

Analysis of the data from 2020 shows that higher numbers of self harm incidents are predominantly due to a small number of service users across mental health inpatient wards.

Barnsley is the area with the highest number of reported actual self harm incidents, followed by Calderdale.

TB informed the Committee that a deep dive is being undertaken in a couple of areas of concern as levels are not presenting as normal. Also, there is a reduction in apparent suicides in comparison to last year which will be discussed further on in the agenda. There are no immediate themes or root causes at the moment but this will continue to be monitored.

CD queried as to whether the figures reported included Wetherby and Adel Beck. TB confirmed that they are included and that incidents are recorded on Datix which in turn populates the reports. MD went on to confirm that the Trust receives Datix reports from Wetherby and Adel Beck, some of which the Trust are engaged in however others would be reported through the prison systems.

MD reported an issue in Barnsley on female wards with numerous self injuries where violence is monitored regularly. This is covered later in the agenda.

The Committee noted the update.

The Committee NOTED the analysis of suicide and self-harm incidents during the Covid-19 pandemic.

16.3 PPE Arrangements
The recent Covid-19 pandemic has placed a premium on personal protective equipment (PPE). As a result, it is imperative that NHS bodies have robust arrangements in place for:

- The identification of PPE need (prior to a procurement request being made);
- Secure receipt and storage (both centrally and at other Trust sites);
- Prompt and reliable distribution to the end user; and
- The maintenance and the replenishment of adequate stock levels.
- Strong processes in place in terms of what needed and demand.
- Need to keep a close eye on deliveries which is monitored regularly through silver command.
- No major issues at the moment.
- Mutual partnerships in place in relation to PPE.
- 360 internal audit also underway.

16.4 Outbreak Management
Discussed above.

CG/20/100   Issues arising from Integrated Performance Report, not covered on the agenda (agenda item 17)
TB updated the Committee in relation to supervision. There had been an issue regarding recording however this is now high on people's agendas and is being monitored through operational management group (OMG).

The Committee noted that this is an area of concern especially within the current climate.

CL informed the Committee that this has been identified on the wellbeing agenda and work is underway with Matrons and Governance Leads. Figures are starting to improve and this

is an operational priority which is being dealt with on a ward by ward basis and there is the commitment to achieve the 80% target. Further update will be provided at the November Committee.

The Committee RECEIVED and NOTED the update.

CG/20/101   Update of topical, legal and regulatory risk horizon scanning (agenda item 18)
Discussed above.

CG/20/102   Child and Adolescent Mental Health Services inc Wetherby & Adel Beck (agenda item 19)
Dave Ramsay (DR) gave an update to the Committee.

The report provided a further update regarding clinical governance/risk issues and development plans in Barnsley, Calderdale, Kirklees, Wakefield and Wetherby YOI/Adel Beck CAMHS.

Covid-19
Since March 2020 there had been a marked decrease in generic referrals to CAMHS (initially 50%+). Levels have increased over recent weeks but remain below those typically expected. The upward trend in referrals for autism spectrum condition ASC/ADHD diagnosis in Calderdale and Kirklees has continued. In all areas CAMHS has participated in workstreams planning for the return of children to school in September 2020.

A significant proportion of assessment and treatment activity has been delivered by telephone/video-link but face to face support had been provided where a clear clinical need was identified and/or where a child/family had been unable to engage with an alternative offer. Face to face activity is now increasing as part of service recovery plans. This process is being informed by evaluation of the new ways of working developed through business continuity with an emphasis on locking in good practice. Progress in delivering waiting list initiatives in Barnsley and Wakefield has been maintained but neurodevelopmental assessment initiatives in Calderdale and Kirklees have been compromised by the temporary cessation of face to face contacts.

CAMHS Improvement Group
The CAMHS improvement group continues to meet on a monthly basis. Additional project support has been secured and detailed action plans have been agreed for the Barnsley and Wakefield services, specifically in relation to reducing waiting times. The intention is to expand group focus to incorporate Calderdale and Kirklees (and neurodevelopmental assessment waiting times). Wetherby YOI and Adel Beck CAMHS diagnostic assessment look at it at a system level.

Barnsley
The CAMHS procurement was formally cancelled on 19 June 2020. The clinical commissioning group (CCG) extended the contract for CAMHS to 31 March 2021 and a joint steering group has now been established to progress delivery of the specified service model.

Waiting Lists
The agreed intention was to accelerate improvement and from December 2019 to end July 2020 achieve a waiting list of no more than 45 children and young people. This position was seen to equate to a waiting time from referral to treatment of 4 weeks. The initiative involved

building capacity in CAMHS treatment pathways and ADHD diagnostic assessment - and in Mindspace/Chilypep (mental health first aid) provision. At the end of August 2020 a total 74 children/young people were waiting for treatment. Whilst short of the target figure this compared with 330 at the start of the initiative and in the context of Covid-19 continuity arrangements has been recognised by the CCG as excellent progress.

Calderdale
The CCG recently agreed £100k non-recurrent funding to increase diagnostic assessment capacity and a business case is currently under consideration with regard to additional recurrent investment. CAMHS is currently commissioned to provide 67 neurodevelopmental assessments per annum against 2020/21 full year referral trajectory of 335. Addressing the capacity shortfall requires additional recurrent investment of £390k.   It should be noted this investment would only meet the demand as currently forecast and would not directly tackle current waiting lists or any increase in future demand. If demand continues to rise at current rates the service could expect 445 referrals in 2021/22

Kirklees
In 2020/21 the CCG has provided additional £100k recurrent funding to strengthening neurodevelopmental pathway capacity. However this is recognised to fall significantly below the level of investment required to keep pace with referrals rates and the increase in numbers waiting. Commissioned capacity is now based on 450 referrals per annum whilst the 2020/21 trajectory is 1,140 referrals. Further demand/capacity work is being undertaken to inform a business case.

Wakefield
A proposal was agreed by Wakefield Mental Health Alliance for a January to July 2020 initiative targeting waits for specialist pathway. This supported existing workstreams in relation to demand/capacity analysis and strengthening of the primary intervention team (PIT) service offer. The overall expectation was a reduction of referral to treatment waiting times of no more than 26 weeks. By end July 2020 the waiting numbers for Psychodynamic Interpersonal Therapy (PIT) had reduced from 207 to 45 (waiting time 2 weeks) and 52 were waiting for a core CAMHS treatment – down from 210.   The waiting time for a core intervention had been reduced from 59 to 13 weeks. For specialist pathways (including psychotherapy and psychology) waits had reduced from 97 (52 weeks) to 62 (26 weeks).

Wetherby YOI and Adel Beck
A Children's Clinical Governance Group has been established to incorporate Wetherby and Adel Beck alongside other Trust children's services.

Contract improvement notice
The improvement plan was completed and signed off by Leeds Community Health (LCH) at the Contract Management Board meeting on 7 January 2020. However, as staff recruitment and retention continues to be a challenge the contract improvement notice is still in place. An action plan in this regard was agreed with NHS England and LCH at the Contract Review Meeting on 3 August 2020.

Self-harm
The risk of self-harm in Wetherby continues to impact on service demand. There remain a high number of children requiring constant supervision following explicit statements they want to end their life. A new Band 7 post with a portfolio for self-harm has been recruited. There were two serious incidents relating to significant self-harm during constant supervision in 2019. The SI investigations identified a lack clarity in documented care plans regarding risk priority and frequency/quality of contact. Action plans have been developed to underpin improvement and an audit is scheduled for November 2020.   There are two CAMHS local

level Investigations underway at Wetherby YOI and one at Adel Beck. Two of these cases are related to risks associated with prolific self-harm.

The Committee requested further details in relation to this and DR will report at the next meeting.

Action: DR

CAMHS Leadership Structure
A review and strengthening of CAMHS management and leadership structures will be completed by end September 2020 and will include Wetherby and Adel Beck.

The committee thanked DR and the team for a comprehensive report and good work and noted that Jo Webster (Wakefield CCG) has also commented on this.

The Committee queried how sustainable the waiting list improvements and also collating of protected characteristics information are and DR informed that these are sustainable due to the capacity within the service and can be maintained if the position in relation to the referral rates stay as they are at the moment.

Andrew Broadhead reported that all mandatory training had been deferred for 12 months as agreed with NHS England due to the pandemic however this is now starting to return.

TB noted that the improvement group is spanning all districts and can produce a report from that improvement work to support the governance and align the effort.

The Committee were happy with the clear report and the good progress that had been made.

The Committee RECEIVED and NOTED the update.

CG/20/103   Quality Impact Assessment (agenda item 20)
20.1 Quality impact assessment review
The Committee received and noted the report.

TB highlighted to the Committee that the QIA is not done in isolation. It is tied in with services and Equality Impact Assessments (EIA) and has been applied across a range of services which will support improvement.

The Committee NOTED the update.

20.2   Recovery planning
Sue Barton (SB) gave a brief overview to the Committee and noted the following:-

➢ The recovery and restoration of services framework, process and documentation has been developed by representatives from the strategy directorate and the nursing, quality & professions directorate. It has been agreed by the Operational Management Group (OMG).

➢ This process, framework and documentation has been designed in order to help services feel confident to recover and restore services. It aims to:

- Provide some clarity to explain what is a complex and iterative process

- Build on current processes that have been used and found to work e.g. Quality Impact Assessments
- Ensure we respond to any differential impacts or health inequalities with robust Equality Impact Assessments

➢ The document consists of:
- Flow chart of the process on the front as summary
- Recovery restart checklist including template for optional recovery plan
- Framework for testing new clinical models including, as appendices the following
  o Guidance Form for demonstrating due regard to equality on urgent decisions with the due regard to equality - urgent decision making form
  o Quality Impact Assessment Tool for Recovery & Restoration. July 2020

AM noted that this was a really good paper and framework and the three levels of change model is clear. CD queried how the Trust know that staff are adhering to the framework and whether there was clarity around local change and Trust wide change.

SB advised that the framework had been through OMG and they had helped to shape it. The table suggests this is clearly defined. Deputy Directors will monitor this and offer conversations and discussions where necessary. Monitoring processes will be discussed in OMG.

CL reported that this is a work in progress for operational services and people appreciate the flexibility of the model. It has been seen as a useful and practical model which is not onerous on front line staff.

CL also noted that this is stress tested through bronze command meetings.

It was agreed that worked examples could be brought back to the Committee to show the breadth of work and improvement.

Action: SB

The Committee RECEIVED and NOTED the process.

CG/20/104   Serious Incident Quarterly Report Q1 inc Trust response to LeDer Report and Healthcare Deaths (agenda item 21)
MD gave a brief overview to the Committee.

MD advised that the report provides information on incidents in Quarter 1 and more detailed information in relation to serious incidents. It also provides assurance that learning from healthcare deaths arrangements are in place. The learning from healthcare deaths report requires publication on the Trust website.

MD informed the Committee that there has been a steady decline in serious incidents this year. In terms of this quarter serious incidents are down however deaths have seen an increase since April. The Trust continue to identify lessons and share learning in clinical mortality review and mortality review meetings. Bluelight alerts are also used.

The Trust continues to have a good reporting culture for incidents.

MD went on to note that not only have serious incidents reduced but also violence, aggression and suicides and that this could be due to the impact of lockdown rather than Covid-19 itself. In general, a decrease had been noted.

In relation to learning from healthcare deaths, AM raised a query regarding structured judgement reviews and do the Trust have any capacity issues. AM also asked in relation to the LeDer update and the reviewing of the recommendations against our practice and where the Trust is on this. MD informed that work had been done with LD colleagues to identify the learning from the national report and the action plan produced for SWYPFT. MD noted that in terms of structured judgement reviews, there are pressures on getting reviewers and this is monitored weekly via risk panel with any deficits identified as well as individuals who can undertake the review.

Kate Quail joined the meeting at 4pm.

Clinical Governance & Clinical Safety Committee RECEIVED and commented on the Serious Incident Quarterly Report Q1 inc Trust response to LeDer Report and Healthcare Deaths and to NOTED the next steps identified.

CG/20/105   Apparent Suicide Annual Report (agenda item 22)
MD reported on the above and informed that the report included analysis of data for the 45 apparent suicides reported within the Trust during the year 2019/20. Key headline data for apparent suicide incidents informed our understanding of what the circumstances can be for someone who tragically takes their own life. It is through better understanding and analysis that the Trust can refine and improve the services offered to our service users and carers.

Committee agreed that this was a full, extensive and good report.

MD noted that all suicides are included within the report. MD also noted that the main findings are that age groups had changed and are now 45-54 which collates with the National picture.

MD informed that the Trust had 3 incidents and identified learning from those will feed into specialist training plans in terms of Applied Suicide Intervention Skills Training (ASIST) and Formulation Informed Risk Management (FIRM).

MD reported that a large audit was undertaken last year and a recent update has been received and we now have priorities for next year. One area to be looked at from this was ethnicity and sexuality as this is not collated at the moment and more reliable data was needed. The findings were mixed in terms of ethnicity and spikes have been found locally. The West Yorkshire and Harrogate Integrate Care System (WY&H ICS) are looking into this.

CD queried when greater clarity on ethnicity will be received. MD informed that Dawn Pearson's teams are looking into this and how it can be done.
MD informed of next steps:-

➢ Working closing with W&H ICS and MD will report on the annual plan at an upcoming meeting. Good progress on specific groups for men, place based public health provision. Real time surveillance and training.

- SWYPFT are looking at clinical practice and training and if each ward and service can look at self help towards self harm and suicide. There is also a lot of work going on with families and support information for families.

- Preventive measures implemented on Scammonden bridge.

- Covid-19 – Face to face training has been difficult. FIRM is now available online. Plans have been cancelled for face to face men's bereavements groups however these are now on line.

- Suicide prevention training has been held at Featherstone Rovers Football Club.

The Committee RECEIVED and NOTED the annual report.

CG/20/106   Whistleblowing inc Freedom to Speak up Guardians (taken at previous meeting (agenda item 23)

CG/20/107   Internal Audit Report – Incident Management Review (agenda item 24)
TB informed the Committee that this was reported on at the last meeting however the report was not available then and is here today to receive. The Committee felt fully assured with the report.

The Committee RECEIVED and NOTED the report.

CG/20/108   NICE Annual Report (agenda item 25)
The Committee received and noted the NICE annual report.

CG/20/109   Mandatory Training Annual Report (deferred) (agenda item 26)

CG/20/110   Patient Led Assessment of the Care Environment (PLACE) (agenda item 27) (deferred)

CG/20/111   Safeguarding Annual report (agenda item 28) (taken at previous meeting

CG/20/112   Review of Healthcare Deaths Policy (included in quarterly report) (agenda item 29)
Covered at item 21.

CG/20/113 Improving Access to Psychological Therapies (IAPT) (agenda item 30)
30.1 Calderdale & Kirklees
Covered at item 10.

30.2 Barnsley
Covered at item 10

CG/20/114 Update of Smoking Policy (agenda item 31)

Subha Thiyagesh (STHi) briefed the Committee on the smoking policy and noted the ongoing review of the Trust's changes to the smoking policy during Covid-19 and assurance that robust arrangements are in place to support inpatient smokers with smoking abstinence or quitting during their inpatient stay.

The Committee noted that this is a really complex issue and wanted assurance of how this is moving forward within timescales.

STHi informed the Committee that a few more weeks / months are needed to be able to understand the position more clearly. Next steps are to include discussions within the steering group with focus on inpatient units.

CD queried if there was a timeframe to achieving training. STHi informed that there was no immediate answer as yet and this will be taken back to the steering group for discussion and a training package is being put together. STHi to bring back an update.

Action: STHi

STHi raised with Louise Horsley (LH) (CCG) that the Quit programme for SWYPFT is mainly funded for South Yorkshire and would prefer this to be in the rest of our localities.

LH will take this back for discussion.

Action: LH

AM queried as to whether rules on vaping on Trust sites applied to both staff and service users and CL confirmed that the rules apply to all staff and services users.

An update to come back to the November meeting.

Action: STHi

The Committee NOTED the update.

CG/20/115   Sub-groups – exception reporting (agenda item 32)

Drug & Therapeutic
Report received and noted.
It was RESOLVED to NOTE the report.

Safety & Resilience
AB informed the Committee of the issues with the Health and Safety Executive (HSE) in relation to first aid training. It was acknowledged that Covid-19 and social distancing measures had disrupted training with only 3 people permitted in the First Aid training room. It was agreed that this was not sustainable and Debbie Burton had suggested contracting out training to an external provider until numbers for face to face training were viable. Nick Phillips had considered this to be a useful way forward in acknowledging that there was a plan but not the environment to increase training. Refresher training needs to be complete by 30th September. AB informed that there was no internal capacity and that there is a quote

from an external provider with a cost for £8,000 which can be funded through the Learning and Development training budget. The Committee supported this approach.

Lone Worker Update
AB noted that the contract for loan devices is £100,00 and the Trust is only using around 1/3. This has been discussed at OMG and Nick Phillips is overseeing a new contract for this.

CD queried if there were any pressure points in premises / social distancing. AB noted that the main pressure is within the wellbeing and learning centre. In terms of localities within services this is being dealt with locally. CL added that building risk assessments are in place and Nick Phillips is preparing a paper for EMT to reduce pressure and consider the repurposing of space.

Report received and noted.
It was RESOLVED to NOTE the report.

Infection Prevention and Control & IPC BAF
MD noted that silver command are considering guidance on face to face meetings in relation to the rule of six.

Report received and noted.
It was RESOLVED to NOTE the report.

Safeguarding adults and children
Report received and noted.
It was RESOLVED to NOTE the report.

Reducing Restrictive Physical Interventions Group
Report received and noted.
It was RESOLVED to NOTE the report.

Improving Clinical Information Governance Group
Report received and noted.
It was RESOLVED to NOTE the report.

Physical Health
Flu vaccines have been received into the Trust today.

Report received and noted.
It was RESOLVED to NOTE the report.

Clinical Ethics Advisory Group
Report received and noted. STHi highlighted that the update should come from the chair of the group. SH will update.

Action: SH

Report received and noted.
It was RESOLVED to NOTE the report.

CG/20/116   Serious Incidents Update (agenda item 33)
TB updated on the following:-

> ➢ Sancus report yet to be resolved.

- DH Review in Kirklees is underway and discussions underway with and author in respect of diagnosis. No internal SI has been done.

- Report for inpatient in forensics received and being worked through.

- Hostage incident in Kirklees nearing completion. An external reviewer has been appointed for this report.

CG/20/117   Issues and items to bring to the attention of Trust Board and other Committees (agenda item 34)

- Waiting times and IAPT performance – to ensure clarity of role between CGCS and Finance, Investment and Performance Committee.
- Quality Accounts – approved with some minor amendments, to include in private session of Trust Board and then into Members Council.
- CQC improvement Plan update – positive progress noted during pandemic and engagement remains strong.
- CAMHS – positive performance acknowledged and extension of improvement plan across all places noted.
- Clinical risks in terms of Covid-19 – report received and action noted.
- Apparent Suicides Report – good quality report, to consider version for Members Council via Members Council quality group.
- Serious Incidents Q1 Report - report received and discussed.
- Smoking Policy – update report received further detail on implementation plan to come to next CGCS.

It was noted that the Committee continues to move further towards an improvement focus rather than assurance to support the quality improvement drive in the Quality Strategy. In terms of the meeting that has taken place today TB noted the following focused on improvement:-

- CQC improvement plan
- CAMHS improvement plan
- Restoration and Recovery, in context of service improvement.

TB and CD will discuss further how improvement can continue to be the focus and it was agreed that this would be discussed.

Action: TB / CD

34.1 Updated ToR
The Committee confirmed the ToR.

34.2 Learning for the Committee
TB and CD have already had a conversation in relation to this and noted the move to focus more on an improvement basis rather than assurance. A working sub group will be stood up and details brought back to the February meeting.

Action: TB / CD / SLH

CG/20/118 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 35)

TB reiterated the impact of testing issues and the availability of tests. It was noted that the Trust have stood up a testing centre to accommodate some of our staff.   MD informed the Committee that the army are setting up mobile testing again in the future.

CG/20/119   Work Programme (agenda item 36)
Noted the items that have been deferred and all items have been logged due to Covid-19

CG/20/120   Date of next meeting (agenda item 37)
10 November 2020 – 2pm – 5pm – MS Teams

Finance, Investment & Performance Committee (FIPC) – Tuesday 22nd September 2020
Virtual meeting, via Microsoft Teams

Present Members	Jane Wilson (JW) (Note taker)	Apologies
Tim Breedon (TB) Mark Brooks (MB) Carol Harris (CH) Chris Jones (CJ) (Chair) Kate Quail (KQ) Rob Webster (RW) Sam Young (SY)		None

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Introductions and apologies	Chris Jones (CJ) welcomed everyone to the meeting. MB advised that the meeting was quorate	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 25th August were approved.	CJ	Action - JW
4.	Review of progress against agreed actions	It was noted that progress against agreed actions was taking place and there was nothing further to update.	MB	
5.	Review of committee related risks and any exception reports as required.	MB explained that the risks will be covered in main body of meeting and there is a separate paper on both the forensic lead provider work and financial arrangements or the remainder of the year. He commented that the committee might want to revisit this item at the end of the meeting should they feel any risks require updating.	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
6.	Current year financial performance	MB provided month 5 key highlights: - • A break-even position has been reported for month 5. • A much higher retrospective top up claim this month, in excess of £900k. • The level of cost is increasing compared to the beginning of the year. Initially there was very little spend on out of area beds, there is now a much higher cost per day on out of area which reflects the cohort of patients. The proportion is heavily weighted towards PICU which have higher costs attached including additional observations and transport. • Pay costs are similarly increasing. Within the month there was an additional £150k incurred on clinical excellence awards which was expected. Agency costs are also increasing, along with overtime and substantive pay costs. • Capital spend is still very low, there is an action for the estates tag to review the forecast for the full year. An updated forecast needs submitting at the end of September and given the current capital regime if we do not believe we will spend our full budget we should forecast this and allow other priorities in the ICS to be covered. MB stated he felt it was very unlikely we would spend £6.1m in last 7 months of year. • RW commented that it looks like we are nowhere near the run rate on capital. In principle offering up some of our Cdel to others is a good thing but he asked if there are any additional capital works we should be spending money on in relation to ligatures and other new priorities. • MB explained that the focus is on generating an accurate forecast and that we have not given any message not to spend in line with our plan. In practice the majority of saving will come from not spending any money on developing a North Kirklees hub this year. Within minor works some programmes of work have been added in as a priority whilst others are either currently a lower priority or delayed because of Covid-19. In terms of national capital bids facilitated by the ICS it appears unlikely there will be any additional funding forthcoming to the Trust. • CJ asked if we have any Covid-19 plans requiring capital investment, as we need to achieve our own priorities at same time as being a good partner. As a committee he is happy to support a change in forecast providing we have enough capital money to pay for our improvements. MB confirmed that the forecast is generated by those senior managers with the detailed knowledge of what is required and what it is feasible to complete and spend in the year. • SY asked what the capital funding was likely to be next year. MB replied that at this stage he was not clear on the detail, but the likelihood is that the process would be similar to this year with increased prioritisation and allocation of resource via the ICS. Barnsley locked rehab • MB explained that the Trust in practice has relatively little control over this area of expenditure. Costs have typically increased in recent years and there have been additions to the contract income value to recognise this. Since Covid-19, there has been a massive spike with an overspend of £800k after five months and a projection of £1.6m by the year-end. Given the current financial arrangements there is no scope to negotiate with the CCG for additional funding for the remainder of this year. MB stated both he and the finance director at the CCG would review the financial arrangements for		

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		the remainder of the year to identify if there is any system funding available to cover any of the cost, but he felt this was unlikely to arise. MB explained that issues such as this have been raised both internally and with the CCG in readiness for future contracting discussions. • CH agreed that there was relatively little the Trust could do currently to make a notable dent in the scale of the overspend. • RW asked if we have any concerns that clinical behaviours have changed in Barnsley. • CH responded that this is not the case and clarified that locked rehab is not an alternative to an acute admission. CJ summarised by stating that the Committee notes the conversations taking place and recognises the risk that MB continues to bring to our attention. MB reminded committee members that the financial risk in the first six months has been covered off by the retrospective top-up funding available. However, it is an accelerating cost and could have an impact in the latter part of the year.		
7.	SBS Finance ledger system implementation update	MB provided the key headlines: - • The go/no go meeting was held recently. Since the report was written there are a number of updates to report on. • There has been an internal review of each workstream in detail. The teams have made good progress and the majority of issues outstanding have been covered off. • There is a report explaining what is outstanding and mitigations to cover these. • Flash player expires 31st December, SBS have a plan in place to have this resolved by December as this would impact on all of their clients. • IT connectivity - 25 end users have tested and confirmed connectivity. There is a need to conduct wider testing to ensure there is no risk. • A review was carried out into any IG risks associated with printing and identified minimal risk with enough mitigations in place to address. • BACS payments - the testing of this still needs to take place and the issue has been escalated with the bank to ensure it is fully tested prior to go-live. • Edge for health - which loads all electronic catalogues has been amber or red since the project commenced and it is not currently where it needs to be. There are plans to use finance staff and SBS staff to support procurement in loading these catalogues. More assurance is required on this item if we are to go live. • MB added that there are other risks for the committee to be aware of. All training has been conducted remotely which is different to face to face. MB suggested that having attended some of the training that it is fairly intuitive, and people will really learn how it works by using it. • Another risk is that of key staff absence and that is currently a challenge with the project lead currently off work and likely to be for a longer period of time.		

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		• MB reminded committee members that the implementation of SBS unfortunately meant staff in creditor payments being put at risk of redundancy. The majority have found other roles within the Trust. MB suggested that as a result of this there is also a risk of not going live as there are very limited numbers of staff left within creditor payments. • MB explained that a balanced approach is being taken regarding go live. He asked at project board yesterday whether anyone had a problem of such an extent that they felt it would not be appropriate to go live. The response was that go live was appropriate providing assurance was gained on BACS payments and procurement catalogues. MB asked the committee if they had any questions following his update RW thanked MB for presenting a really clear paper. • RW noted that in the project risk register the risk relating to staff illness is categorised as a red risk and has come to fruition with the project lead being off. It also sounds like Edge for Health is not yet fully resolved. He questioned whether given these two risks it was appropriate to go live. • MB explained that he has given this a lot of thought and feels that assuming sufficient assurance can be gained on the issues raised earlier the bigger risk is not going live. Given the projections for Covid-19 infections, we could be in a far worse position in terms of staff absence in November. The honest answer is there is not an ideal time. MB stated his personal view is that delaying by a month will not necessarily help to any great extent as the key issue will be user familiarisation of the system and we need to go-live in order to enable users to access the system on a regular basis. From a finance perspective the month 6 close will be carried out on agresso so it will be early November before the finance team need to use it. • MB added that to gain further insight into preparation he had written to six members of staff in finance and asked for their views which we would treat confidentially. 80% of feedback was positive with key areas of improvement identified as being more hands-on use of the system and more regular communication, and slightly better comms in finance. The finance leadership team have responded appropriately to this feedback. • RW explained that if the issues with Edge for Health are addressed the onus will be on MB to find capacity to oversee the implementation in RA's absence and this is a risk we are dealing with. MB acknowledged this and also recognised the level of reliance and therefore pressure on the Head of Financial Accounting, Susan Baines. • RW commented that MB's assertion around the risk of increased Covid-19 prevalence and staying with Agresso were helpful. CJ summarised by stating the committee noted the progress made to date against the project, whilst also noting the risk log and associated mitigations. The committee are comfortable with the finance director's decision whilst recognising there is always a degree of uncertainty with any new project.		

With all of us in mind.

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		MB to inform committee of the final decision within the next 24 hours.		MB
		The committee chair asked MB to pass on the committees best wishes to Rob Adamson.		

8.	Financial plan 20/21	MB presented the key headlines and informed the committee that the he had only received the updated financial guidance for the remainder of the year very recently
		
		Income flows
		• Updated block contract based on month 9 2019/20 updated for material adjustments.
		• Prospective top up and retrospective top up payments and the ability to reclaim Covid costs all cease being provided directly to trusts from October 2020.
		• There are three other means of funding which are being provided to systems (ICSs) for allocation to individual organisations. These are:-
		  - growth funding
		  - system top up funding
		  - covid-19 funding
		  - addition Mental health investment funding (MHIS) is ring-fenced and needs to be agreed directly with commissioners
		• In terms of the block funding we have received an adjustment as expected for Barnsley CAMHS and a further adjustment for forensic services, although this wasn't as high as we expected. MB reported there is no scope for further challenge.
		Timescales
		• Each system needs to submit a draft financial plan by 5th October.
		• More detailed trust plans need submitting by 22nd October.
		• Ideally, we need to agree by 1st October, so the ICS has time to review and aggregate individual organisational submissions. MB added there is currently a lot of work taking place both at the ICS and within the Trust.
		• MB stated that capacity in the finance team is not where it needs to be given the head of financial planning and development role is currently vacant, and the deputy director of finance not in work, but we will have to find a way of overcoming this.
		• MB added that there is an elective incentive scheme for acute trusts which could impact on the wider ICS and organisations within it if the targets are not achieved.
		• A further risk relates to the potential need to create an additional holiday pay accrual given the entitlement for staff to carry over untaken annual leave.
		• At this time MB stated he was not aware of how the funding being channelled via the ICS would be allocated, but he expected there would be some 'fair share' basis used.
		• MB drew attention to the set of financial principles included in the report developed and adopted by all organisations within the West Yorkshire ICS.		

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		• MB commented that he has taken a high-level review of the numbers and based on what he has seen to date believes there is a £3.5m challenge. More detailed work needs to be carried out though in order to verify this. • The national assumption is that systems have enough money to break even. It is acknowledged that there may need to be some level of efficiency saving delivered in order for this to happen. • MB stated that some of the work in the Trust's financial sustainability plan is not necessarily as relevant as it was six months ago. For example, some of our pathways may be changing and there is clearly an impact of Covid-19 on face to face interventions and group work. There are also increased demands for staff and other costs in some areas e.g. infection prevention, cleaning, IT systems and devices etc. MB asked the committee if they had any questions following his update: - • RW agreed that MB's analysis of the position is right. One issue that is very questionable is whether the NHS can restore non NHS income levels to pre Covid-19 levels in the last six months of the year. RW stated that in his conversations with Jonathan Webb there is a real understanding of this issue nationally. Within the ICS RW stated he is aware of two technical adjustments, approximately £25m from one trust. This currently leaves the ICS with a £40m difference between income and expenditure. Many organisations have not focussed on efficiency and waste reduction in the past few months and it is clear that Treasury now want us to. RW further added that additional monies are being made available, for demand and growth in each system. If the Trust is able to access our fair share of this growth funding and it leaves us with 1% efficiency target this would feel fair, but he noted there is a lot of work to be done to get to that point. • RW explained there is a planned discussion about tactics to take place with four ICSs. It feels that there is a risk shift from the centre to ICSs, RW commented that the ICS is our collaborative and we cannot submit a plan that is not deliverable. Collective behaviours amongst directors of finance and leaders of ICSs are very important. • TB felt that it will be complicated managing the financial message to clinical staff. • KQ asked whether in respect of non NHS income, do we have a risk with that. MB responded by stating that our non NHS income is relatively low and therefore low risk. Our more significant risk issue from an income perspective is the continued suspension of non contract invoicing for example gender specific out of area bed placements. • KQ raised the issue of unknown future demand and that the assumptions in the guidance appear to be based on Q1 when there was higher prevalence in London. • MB noted that the planning guidance is based on an r rate of 1 and currently the rate is above that regionally and nationally. MB added that some of the Covid-19 costs reclaimed in the first part of the year should not arise to the same extent in the second half e.g. we have purchased a significant number of PCs to support agile working. On the other hand we have benefited financially from staff being re-deployed into other roles in the earlier part of the year. This is unlikely to be repeated as reset and restoration of services takes place. • MB acknowledged that it is appropriate to reinforce financial control as we are all responsible for spending public monies in an appropriate manner. MB added that our headcount has increased by circa 200 whole time equivalents year on year and		

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Item no.	Item/area	Progress and actions/decisions	Lead	Action
		we need to have better clarity regarding what outcomes we are getting for this increase in staff. Clearly some relates to the Covid-19 response.		
		• SY observed that the timeline for completion of the financial plan is really tight and despite having guidance there is an awful lot of unknowns that will only be fully understood by discussion and negotiation. Do we have sufficient understanding of what the challenge is, and sufficient confidence that the ICS and finance directors are going to do the right thing?		
		• MB provided a summary of what work has taken place so far. We have already completed an expenditure forecast for the rest of the year which just needs updating for any notable changes. We also know what our core block income is going to be. Focus is therefore being applied to system funding and mental health investment standard (MHIS). MB added there is a scheduled sector review on Thursday which will give us a better understanding of consistency in approach to developing the plan. Once we have a better understanding of the allocation of the system and MHIS income we will be in a better position to understand the scale of the challenge. MB added that the financial principles have been developed by the finance directors' group and there is clearly intent to work collaboratively together.		
		• RW stated that there is realisation amongst four ICSs that we will need to negotiate with the centre. RW added that the Dofs from acute sector wrote collectively stating they are not changing the way they work clinically to respond to the financial rules so we have evidence of them wanting to do the right thing. The ICS draft plan submission is likely to state we want some relief on income, along with other caveats.		
		• KQ asked if we are returning to the need to deliver CIPs. MB stated that in his personal opinion this will definitely be the case for 21/22. In the current year we need to ensure we do not waste money and carry out services as effectively and efficiently as possible in the circumstances we find ourselves in.		
		• CJ asked about tactics. If we think we have a £3m shortfall what will the response be? MB responded that we need to better understand the financial challenge before we can determine how we approach this. He added that he is nervous about the potential run rate moving into next year and whilst we currently have a healthy cash position any deficit would reduce this. Our cash balance does provide some flexibility regarding future capital works.		
		• CJ asked what the response would be if all trusts submitted deficit plans and what would it do for regional/local organisations.		
		• RW explained that the view amongst his colleagues is that we are doing everything we can to deliver as much as a service as we can to deliver for the local population, and we should not do that in a way that is risky. We do not know what the financial position is across other ICSs at this point. RW's approach is to have a realistic plan. Last year we delivered our control total across the ICS, which benefited the system in terms of money coming in. RW commented that our credibility is good and we will aim to work towards a negotiated deal.		
		• CJ asked internally what are we going to do in terms of looking for cost reductions?		
		• MB reminded committee members that the financial guidance is very new and still needs discussing in detail with EMT colleagues. An executive view on tactics and approach can be taken then.		
		• CJ thanked MB for providing a very useful paper. He stated that effective and transparent planning is key given the uncertainty and we need to continue to play a supportive part in the ICS.		

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Item no.	Item/area	Progress and actions/decisions	Lead	Action
9.	Lead provider collaborative – eating disorder update	MB provided the key headlines: - • Leeds & York Partnership NHS Foundation Trust is the lead provider for eating disorders across West Yorkshire. • Due to go live on October 1st, Izzy Worswick and Sean Rayner are the representatives for the Trust and we have been fully engaged and involved • In total this represents £5m of business • The exposure in terms of risk share is considered minimal • The directors of finance have agreed the approach to financial risk share and it is recognised that any basic operational financial risks would be picked up by inpatient provider, i.e. agency staffing, meeting efficiency requirements • The potential financial risk will relate to any additional demand which will also be split with Leeds and Bradford and based on population. • MB also commented that from his involvement and knowledge he felt this represented a fair and appropriate approach to financial risk share. After discussing with the committee CJ stated they could endorse the business case, based on scale and minimal risk, and potential benefits as articulated by MB.		
10.	Forensic lead provider collaborative – financial due diligence	MB provided key highlights: - • We have a number of questions relating to the financials and reminded committee members that work had been paused from mid-March to July • MB stated there was considerable complexity in managing a change of this type. • Given the current financial deficits in each NHS provider and adjustments made to the baseline position there is further understanding required. MB added that it will be helpful to understand other collaboratives' bed plans as they could impact on the bed requirements and associated finances. • The three deputy directors of finance in West Yorkshire NHS providers are all involved and are working on comparing assumptions behind the numbers. They are satisfied there is appropriate consistency behind them. It is noted that £4m of income is currently generated by out of area service users. • Some points of clarification have been requested from the specialist commissioner with regard to the baseline adjustments made. • A range of financial risks have been identified which includes the income associated with out of area placements. • A business case is required by early November and will be submitted to NHS England. All provider governing bodies will need to approve the business case. • MB highlighted that further work needs completing regarding potential financial benefits including any that can be generated by the community forensics model. A pilot is currently taking place, but as a result of Covid-19 has been delayed.		

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		• MB also expected potential efficiency improvements to be identified by learning from best practice. An example is where length of stay is high. • MB explained that the programme board for the forensics provider collaborative is running parallel to this meeting and given notable capacity constraints within finance he has been unable to support that meeting which highlights the need for additional focused resource on this genuinely complicated programme of work. MB asked the committee if they had any questions following his update: - • TB asked about commissioning costs and whether they would be included in the business case as well. MB responded that they need to be. He added that there is a recently appointed head of commissioning on 12-month contract for West Yorkshire. This role also covers CAMHS and eating disorders. They can be paid for via transformational monies for a period and will then need to be paid for out of the baseline income. MB suggested more work could be carried out on understanding if any of the commissioning roles could be carried out across a wider geography and would also like to understand if any existing specialist commissioner resource could transfer.into the commissioning function. • MB commented that he felt some additional analytical support would be very beneficial. • RW stated he had met with Richard Barker and made a point about capacity. It is the same people doing the planning, who are doing business case and there is also lack of resource shifting from the current commissioner into the collaborative. RW stated it would be difficult to recommend to board to take on the lead provider role and go live when there is so much financial risk. He added that the deadline for implementation looks like a stretch. Timescales on this may yet extend slightly. • KQ summarised by stating that all the risks are very clear but in terms of benefits they are not as clear. She asked when will we get proof from the community forensic pilot model that there are any benefits. • MB responded that in his opinion we are quite a long way off. Roles have been recruited into but the pilot work has barely started given the impact of Covid-19. He expects it to take a year to get a view, although there maybe pilots elsewhere in the country we could learn from. • CH stated from discussions she has had the national team is convinced the evidence is already there. The return is not as great as possibly expected. She emphasised that the community pilot is a separate programme of work to the lead provider collaborative although there are clearly links between them. • MB reminded committee members that at Trust Board Sean Rayner articulated that a lot of the benefits will not be financial • CJ summarised by stating the committee noted the progress and encouraged further work and dialogue. The committee will want greater assurance on risk mitigation and clinical and financial benefits. MB added that a fuller project update will be provided at the Trust Board next week.		
11.	New risks identified	Key highlights: - • RW commented that there are no new risks but an enhancement of existing risks and we need to ensure these are identified in the risk score.		

With **all of us** in mind.

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		• RW suggested there is an emerging risk relating to capacity driven by internal issues such as ill health, and volume of work. MB stated there was already a risk on the organisational risk relating to capacity and that it is definitely a risk for finance currently, but that it is more a team risk. • RW added that the financial risk around the lead provider collaborative can be updated now we have more information and understand it in a bit more detail.		
12.	Annual work plan	• Update on internal benchmarking/productivity, CJ to discuss with MB outside of the meeting the practicality of this being on the October agenda.		
13.	Items to be brought to the attention of the trust board	• Update on lead provider risk has been clarified and the planning and finances for this major change are complex. • Financial performance - update on the surge in the use of out of area beds and increase in acuity. • Updated financial planning guidance provided and needs further work to better understand the financial challenge. • Concerns around timing and nature of financial planning process and where it will leave the Trust if the arrangements do not provide us with the income we need.		

With **all of us** in mind.

Finance, Investment & Performance Committee (FIPC) – Monday 26th October 2020
Virtual meeting, via Microsoft Teams

Present	Jane Wilson (JW) (Note taker)	Apologies
Members		None
Tim Breedon (TB)	**In attendance:**	
Mark Brooks (MB)		
Carol Harris (CH)	Mike Ford (MF)	
Chris Jones (CJ) (Chair)	Alan Davis (AD) (item 12)	
Kate Quail (KQ)		
Rob Webster (RW)		
Sam Young (SY)		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Introductions and apologies	Chris Jones (CJ) welcomed everyone to the meeting. MB advised that the meeting was quorate	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 22nd September were approved.	CJ	
4.	Review of progress against agreed actions	It was noted that progress against agreed actions was taking place and there was nothing further to update.	MB	
5.	Review of committee related risks and any exception reports as required.	MB provided the update stating that given the committee look at this monthly there is not much change since the last review. He summarised the most notable changes:- • We have been able to update what the plan arrangements are for the remainder of this year • Lead provider collaborative additional financial risk identified that will be covered in further detail at the forthcoming Trust Board.	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• CJ asked with regard to financial sustainability when do we start to find out anything about what next year might look like. He commented that in light of current circumstances and arrangements it seems very difficult to consider financial sustainability in any significant sense. • MB responded by recommending that we focus on what we can control and influence ourselves, which is our internal costs. • SY asked if in respect of risk 1114 financial unsustainability whether the risk likelihood needs to be increased given the level of uncertainty regarding future income and costs. • MB suggested that not at present given the fact the Trust has a reasonable financial plan for this year, there is a five year funding commitment for the NHS and the Trust's cash balance. This is a risk to keep under close scrutiny though and we need to be able to respond to any changes in the financial and operating environment. The committee were satisfied that current risk levels are appropriate and that they will keep an eye on how things evolve in terms of the financial planning regime.		
6.	Current year financial performance	MB provided month 6 key highlights: - • A break-even position has been reported for month 6 • Received last retrospective top up in September • The medics pay award for the first half of the year was all covered in month 6 and is around - 250k. This was in line with national guidance. • Continuation of the locked rehab overspend in Barnsley. This is a risk and unlikely to change significantly in the next six months. • Inpatient costs are another risk given high occupancy and acuity. In terms of pay costs MB stated it is important to not look at agency in total isolation, but our total pay costs including substantive, agency and bank staff as well as overtime. • Pay costs did increase in the month in some areas. In both camhs and learning disability services we have 4 agency medics which are high cost, particularly when the costs of on call are taken into account. • Capital expenditure is relatively low and we have submitted a reduced forecast for remainder of the year as discussed at the previous meeting. MB asked the committee if they had any questions following his update:- • CJ stated he is trying to understand the ongoing increasing bank staff costs and to verify from executive colleagues that this is a preferred route to access temporary staff compared to agency, given they have been through some sort of recruitment process. CJ noted that MB made reference in the last minutes that we have 200 more staff than we had last year and how do we know we are getting value from that. In terms of total pay costs CJ asked if we have sufficient controls in place to make sure we do not see costs continuing to increase in an uncontrolled way, whilst accepting that Covid and sickness absence and acuity are likely to drive it in a particular direction.	MB	

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Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• MB commented that the finance team is currently conducting a high level exercise to explain the main reasons for staffing movements by BDU/support service year on year and this should be available for the next meeting. • KQ asked about the Flowers adjudication. The committee went on to discuss the handling of the Flowers judgement and associated financial consequences. • MF noted that on page 8 of the report the substantive pay bill has gone up for the month of September but the staff number has gone down and asked if that is the pay award. • MB confirmed it was due to the medics pay award. • MF asked why there is a dramatic decrease in cash in the last month of year. • MB explained it is the assumed reversal of all NHS trusts having been paid one month income in advance to support cash flow and payment of suppliers within seven days. The value of this is approximately £17m. • RW stated he believes the capital expenditure forecast is a risk and that there have been several conversations at EMT about making sure that money is spent on the areas of priority for the Trust. • SY commented that it is great to see that we have kept better payments at the same level throughout September, adding that she recognised there may be reduced performance for a period of time given the implementation of the new system. • CJ commented that he had noticed that there have been some significant payments to other health trusts and he understood that inter health organisation transactions had been cancelled. • MB explained that the rules do not allow for invoicing of non-contracted activity, however for regular provider to provider charges arrangements are in place e.g. rental contracts for The Dales and Priestley. • RW suggested that in terms of staffing, there is a different way of reading the situation, which is to say we have been much more successful in recruiting and retaining the appropriate number of staff we have budgeted for. We need to understand what has changed and what this will mean for us financially. This places more emphasis on benchmarking and in planning for next year we need to consider how we apply different approaches to managing our budgets which do not rely on underspending on staff.		<u>Action: MB</u>
7.	IPR Update	CJ commented that this is a major item for discussion at Trust Board tomorrow, and that MB should provide an update of the headlines. MB highlighted the following:- • The number of days children and young people spent in adult wards was 26 which was higher than April-August combined • Clinical supervision showed little change in quarter 2 • IG breaches remain fairly consistent in number • Staff Covid absence is increasing • CAMHS referral to treatment times have improved consistently for a number of months • PPE deliveries have recently increased. • Food safety training - currently every bdu is below target. We are currently looking at who has to complete this and how, as certain elements are currently required to be conducted face to face, which is having an adverse impact on the ability to complete this.		

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		• RW focused on the positive work that continues on CAMHS despite all the pressure. In terms of staff absence once shielding is adjusted for absence rates are at the level they were in June and that is starting to be a problem. This is a significant risk on our future performance. • CJ asked is there any sense that the increase in Covid related absence is going to stop? • RW responded that it is currently unclear what impact the various regional restriction tiers will have. Effective local test and trace is likely to make a difference and, there is some evidence from Bradford and Calderdale that have local test and trace systems that it does make a difference in turning the curve, but the r rate is above one at the moment and has been for some time. We have asked the local resilience fora to make sure that local test and trace is available in all places in West Yorkshire and part of the tier 3 restrictions in South Yorkshire is that local test and trace will be made available. • SY asked if there are any specific absence issues in any of the BDUs. • CH responded by stating that we have a specific issue in forensics given the level of inpatient service and staffing and that there can also be issues in learning disability services on some days. • RW noted that the Business Intelligence Team has amended the absence data and the analysis, so it includes increased drill down and is updated every 10 minutes. All NEDs with laptops and VPN access have access to this. • RW commented that a conversation needs to take place with AD to ensure the talent pool is reinstated. As CH stated earlier, if someone is well but is self-isolating they may be able to carry out other work. • MF asked a question about fill rates and whether there are areas with fill rates greater than 100% and does that mean there is capacity to move those staff on to different wards. • CH responded by stating what it means is that it is over and above the establishment that we have planned for that ward. It could mean that we have more than one service user on additional observations who may always need two staff with them, sometimes more. Those areas with higher fill rates tend to have increased acuity resulting in us requiring a staffing establishment over and above what has been planned. • MF asked why section 17 leave has been red for a number of months and what is the scale of issue, and what are the consequences. • CH replied that it is leave approved by the multi-disciplinary team and there is a process that has to be followed. Covid-19 has had an impact on performance because all leave was stopped in the forensic unit. There has clearly been a lot of work done but we are not where we should be in relation to performance and this is monitored through the Mental Health Act Committee. • KQ noted that performance can often look worse than it is as there is a principle that it is not rated green unless it is embedded. • RW asked if we have seen this reflected in CQC Mental Health Act visits and feedback and have the committee taken action on that. • KQ confirmed the CQC totally understand the process and think it is a good approach. There has been genuine movement and the improvement is real. The section 132 is about reading patients their rights and reiterating their rights		

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		which is vitally important, and we have had a real problem with this. There was 30/40% compliance last July and this is now up to 92% across the trust which is a real testament to staff and matrons along with mental health act office staff. • RW reaffirmed this is something we need to keep the focus on as there are consequences if we get it wrong with CQC and for individuals. • RW commented that regarding MF's earlier comment re safer staffing that we refreshed the establishments 18 months ago because we were typically always well over 100%. We rebased them so they should be close to 100% most of the time. We have a number particularly around PICU, Horizon and acute inpatients which are well over 100%. The reasons why Horizon is over 100% are known. As CH stated it is acuity levels and we have taken in one individual that requires significant additional support over and above what would be required normally. Some of the other wards are consistently over, which is either a reflection of acuity or the assumptions in the baseline are incorrect or out of date, or a reflection of a lack of control over staffing. This needs to be explored further, if it is acuity and we have that much pressure then we need to go back to commissioners or we need to recognise that the system is under significant pressure and the staff need more support. • CH confirmed that we need to recognise the system is under pressure and staff do need more support. The other measure to look at to balance this is our out of area bed spend. We are managing this closely and have not placed anybody out of area in an adult acute ward for over a month and we have been averaging 3 or 4 PICU out of area placements. This has likely had an impact on acuity on inpatient wards and our staff are telling us this. Discussions with commissioners are ongoing because they are part of the care closer to home work. Ultimately, we need to have more conversations with commissioners around the level of acuity and our ward sizes. If we could reduce ward sizes this would have an impact on the number of staff we needed and the way we manage acuity. • TB added to what CH has said by reflecting about the use of the safe care model tool to add into our e-rostering which will help us in terms of some of our predictions in terms of activity and matching our staffing accordingly. In terms of our establishment figures compared to the baseline we need to understand how much is related to Covid and how much is related to overall general increase in acuity. We will monitor this through the safer staffing group. • RW stated it would be really useful in the analysis if we could cluster the ward types. • CJ explained he has discussed the safer staffing reporting separately with TB. As a NED it is difficult to understand what the target is, particularly when the figure is in excess of 100%. This might be a topic for a deep dive into some wards that have higher percentages and try to track occupancy, acuity, establishment and actual staffing levels to gain better understanding. • RW suggested we could ask the care closer to home programme to carry out a review. • CH explained that we do not tend to look at the older adults, but we can ask the care closer to home group to review. Alternatively, she can bring a brief back to a future meeting.		Action: CH

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
8.	SBS Finance ledger system progress update	MB stated that in terms of go live we are currently in effect using the purchase ordering and invoice payment system. This has not been without its challenge as staff across the organisation adapt to a new system. The October financial month-end close will be carried on using SBS and staff are currently being trained on how this works. Key headlines:- • Much less queries since the first couple of weeks • One of the biggest challenges is getting directors and senior managers to approve invoices • Payment within seven days is unlikely to be as good in October and November given the transition to the new system. • Key challenge for the finance team will be month end reporting. We have a requirement to report into the ICS within 5 days. This may not be achievable in the first couple of months given the newness of the system and how it works. CJ stated it sounds like the implementation is going as well as it can do in the circumstances and congratulated everybody involved.		
9.	Financial plan 20/21 Update	MB explained the paper had been discussed in depth at the extraordinary board last week, and that he wanted to give the committee members an opportunity should they want to identify anything they required review or understanding of in further depth. MB stated he would take the paper as read as it was approved at the meeting last week. • SY stated it feels strange to have an assumption of an r rate of 1 when we know that is not the current position. This was acknowledged.		
10	Capital expenditure forecast	MB explained this paper has been provided for information purposes as the forecast had been submitted following the issue being raised in principle at the last meeting and discussed in detail at EMT. He felt it was important to provide the committee with more depth of understanding about where changes have been made. • MB explained that typically the changes have been fairly cosmetic with the biggest change relating to no in year expenditure on a North Kirklees hub this year. He added that there have been some schemes that have extended into the 21/22 due to Covid-19 and some additional schemes now required also as a result Covid. • MB also explained that lead times for some IT equipment have increased as a result of the pandemic. CJ asked about the level of confidence in the current forecast given the low spend to date. MB responded by stating that the forecast has been through a robust process but has made assumptions about accessibility to our sites and supplies which may prove more challenging given the increased prevalence of Covid-19. The £1m reduction is appropriate at this point in time but will continue to be reviewed. • MF noted with regard to the minor works schemes there is quite a long list of things that have not yet started and asked whether it is reasonable to assume that they will all start and finish this year.		

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• MB responded by stating it will be a challenge, but the team is very confident. He noted that there was a similarly high level of activity and spend in the latter part of last year. He added that all the schemes are required programmes of work so we should give the team the opportunity to complete the work. • CJ asked about clarity of prioritisation and the risk of a high number of single tender waivers in February and March to achieve our spend target. • MB explained that EMT are very much guided by the work carried out by Nick Phillips and his estates team working in conjunction with the BDUs. They have determined what the priorities and safety risks are in the first place. Furthermore, there is a detailed prioritisation process that takes place every year. MB added that in his view this is a very good process with significant engagement and governance supporting it. EMT endorse the programme of work recommended and empower the team to spend against it. • RW agreed and added further assurance by explaining there was a long discussion at the most recent EMT around the update on ligature risk audits and the capital works required to address them. • CJ asked if there are any implications for not pursuing the North Kirklees hub this year. • MB responded by stating that given the impact of Covid-19 any such development would need to be agreed in the updated estates strategy. There is a recognition that we have hubs elsewhere and not currently in North Kirklees • CH added that the way we are using hubs currently is not what in line with how they were working pre Covid-19. The committee agreed to endorse the capital expenditure forecast for 20/21		
11.	Investment appraisal	MB presented the key highlights: - • The report identifies where there are current tenders or other funding opportunities available. • There is currently only 1 tender, which is the Breathe contract in Barnsley. In addition, there are other avenues for accessing funding that require business cases and these are all identified. • The Trust is also heavily engaged with work onlead provider collaboratives, and noted we are involved with CAMHS as well as leading the forensics collaborative. • MB added the report notes there are monies available from next year onwards in relation to community mental health transformation. MB suggested that activity is building up again. He also noted there will be a challenge as our Head of Business Development has been successful in gaining a new role on secondment in the Trust. • RW agreed that the number of live and open business cases and business development work is a significant capacity pressure and we need to keep that in vie. RW agreed to raise this through the ICS. • CJ asked about partnership arrangements for the Breathe tender and a discussion followed. • MF asked what the financial impact on the Trust would be if we are successful with all of them.		

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• MB explained that we look at each on a case by case basis and will consider the financial impact during the planning and forecasting processes. • MF asked if each opportunity helped us achieve one our strategic objectives. • MB responded by stating we have a decision tree process for each opportunity that goes through EMT and one of the key questions is around strategic alignment. • MB noted that with regard to national and regional opportunities our CCGs have been very helpful in supporting the process. The committee noted the report		
12.	Agency - Self certification	AD presented the key highlights:- • AD confirmed that new arrangements have been agreed for Agency Staff and reducing agency spend will now be part of a Flexible Workforce Model task group. The task group will create a more flexible substantive workforce supported by a staff bank and the use of agency staff in key/specialist hard to fill posts. • AD - these new arrangements will allow the staffing group to focus on safety and clinical issues including the role out of Safecare linked to the e-rostering system. Safecare is a system designed to support more effective rostering of staff linked to acuity. • TB emphasised the importance of getting the Safecare system operational and this will support better planning around predicting acuity and matching staff levels based on clinical need. • AD - the flexible working group will also have a role in developing effective and efficient rostering. • CH - this a new process which pulls together a number of streams, it is bigger than just agency, and this is a more helpful approach of looking at it. • SY - AD talked about a subgroup linking back into WRC, we are going to talk about this and how it will work in more detail at the meeting on the 12th November. • CJ - it does sound like this piece of work is critical and is all about having the right people in the right places. Having oversight of it as a committee seems to be moving away from FIP and more towards WRC. • SY - I am comfortable with that, and following review of Alan's paper on 12th November, SY to have a conversation with CJ to finalise this. • AD - WRC have always received an update report on agency spend as part of HR performance, more for information and connection as we appreciate the management of this has been through FIP, but we might want to look at how this links together now. • CJ - AD mentioned healthcare support workforce, we are still spending £1m on agency and why is that? • AD - easier to call an agency, and so a convenience for ward managers and bank, what we must not do is make anything harder for them. It is all about the right balance, and what do we need to increase in our establishment and what do we need to increase in our bank. We really have to be careful; agency is not bad, it is a really helpful way of us managing our		

With **all of us** in mind.

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		workforce and our resources. What is bad is using too much agency and the over reliance on it, and that is where we need to get the balance right. There does need to be a more industrial recruitment process, which is one of the reasons why we have been talking to NHS Professionals to see so if they could help with this and go through a large recruitment exercise. We are also finding, given the current economic situation that we are getting more people of good quality applying for these roles. The reputation of the NHS has gone up as a career, the economy has deteriorated, and people are seeing this as a much more stable and long-term offer, and I think they are the main aims of where we are at with it.		
		• KQ - endorse that feeling when I speak to staff, there is a strong feeling that agency and bank kind of help the numbers but do not always help if they have not been on a ward before, and service users always go to established staff when they need anything difficult.		
		• KQ - what do we do about e rostering.		
		• AD - we have had e rostering in place for some time now, what it didn't have was connection between acuity and that is where Safecare comes in.		
		• RW - picking up on AD's comment about health care support workers, my guestimate on average for £1m you get 25 staff with all the on costs, as healthcare supporters are paid less. We are only looking at 40-45 wte staff, do we have any idea how many bank healthcare supporters we would need to recruit to cover that. I do not understand the rationale of going for agency when you could go for the bank.		
		• AD - I do not have the real figures with me, people have worked through this on the safer staffing group. It is an opportunity and something we need to focus in on as people are more willing to come into these roles.		
		• MB - for information and awareness really, not quite half, but not far from it of our agency costs relate to 8 locum medics in LD & camhs. If we did not have those and we have had these for some time we would be talking of a much lower number.		
		• RW - just to reflect that it doesn't save much money to recruit them permanently.		
		• SY - that was the point I was going to make, so presumably the health care support workers we have got vacancies.		
		• AD - it is a bit more complex than that, it is not just vacancies, we do not have that many vacancies, but we have the expenditure around it and in terms of health care support workers there are a variety of issues.		
		• CH - we run with very few health care support worker vacancies if indeed any. We have over recruited this time and we have put some health care support workers in the peripatetic workforce that is attached to the bank so they are full time workers, and it will not be long before they are then slotted into vacancies. Where we are recruiting healthcare support workers, if people are appointable and we do not have a position we have got the option of the peripatetic workforce, and we use it because we use so many bank and agency support workers. To reassure the committee we are not sitting on vacancies in the healthcare support worker role. The agencies have a different level for recruitment than we do, and the agency support workers will not have gone through the same level of training that we as a trust do, and to apply for a role within the trust is more of a career option, and some people just choose to work on the agency and will only want to do that. Going back to KQ's point we do try to use regular agency or regular bank, people tend to choose either forensics or acute or older people, and we do try to book them for the same wards to try and minimise disruption, but we also		

With all of us in mind.

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		encourage people to apply for permanent jobs and encourage agency to apply for bank jobs with us, it is not a case of us having random people working on our wards.		
		• SY - there is no real financial advantage in the case of health care support workers because they are a cost in agency and they will become an additional cost on baseline if we move them over, is that right.		
		• AD - as CJ said a lot of this is around quality agenda, we do need to be careful we do not increase the overall bill. We have a significant increase with Covid around overtime which was minimal but now a significant expenditure for us in terms of cover. We also do not want staff working too many hours, it is all about getting the right balance.		
		• CH - as a reminder with issue of Covid, and inpatient areas, if people have to work from home because they are isolating we have got no choice but to replace them on the ward, whereas in the community, people can generally do their work from home. There is an automatic double running cost the minute somebody is not on a shift, there are odd occasions where we can move people around.		
		• CJ - when we get to the financial plan that was one of risks that MB had highlighted as a factor going forward to try and anticipate that.		
		• CJ - we have had a good conversation on agency and its importance to the trust operationally and financially and SY and CJ will pick up that conversation following the update at the next WRC on 12th November.		
13.	New risks identified	• It was agreed no new risks were identified		
14.	Annual work plan	• CJ and MB to have a conversation around frequency of meetings which can influence what is on the workplan		Action: CJ/MB
15.	Items to be brought to the attention of the trust board	• The change in arrangements for oversight of agency and flexible working and update provided by Alan Davis. • Noted break-even in M6, whilst also noting we are moving into less secure financial arrangements for the remaining half of the year. • Implementation of SBS and next phase of development which is month end reporting • Agreed changes to capital expenditure forecast for the year • Business development opportunities noting the workload for colleagues, and the desire to see less process attached to national bidding opportunities.		

With all of us in mind.

**Minutes of the Mental Health Act Committee Meeting held
Virtually via Microsoft Teams on
25 August 2020**

Present:	Dr Subha Thiyagesh	Medical Director (lead Director)
	Kate Quail	Non-Executive Director (Chair)
	Tim Breedon	Director of Nursing and Quality
	Laurence Campbell	Non-Executive Director
Apologies:	<u>Members</u>	
	Erfana Mahmood	Non-Executive Director
	Salma Yasmeen	Director of Strategy
	<u>Attendees</u>	
	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Clive Barrett	Head of Safeguarding, Mid Yorkshire Hospitals NHS Trust
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	Chris Lennox	Deputy Director of Operations
In attendance:	Julie Carr	Clinical Legislation Manager
	Gary Haigh	Independent Associate Hospital Manager, Chair of the Hospital Manager Forum
	Carol Harris	Director of Operations
	Yvonne French	Assistant Director, Legal Services
	Kelly Reittie	Admin MHA/MCA Manager
	Victoria Thersby	Head of Safeguarding (Calderdale & Huddersfield NHS FT)
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative
	Sarah Millar	PA to Medical Director (author)

MHAC/20/27   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.

With **all of us** in mind.

MHAC/20/28   The Act in Practice (agenda item 2)

MHAC/20/28a Hospital Managers and hearings during Covid 19 (agenda item 2.1)

Presentation from Gary Haigh (GH) and Kelly Reittie (KR), MHA/MCA Admin Manager for Calderdale, on developing and running virtual hearings and paper reviews due to the Covid 19 pandemic.

GH fed back from a Hospital Manager's perspective and gave an example of a case in which a virtual hearing had been carried out. GH indicated that the Hospital Managers had been very accommodating and many had upgraded their home computers and equipment to facilitate the hearings. Difficulties of virtual hearings included being unable to 'read' people's expressions if their face cannot be seen and being unable to scrutinise reports. GH added his compliments to the Mental Health Act (MHA) Office staff who had ensured that all patients' rights were protected throughout the process. KQ echoed that the role of the MHA Office staff in making improvements during a really difficult time had been fantastic and this was another example of that.

KR gave an overview of the changes that had been implemented by the MHA Office teams to ensure that the virtual hearings could take place.

Tim Breedon (TB) thanked GH and KR for their efforts and indicated that it meant a lot to both the Trust and service users that hearings have continued.

Committee agreed that it would be good to get feedback from a service user perspective and Subha Thiyagesh (ST) advised that a service user survey had gone out to ask about their experiences. Yvonne French (YF) added that feedback was likely to come to the next meeting in November.

Action: Yvonne French

MHAC/20/29   Legal updates (agenda item 3)

MHAC/20/29a Impact of Covid 19 MHA/MCA/DoLS (agenda item 3.1)

YF advised that the paper had been updated since the last meeting and would be a rolling record of changes related to the Covid-19 pandemic. Mental Health Act Committee (MHAC) noted:

- ➢ Department of Health and Social Care legal advice version 2 was released on 19 May 2020 and a review of the guidance was undertaken in respect of the Mental Health Act 1983. Changes were made to existing processes as appropriate.
- ➢ All Mental Health Act statutory forms can be completed electronically and electronic signatures are acceptable.
- ➢ Consideration has been given to undertaking a renewal or extension of a section via video assessment. This has not yet been used in practice although the Trust is prepared for a potential second wave and the Standard Operating Procedure has been updated.
- ➢ Mental Health Tribunals within the Trust are being undertaken by telephone conferencing and service users are being asked about their experiences of this in the service user survey.
- ➢ It had been previously agreed that in certain circumstances seclusion reviews could be done remotely, however version 2 of the legal advice indicates that all reviews should be done face to face and SWYPFT has reverted to the original guidance.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/20/29b DHSC/NHSE Digitalising the MHA consultation response (agenda item 3.2)
Julie Carr (JC) reported that the Trust had submitted its response on 6 July 2020 and the response was broadly supportive of the proposed changes for the serving and receiving of detention papers via digital means. The response welcomed the suggested changes as a positive approach to modernising the MHA 1983 although the potential for Information Governance (IG) breaches had been identified and would need to be addressed. We will now await the release of the revised regulations and if there are any significant changes, the MHA Office will put together an implementation programme for the Trust.

Laurence Campbell (LC) queried whether the use of electronic signatures could be trusted if they were over-used or delegated and added that the United Kingdom is fundamentally lax with regulations for the use of electronic signatures, unlike other countries. JC advised that SWYPFT is following both the Department of Health and Social Care (DHSC) guidance and guidance that is emerging from the courts to ensure compliance. KQ added that we are currently in the consultation phase and await clarification on regulations and confirmation of what the law is asking from us. YF will liaise with Julie Williams, Assistant Director Corporate Governance, Performance and Information to ensure we are complying with all necessary governance.

KQ thanked JC for submitting this helpful response on time to DHSC.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/20/29c Detentions under the MHA annual report (focuses on detention and ethnicity) (agenda item 3.3)
JC reported on the national annual report on Detentions under the Mental Health Act (MHA) which was published on 26 May 2020. All hospitals that admit people under the MHA were required to submit data and the focus of the report had been on the impact of ethnicity on admissions and detentions. Committee noted that as the report covered national figures, it was difficult to make a comparison against our own Trust however JC gave some contextual figures for SWYPFT which indicated that our figures were lower than the national rates.

ST highlighted that work had been ongoing in MHAC for the past two years to improve ethnicity data collection and that this has shown significant improvement.

MHAC had also started work to specifically address the concerns that were raised in last year's national report around BAME detention rates.

The work that MHAC started with Cherill Watterston, Chair of the BAME staff Network, will help us to gain more information about the different experiences of BAME service users as it is acknowledged that there are a number of ways that people can be adversely impacted and affected. A preliminary meeting has taken place in relation to developing this work using the Trust's patient engagement toolkit. It is anticipated this will be a systematic and thorough way of getting feedback and will also include a research element. An update will come back to the next MHAC meeting in November.

Action: Yvonne French

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

<u>MHAC/20/29d DHSC updated MCA/DoLS Guidance (agenda item 3.4)</u>
JC gave a further update on the guidance that had been issued by the Government at the start of the pandemic which recognised that the restrictions for the care and treatment of Covid 19 would not constitute a Deprivation of Liberty and that emphasis had been put on Principle 2 (all things practicable to involve the person in decision making) to support participation and understanding of the unprecedented circumstances imposed by the pandemic.

The guidance was updated on 29 May explaining the interaction between the Mental Capacity Act (MCA) 2005 and the Emergency Public Health Powers and again on 10 June to provide information on rights of appeal against a DoLS authorisation.

JC confirmed that measures are in place to support virtual contact with family and friends during periods of restricted contact as a consequence of Covid 19 including advocacy where required.

KQ summarised that Committee have noted the processes in place and that JC is working with the local authorities.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/20/30   Local Authority and Acute Trusts (agenda item 4)
The following updates were noted:

Stephen Thomas (STh) – Wakefield Council
➢ Around 4 or 5 virtual MHA assessments have been carried out in a bid to reduce footfall into hospital. It was noted, however, that a virtual assessment is not appropriate in all cases.
➢ A shortage of beds had become an issue again with one person having to wait for more than 2 days after being assessed. In another case a bed was found overnight in the private sector but the unit would not take the patient until 10.00 am the following morning and this had been escalated. Carol Harris (CH) advised that we are often in a difficult position with private providers as they have what we need and may have reduced numbers of staff overnight and therefore not deem it safe to admit out of hours. CH added that it is really important to strengthen community services to keep people at home wherever possible and avoid hospital admissions or have more local availability if absolutely needed.
➢ STh is liaising with JC to refine the pathway and clarify the difference between 135(1) and 135(2).
➢ The current AMHP workforce in Wakefield is around a third of its usual complement due to several people having underlying health conditions and not undertaking face to face assessments. There are processes in place to deal with the shortfall.

Victoria Thersby (VT) – Calderdale and Huddersfield NHS FT
➢ Also reported a shortage of mental health beds although acknowledged the support of the liaison team 24/7. Queried if this was a commissioning issue and CH advised that the issue is wider than just bed numbers and commissioners are involved in the Care Closer to Home group.
➢ Positive working relationships with mental health partners and developing overarching Mental Health Policy.

➤ Been successfully able to undertake remote assessments. Some initial decrease in DoLS applications but back up to usual numbers now and seen a spike in detentions in July.

The following updates had been submitted in writing:

Anne Howgate – Kirklees Council
➤ The number of referrals has reduced.
➤ There appears to be an issue with undertaking MHA assessments at night. This may be due to being unable to access 2 doctors and there is evidence of this in some cases but not all.
➤ There continues to be a lack of understanding of how the MCA 2005 is implemented in the community across all teams, for example requesting MHA assessment for those who have not consented with little consideration for the fact that the person may not have the capacity to consent.
➤ There have been a number of contacts from A&E asking for investigations into the lengthy delays in hospitals. There have been a number of reasons for the delays, one of which was because the AMHP service was not covered due to ill health. The others were related to lack of doctors or bed provision.
➤ Continue to value partnership working with all the SWYPFT teams across Kirklees.
➤ S135 continues to not have the same priority as S136 in the suites. This can make it very difficult for a warrant to be served in the community if a place of safety cannot be provided. This leads to lengthy delays in assessing patients who are believed to be high risk in the community. Getting the police and the doctors available is challenging enough but then not having anywhere to go is problematic.

Shirley Atkinson – Barnsley Council
➤ SWYT has reinforced the need for s12 doctors to register with the s12 Solutions app in South Yorkshire. YF confirmed that she is involved with this and the plan is to roll out to West Yorkshire.

Clive Barrett – Mid Yorkshire Hospitals NHS Trust (MYHT)
➤ SWYPFT Psychiatric Liaison Team (PLT) continues to provide a service into MYHT and no issues to report in relation to this for the past quarter (April to June 2020).
➤ There are regular 'catch-up' meetings with SWYPFT's MCA/MHA Manager, Carly Thimm, to identify any issues and take appropriate actions. The MHA Office recently provided the data on MHA detentions for 2019/20 at Mid Yorkshire Hospitals Trust which is included in the MYHT Safeguarding Annual Report, due for approval next week.
➤ As Covid 19 lockdown has eased A&E attendance has increased including the number of people presenting with mental health problems. There have been long waits for some of these patients but these tend to be waits for available mental health beds, not waits for Section 12 doctors to undertake mental health assessments.
➤ There have been some recent issues with the Wakefield out-of-hours AMHP service provided by Social Care Direct and these are being addressed directly with the Wakefield Council manager responsible for this service. One issue has been the refusal of the AMHP to attend Pinderfields Hospital A&E to undertake the MHA application in the early hours of the morning which resulted in the patient remaining there for an extended period of time. STh indicated that the local authority did not accept this version of events and were clear that they believed the account to be incorrect.

Post meeting note: CB advised that this matter had been resolved following an investigation where it had been found that there was no delay or refusal by the AMHP.

➤ There is ongoing progress in relation to work between SWYPFT CAMHS services and MYHT to improve the experience of children attending MYHT sites with mental health needs. This was referenced in the last quarterly report.

➤ A Joint Operational Mental Health Group involving representatives from both SWYPFT and MYHT has recently been established and has met twice.

➤ Key staff at MYHT are aware of the guidance in relation to the MHA in response to the Covid 19 pandemic and the temporary changes made to the MHA and MCA by the Coronavirus Act 2020. As these changes are prospective and have not yet been enacted, there has been no impact on the Trust.

MHAC/20/31   Minutes/Actions (agenda item 5)
MHAC/20/31a Minutes of previous meeting held on the 12 May 2020 (agenda item 5.1)
It was RESOLVED to APPROVE the notes of the meeting held on 12 May 2020 as a true and accurate record of the meeting.

MHAC/20/31b Action points (agenda item 5.2)
The action points were noted and the following item raised:

➤ MHC20/07a – Performance report – YF confirmed that the 3 Hospital Managers/Tribunal hearings that were reported to have been cancelled due to service users being transferred on the day of hearing was an error due to the way the question had been framed.

MHAC/20/32   Matters arising (agenda item 6)
MHAC/20/32a Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.1)
KQ reported that there were four current risks on the Organisational Risk Register that were directly relevant to the Mental Health Act Committee (these were Risk numbers 1545, 1424, 1319 and 1368). It was noted that these risks were allocated for assurance and oversight to the Clinical Governance and Clinical Safety Committee (CGCSC). Assurance is provided to MHAC via the 'notes for other committees' section on the CGCSC agenda.

The plan for future MHAC meetings will be to also review the MHAC Risk Register and YF has scheduled regular meetings with Corporate Governance to update the risks ahead of MHAC meetings.

MHAC/20/33   Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)
MHAC/20/33a Performance report – Monitoring information Trust wide April-June 2020 (agenda item 7.1)
The report was considered and the following noted:

➤ There is continued improvement in ethnicity recording.
➤ There have been some significant fluctuations in detention rates with a notable increase in detentions but not admissions.
➤ The rate of admissions had increased from the same period last year however, with the percentage then being 42% compared to 51% this year.

- x3 young people under 18 years admitted (x1 informal and x2 under MHA).
- In relation to an issue that had previously been raised whereby DoLS patients were discharged before their application was processed, there is now a system in place to flag when this happens and to record the reason for discharge.
- It was suggested that it should be made clear that some people are excluded from the graphs reporting on ethnicity as they could appear to be misleading.
- One concern raised – relating to a care coordinator not attending. Noted that attendance was improved now virtual hearings taking place.

Post meeting notes: There were some discrepancies noted within this section as follows:
- *It was reported that there was 1 Tribunal hearing cancelled due to the patient being transferred on the day of hearing however there were none.*
- *A reported total of 35 sections and CTOs being renewed or extended should read 5.*
- *CH had raised in the meeting that there were 3 deaths of detained patients. It has subsequently been confirmed that the report is correct in noting 2 deaths in Quarter 1 and the other will be reported in Quarter 2.*

It was RESOLVED to RECEIVE and NOTE the contents of the monitoring report.

MHAC/20/34   CQC compliance actions (agenda item 8)
MHAC/20/34a MHA/MCA Code of Practice oversight group feedback (agenda item 8.1)
YF gave an update on the following workstreams:

- Leave implementation group – the completion of Section 17 leave forms notifying carers and escorting staff of the conditions of the leave has been a Key Performance Indicator since October 2019. During the pandemic leave had been suspended and only reinstated in July 2020. There has been some improvement in the completion of page 2 in Forensic services as this is now being monitored by someone within the service who is not currently ward-based.
- Seclusion and Segregation and Reducing Restrictive Practice – workshops will be scheduled to review current plans and agree future development.

It was RESOLVED to RECEIVE and NOTE the activity.

MHAC/20/34b MHA/MCA/DoLS mandatory training update (agenda item 8.2)
JC reported the current position as of Quarter 4:
- Mental Capacity Act/DoLS training – 90.7% compliant
- Mental Health Act training – 87.27% compliant
which was noted to be in excess of the 80% target although a slight reduction on Quarter 3. A couple of hotspots had been identified and targeted training would be offered.

JC added that e-learning provision had been offered to all clinical staff in an effort to comply with the 80% target. Going forward there are plans for a blended learning approach for MHA training.

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/20/35   Audit and Compliance Reports (agenda item 9)
MHAC/20/35a Patients' Rights Section 132 MHA and Advocacy (agenda item 9.1)
KQ advised that formal audits had been deferred due to Covid and competing priorities.

JC presented a report that summarised the findings of a manual review of 464 patient notes. This 'deep'dive' found a huge improvement in recording of the initial giving of rights to patients detained to hospital under the Mental Health Act (MHA). Overall the Trust had achieved 92% compliance.

A previous deep dive in July 19 had found very poor recording, with confusion regarding where to record the giving of rights, with several places available to staff. Quality improvement work had been done to ensure a single place of recording was available, this had been reinforced through training by the MHA Office team at local levels. The MHA Office continue to actively monitor the giving and recording of patient rights and providing prompts to the wards on a daily basis.

Committee noted that the matrons and MHA office staff had done an excellent job and thanked them for this.

The report identified that there was some work needed to improve rates of referral to IMHAs and it was noted that informal patients were given their rights but did not automatically qualify for an IMHA referral and this would be considered as part of the next audit. YF also referred to some confusion with recording on SystmOne in relation to access to advocacy and this was being picked up with the SystmOne team.

It was noted that work has already begun to improve access to and referral to the IMHA services. An update will come to MHAC in November.

LC queried whether we are utilising the SystmOne alerts to their full potential or whether this was something that could help us with compliance and reduce the workload for the MHA Office staff. YF confirmed that this was being explored as the MHA Office is currently dealing with around 40 manual reminders each day.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/20/36   Care Quality Commission visits (agenda item 10)
MHAC/20/36a Visits and summary reports Quarter 1 (agenda item 10.1)
JC reported that there were 5 CQC Mental Health Act visits in Quarter 1 to Ward 19, Johnson, Clarke, Nostell and Crofton.

Within the quarter, 5 MHA monitoring summary reports were received relating to ward visits made to; Ward 19, Crofton, Nostell, Johnson and Clarke.

6 responses were submitted to the CQC; Ashdale, Clark, Nostell, Crofton, Johnson and Ward 19.

The Committee received detailed information about the outstanding issues. JC reported that the CQC virtual inspections take place with a week's notice to allow the ward to set up times for various people to speak with them. This has also allowed more service users to get involved and JC asked MHAC to note a number of positive comments and feedback to CQC from service users, carers and advocates. Issues had been identified with care planning and individual risk assessments, which are both addressed by wider Trust work. KQ added that the virtual inspections appear to have been successful and in particular the timely response which was beneficial.

MHAC acknowledged that this had been a very positive experience in difficult times and TB added that when face to face inspections resume, it is anticipated that there will be a high level of scrutiny on records.

It was RESOLVED to RECEIVE the report and to NOTE the positive progress.

MHAC/20/36b Update on CQC MHA action plans (agenda item 10.2)
YF reported that the majority of actions that were overdue was a result of Covid 19 and of particular note was the delay to the roll out of the new risk assessment Formulation Informed Risk Management (FIRM) tool. MHAC noted that some of the actions had been implemented however matrons were keen for the changes to be embedded with regular reviews before rating them as 'green' or removing from the action plan and Committee agreed that this was a good approach.

It was RESOLVED to RECEIVE the report and to NOTE the progress of the actions following CQC visits.

MHAC/20/37   Independent Hospital Managers (agenda item 11)
MHAC/20/37a Hospital Managers' Forum (agenda item 11.1)
The Committee noted that there had been no forum held due to Coronavirus. A written update had been provided to KQ who gave an overview of the key messages:

- Since March, 5 Hospital Managers had resigned, mainly due to not wishing to embrace the use of technology. This had left a shortage that was manageable at the present time but would need to be addressed if there was a return to normal practice.
- It had been noted that the reintroduction of Section 17 leave had had a positive effect on service users. MHAC noted that the ongoing care and recovery pathway had been particularly affected by Covid 19 restrictions, for example with moves to community placements being postponed which was frustrating for both Hospital Managers and service users.
- There were a couple of concerns raised, the first being that it is vital that the reports submitted are up to date. There had been a few occasions when the reports were not particularly thorough and Hospital Managers had to contact the wards asking for more information. A lack of information could lead to a delay in making a decision.
- There have also been some cases where details of the next nearest relative were missing.

GH added that the MHA Office staff had worked really hard to facilitate the remote hearings and may need some support due to fatigue. KQ acknowledged the excellent joint work of the Hospital Managers and MHA Office staff.

TB added that it may be possible to facilitate some remote Hospital Manager recruitment with the correct technology and proper training programme in place.

It was RESOLVED to NOTE the update.

MHAC/20/38   Key Messages to Trust Board and other Committees (agenda item 12)
The key issues to report to Trust Board were agreed as:

- ➢ Service user survey work and BAME study update
- ➢ CQC feedback – quality improvement
- ➢ Section 132 rights – positive compliance with rights across the Trust. Some work identified around access to advocacy
- ➢ Virtual work because of Covid 19 – hearings, etc. ST added that the Act in Practice could be shared with the Board as a positive example.

MHAC/20/39   Work progamme (agenda item 13)
The Committee reviewed the work plan and KQ suggested that the service user and carer work needed to be added on. YF will find out when the audits are deferred until.
<div align="right"><u>Action: Yvonne French</u></div>

MHAC/20/40   Date and time of next meeting
The next Committee meeting will be held on 3 November 2020 via Microsoft Teams.

Minutes of the Workforce and Remuneration Committee
held on 13 October 2020

Present: Sam Young   Non-Executive Director (Chair)
                   Angela Monaghan   Chair of the Trust
                   Charlotte Dyson   Non-Executive Director (Vice-Chair)
                   Rob Webster   Chief Executive

In attendance: Alan Davis   Director of HR, OD and Estates
                    Janice White   PA to Director of HR, OD and Estates (author)

WRC/20/33 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Sam Young (SY) welcomed everyone to the meeting. No apologies were received.

It was noted that the meeting was quorate and could proceed.

WRC/20/34 Declaration of Interests (verbal item) (agenda item 2)
AGD declared he had an interest as part of agenda item 6: Changes to two directors' contracts. There were no further declarations over and above those made in the annual return to the Trust Board in March 2019 or subsequently.

WRC/20/35 Minutes of the meeting held on 21 July 2020 (agenda item 3)
The Committee confirmed that these were an accurate reflection.

The Committee RESOLVED to APPROVE the minutes of the meeting held on 21 July 2020.

WRC/20/36 Matters arising (agenda item 4)

The Committee discussed the schedule of actions from the previous meeting.

(a)   WRC/20/5 Making SWYPFT A Great Place to Work (GPTW): Prototype Integrated Performance Report (IPR)

     The GPTW IPR will now be updated for the next Workforce and Remuneration Committee (WRC) in November due to new arrangements for the Committee.

                                                                Action: Alan Davis

(b)   WRC/20/12 Workforce Risk Register

<u>Succession Planning and Talent Management</u>
It was agreed to invite Andrew Cribbis back to a future meeting to discuss Leadership and Management Development, and Succession Planning and Talent Management.

Action: Alan Davis

(c)   WRC/20/21 Integrated Workforce Performance Report: Review of Workforce Performance Indicators during the pandemic (agenda item 5)

Under the new arrangements this meeting is now a development session and the draft strategies will be brought to the November meeting. It was agreed to invite the Equality and Inclusion Committee to the November WRC meeting as there are a few items on the agenda that overlap with the two Committees.

Action: Alan Davis

(d)   WRC/20/28 Workforce Risk Register (agenda item 12)

AGD informed the Committee that he had made the amendments discussed at the last meeting. The Risk Register is still being developed but AGD thought it would be helpful to have sight of what had been incorporated and it is on the agenda for discussion at the meeting today.

(e)   WRC/20/29 Annual Work Programme 2020/21 (agenda item 13)

SY and AGD confirmed they now meet monthly and have discussed the new arrangements for this Committee and this is an agenda item for the meeting today.

WRC/20/37 New Committee Meeting Arrangements (agenda item 5)

AGD informed the Committee that he and SY had met and reviewed the meeting arrangements for this Committee. The proposal is that the Committee now meets bi-monthly and have more regular but shorter meetings. Under the previous format it was felt that it was a very full agenda with a lot of items for the Committee to discuss in two and a half hours and then there was a long gap in between meetings. It was also felt these new arrangements would provide a better link into the Trust Board. In terms of timing a November start would provide a better sequencing as it would avoid meetings in December and August. The Committee confirmed its support for the new arrangements.

The Committee DISCUSSED and AGREED the new WRC Committee meeting arrangements and will keep it under review.

WRC/20/39: Workforce Risk Register Contracts (agenda item 7)

AGD informed the Committee that the Risk Register had been updated in terms of what had been discussed at the previous meeting, but it still needs further development considering COVID.   The Committee spent some time reviewing the risks and agreed the following actions:

Risk 1154 risk of loss of staff due to sickness absence: to review the actions to ensure they reflect the COVID position.

Risk 1432 risk of problems with succession planning and talent management: review actions and control measures in light of earlier discussions. Also review wording of the risk.

Risk 1526 risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service users, their families and themselves: Is this still current and if not do we need to bring these back if we are in second wave?

Risk 1533 – Great place to work to be re-focused is an action rather than a control measure. It was noted that student placements has been a pressure and area of concern. Also supervision and appraisal need to be considered as part of this risk. This is currently outside risk appetite so need to consider if this is the right ratings and/or whether there is more that can be done.

Risk 1154: to review the link and overlap with 1526.

AGD to review workforce risk register considering the discussions and actions and for it to come back to the next meeting.

Action: Alan Davis

The Committee RESOLVED to NOTE the Workforce Risk Register and the comments stated above.

WRC/20/40 Development Session: Development of Workforce Strategy and Organisational Development Strategy (agenda item 8)

The Committee discussed the development of key strategies and considered the Robertson-Cooper survey.

WRC/20/41 Any other Business (agenda item 9)

(a) **Annual Allowance Tax Bill 2019/2020 for Clinicians**

AGD informed the Committee about national support to clinicians in relation to the 2019/2020 annual allowance tax bill on pensions. The national scheme is that the individual pays the tax bill using scheme pays and when they retire they are compensated for any loss. The scheme is only for Clinicians and further guidance is expected soon.

(b) **Disciplinary Process from NHS England**

AM mentioned the disciplinary process that was received from NHS England/Improvement about benchmarking our policies against the national revised policy and for this to be added to the Work Programme.

Action: Alan Davis

(c) **High Paid Off-Payroll Arrangements**

AM mentioned that a process is required for this item to be reviewed periodically and suggested annually and for this to be added to the Work Programme.

Action: Alan Davis

The Committee NOTED the above items.

WRC/20/42 Date and Time of next meeting
The next meeting will be held on the 12 November 2020 at 9.30am by Microsoft Teams.

Minutes of the Members' Council meeting held on 31 July 2020
Meeting Held Virtually by Microsoft Teams

Present:	Angela Monaghan (AM)	Chair
	Bill Barkworth (BB)	Public – Barnsley (Deputy Lead Governor)
	Paul Batty (PB)	Staff – Social care staff working in integrated teams
	Evelyn Beckley (EB)	Appointed – Staff side organisations
	Bob Clayden (BC)	Public – Wakefield
	Adrian Deakin (AD)	Staff – Nursing
	Dylan Degman (DDe)	Public – Wakefield
	Daz Dooler (DDo)	Public – Wakefield
	Lisa Hogarth (LH)	Staff – Allied Healthcare Professionals
	Carol Irving (CI)	Public – Kirklees
	Tony Jackson (TJ)	Staff – Non-Clinical Support Services
	Adam Jhugroo (AJ)	Public – Calderdale
	Trevor Lake (TL)	Appointed – Barnsley Hospital NHS Foundation Trust
	John Laville (JL)	Public – Kirklees (Lead Governor)
	Ruth Mason (RM)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Debbie Newton (DN)	Appointed – Mid Yorkshire Hospitals NHS Trust
	Tom Sheard (TS)	Public – Barnsley
	Keith Stuart-Clarke (KSC)	Public – Barnsley
	Cllr Nicola Sumner (NS)	Appointed – Barnsley Council
	Debs Teale (DT)	Staff – Nursing Support
	Tony Wilkinson (TW)	Public – Calderdale
In attendance:	Tim Breedon (TB)	Director of Nursing & Quality / Deputy Chief Executive
	Mark Brooks (MB)	Director of Finance & Resources
	Laurence Campbell (LC)	Non-Executive Director
	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Chris Jones (CJ)	Non-Executive Director
	Carol Harris (CH)	Director of Operations
	Kate Quail (KQ)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
	Laura Arnold (LA)	Administrative Support (observer)
	Paul Hewitson (PH)	Director, Deloitte LLP (for item 7.6 only)
	Andy Lister (AL)	Head of Corporate Governance (Company Secretary) (author)
Apologies:	Members' Council	
	Marios Adamou (MA)	Staff – Medicine and Pharmacy
	Kate Amaral (KA)	Public – Wakefield
	Cllr Bill Armer (BA)	Appointed – Kirklees Council
	Jackie Craven (JC)	Public – Wakefield
	Cllr Ros Lund (RL)	Appointed – Wakefield Council
	Cllr Chris Pillai (CP)	Appointed – Calderdale Council
	Phil Shire (PS)	Public – Calderdale
	Jeremy Smith (JS)	Public – Kirklees
	Barry Tolchard (BT)	Appointed – University of Huddersfield

Erfana Mahmood (EM)   Non-Executive Director
Sean Rayner (SR)   Director of Provider Development
Subha Thiyagesh (ST)   Medical Director
Rob Webster (RW)   Chief Executive
Salma Yasmeen (SYa)   Director of Strategy

MC/20/21   Chairs re-appraisal (to be held in private) (agenda item 1)
For confidentiality purposes the minutes relating to this item have been recorded separately.

It was RESOLVED to APPROVE the Chair's interim appraisal. Based on the interim appraisal and approval of the Chair's reappointment, a recommendation for progression along the remuneration range identified by NHS Improvement will be made at the next Nominations' Committee. A recommendation will then be made to the Members' Council for approval in October 2020.

MC/20/22   Welcome, introductions and apologies (agenda item 2)
The Chair, Angela Monaghan (AM) welcomed everyone to the meeting, apologies were noted as above. The meeting was quorate and could proceed.

AM noted it was Eid and this was the reason why some apologies had been received. Steps would be taken in future to try and avoid Members' Council meetings being held on dates of major religious festivals.

AM explained the logistics of how the meeting would be run due to it being conducted virtually through Microsoft Teams.

AM informed attendees that the meeting was being recorded for administration purposes, to support minute taking, and once the minutes had been completed the recording would be destroyed. Attendees of the meeting were advised they should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place.

MC/20/23   Declarations of Interests (agenda item 3)
The following declarations were considered by the Members' Council for Bill Barkworth (BB) publicly elected governor for Barnsley and Deputy Lead Governor, and Adam Jhugroo (AJ) publicly elected governor for Calderdale.

Name	Declaration
BARKWORTH, Bill Publicly elected – Barnsley	Director, Barkworth Associates Limited. Senior Associate with Campbell Tickell, a management consultancy partnership specialising in social housing. The partnership does not work with the NHS but may do so at some stage in the future. Member – Healthwatch Barnsley.
JHUGROO, Adam Publicly elected – Calderdale	Self: Employed in Primary Care Diabetes Team, NAPP Pharmaceuticals. Currently in the process of joining Cygnet Healthcare as a Bank Registered Mental Health Nurse.

Name	Declaration
	Recently joined NHS Professionals as a Registered Mental Health Nurse in relation to the Coronavirus outbreak.
	Clinical Contact Caseworker (Tier 2 – Call Handler) within the NHS Track and Trace Program (NHS Professionals).
	Daughter: Student Nurse / Staff Bank, South West Yorkshire Partnership NHS Foundation Trust.

No further declarations were raised in addition to those noted above.

It was RESOLVED to NOTE the individual declarations from governors and CONFIRM the changes to the Register of Interests.

MC/20/24   Poem to be read by Carol Irving (agenda item 4)

AM introduced the item. Carol Irving (CI) reported that she helped run a charity called Serendipity which included writing groups to help people's wellbeing.

CI stated the poem reflected a moment in time and stepped into another world and reminded the group that mental health touches everyone.

A copy of the poem is appended to the minutes.

It was RESOLVED to NOTE the poem read by Carol Irving and thank Carol for her contribution.

MC/20/25   Minutes and actions of previous meetings held on 1 May 2020 (agenda item 5)

No amendments or corrections were noted.

It was RESOLVED to AGREE the minutes of the Members' Council meeting held on 1 May 2020 as a true and accurate record.

AM pointed out that some of the action points had been deferred due to the Covid-19 pandemic and this had taken place to reduce the burden on the executive team.

MC/20/16 – AM reported the topic of recording meetings had been looked at in detail. This meeting was being recorded and the reasons had been explained. Any member wishing to record the meeting for inclusion purposes could contact the Trust to seek permission to record the meeting. This would be formalised within the Constitution review in October 2020.

Action: Andy Lister

MC/20/17 – This action involved discussions around recovery and restoration. There would be detailed discussion in Strategic Board in September. Governors should contact Salma Yasmeen or Dawn Pearson if they had anything to contribute. Bob Clayden (BC) and Debs Teale (DT) stated they had asked to be involved and hadn't heard anything. The communications team would be asked to confirm that governors had been offered inclusion in this process.

Action: Salma Yasmeen

MC/20/18a – This action related to elections and was on the agenda for this meeting.

MC/20/19b – This action related to the appointment of a new Deputy Chair and Senior Independent Director as Charlotte Dyson's (CD) term would be coming to an end in January 2021. This process was dependant on the appointment of a new Non-Executive Director which was on today's meeting agenda.

MC/20/03 – Action relating to monitoring visits and quality monitoring visits. These matters were ongoing.

MC/20/10 – Safer staffing had featured at the last quality group meeting and would be discussed further at the next quality group meeting. To remain on the action log.

MC/19/34 – This action was in today's meeting agenda at item 8.3

MC/20/26   Chair's / Chief Executive's Update to include feedback from the Trust Board meeting held on 28 July (agenda item 6)

- AM reported she and the other Non-Executive Directors (NEDs) had been working predominantly from home during Covid-19 and this had restricted them in terms of visibility i.e. going to meet teams, services and attending events. They had however maintained contact by attending meetings virtually.
- AM responded to a query and updated that the NEDs had not been part of the formal command structure meetings but had been kept updated in relation to actions and decisions taken through silver command. Initially this had been on a daily basis and then moved to three times a week and was currently twice weekly. There had also been a weekly meeting between the NEDs and Mark Brooks (MB) and Rob Webster (RW) to review risks and decisions taken during command meetings and identify if any required Trust Board sign off.
- Some of the NEDs had attended silver command meetings as observers.
- AM gave a breakdown of what had been to Tuesday's Board meeting, updated on the content of the private board meeting agenda and explained the context of the private meeting.
- AM advised members were able to view all public papers taken to the Trust Board on the Trust website.

No queries or questions were raised.

- Tim Breedon (TB) was representing Rob Webster (RW) in his role of Deputy Chief Executive in RW's absence.
- The Trust was currently spending a significant amount of time interpreting and acting on national guidance through the gold, silver and bronze command structure. This structure had proven to be a strong way of communicating through the Trust on new and emerging guidance.
- Outbreak management was being closely monitored by the Trust. Over 2000 swab tests had now been carried out for staff and their households, 1800 members of staff had received direct swab tests. The Infection Prevention and Control team had been analysing the test results to monitor the virus and its impact upon the organisation.
- Positive Covid-19 tests were very low for the Trust's inpatients.
- 130 staff members were either working at home or absent from work as a result of testing positive for the virus. These staff members were getting additional health and wellbeing support.
- The Trust had ensured the right level of risk assessment was being used for staff, especially those identified to be within vulnerable or high-risk groups.
- TB identified that currently the Trust was monitoring and staying alert to the virus but was also ensuring planning was in place for the stabilisation and recovery work that would follow.
- Learning from the response stage was being coordinated through quality impact assessments and planning in relation to staffing and changes that may follow.

AM reported that governors should be receiving the daily Covid-19 updates, *The Headlines* every Monday, *The View* on a Friday and *The Brief* every month, and these should be keeping them informed on Trust business. Wellbeing packs were being distributed and should be on their way to governors soon.

- Alan Davis (AGD) responded to a query about the timing of Covid-19 risk assessments. He reported the Trust had just completed its return.
- This was being monitored nationally as a high priority. The Trust had been very proactive in completing risk assessments for high risk groups.
- BAME colleagues had all completed risk assessments in July. The risk assessments had then been rolled out to further 'at risk' groups.
- 83% of all staff across the Trust had now completed a risk assessment. In reference to at risk' groups (which included all males) 84% had completed a risk assessment.
- Regionally and nationally this put the Trust in a very strong position compared to other Trusts. Risk assessments were to be reviewed fortnightly or if any significant changes were identified.
- The correct percentages were probably higher than these figures as when the risk assessments began there was no requirement to record them, they were taking place between managers and staff.
- A self-assessment risk tool had also been developed and 3100 staff members had completed this.

BC reported it was good to receive the communications from the Trust, but a lot of the information was embedded on the intranet which governors didn't have access to.

AM reported that *The Headlines* in particular were aimed at staff. Should governors require particular access to an item they could request it through the membership office. Dawn Pearson was looking at a potential 'governor intranet' as part of her inclusion work and AM would check what, if any progress had been made on this given the current situation with Covid-19.

Action: Angela Monaghan

Lisa Hogarth (LH) queried the testing numbers as there were two swabs per person. TB clarified that both swabs counted as one test per person. LH went on to query information governance in relation to testing. When she had been tested, she had provided personal information to a private company and asked what control the Trust had over the information staff were providing.

TB reported that contracts had been set up nationally and any company being involved in track and trace work would need to meet the same information governance standards as any NHS organisation. LH suggested it may be useful to let staff know this as it had been anxiety provoking at the time of the drive-through test.

Tony Wilkinson (TW) asked when the Trust had been made aware of recent developments in Kirklees i.e. the localised lockdown.

TB reported that the Trust was notified early that morning. A Gold Command meeting had taken place at 8:30am to review the information and the information had been circulated Trust-wide in the Covid-19 update briefing that day. A further review would take place on Monday 3rd August.

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

MC/20/27   Members' Council Business Items (agenda item 7)
MC/20/27a   Governor Appointment to Members' Council and Trust Board Groups and committees (agenda item 7.1)
- AM updated that the paper explained the process by which people are nominated to groups and committees.

- The Members' Council Coordination Group (MCCG) manages the process and had received a number of self-nominations.
- The MCCG had made recommendations that Keith Stuart-Clarke (KSC) should be appointed as the Barnsley representative to the MCCG and Daz Dooler (DDo) should be appointed as the representative governor on the Trust Board Equality and Inclusion Committee.
- AM confirmed these appointments were for three years.

It was RESOLVED to APPROVE the recommendations as outlined in the paper.

MC/20/27b   Governor Feedback (agenda item 7.2)
- John Laville (JL) presented two slides reporting that himself and BB had now met (virtually) with over half of the governors, 13/14 public governors, 3/6 staff governors, 0/8 appointed governors, and Members' Council currently held 5 vacancies.
- These meetings were aimed at JL and BB getting to know the governors but also what it meant to be a governor and each governor's thoughts and feelings on the Members' Council.
- Some key themes from public governors were that they would like to be more involved in local community groups. Some had already good established networks.
- Some members wanted to know more about Trust work in their local area. Many had also stated that they felt isolated due to only meeting once every three months and queried whether there were other opportunities to meet more regularly, possibly on a more local level.
- All staff governors agreed it would be of benefit to meet their fellow staff governors, especially through virtual means given their different work locations and disciplines.
- All governors agreed that becoming a new governor was not an easy process and perhaps a buddy system could be utilised to make this process easier.
- JL asked those governors who had not spoken to JL or BB to get in touch and also check the junk folders of their e-mails for correspondence from JL and BB.
- As part of the inclusion strategy a geographical map was being produced including key community groups for governor involvement. Governors would then get to know the key issues and good practice being shared within these meetings.
- Mechanisms for governors to witness the Trust at work, this would only be from an observational perspective to aid understanding of operational practice.

An improved process was required for governors to feedback issues and good practice.
Action: Members Council Co-ordination Group

- Public governors and staff governors reflected that it would be of great benefit to meet more locally outside of Members' Council. Virtual meetings could be a very efficient way of achieving this.
- JL reiterated he and BB were happy to speak to governors about progressing these items and they should get in touch by whatever means possible.
- A query was raised in relation to the extra meetings and restrictions to those governors who worked full time. JL stated that everything would be done to accommodate governors who wanted to be involved wherever possible.
- DDe reported he had not been cited in the feedback paper and asked if he could be included next time. It was noted that he had attended Nominations' Committee, Trust Board and governor Q and A sessions.
Action: Laura Arnold

It was RESOLVED to NOTE the Governor Feedback

MC/20/27c   Assurance from Members' Council groups and Nominations Committee (agenda item 7.3)
AM reported she intended to take the item as read. AM reported that in future, for this item, a brief summary of each group would be provided to aid governor understanding.
Action: Laura Arnold

These items were not for focussed discussion but awareness and an opportunity to ask any questions. AM asked for any questions in relation to the Members' Council Groups or Nominations Committee. No questions were received.

BC noted that his name was spelt incorrectly in the Members' Council Coordination Group minutes. It was noted that this would be rectified in the notes.

Action: Laura Arnold

It was RESOLVED to RECEIVE the assurance from Members' Council groups and Nominations Committee.

MC/20/27d   Nominations Committee annual report 2019/20, including update to terms of reference (agenda item 7.4)
AM explained that committees and groups should produce an annual report and review their terms of reference each year. AM reported this was to assure the Members' Council that the Nominations' Committee was performing its role effectively. The report was against each of the objectives set out in the terms of reference.

AM summarised the report contained the duties of the Committee, the work the Committee had completed over the previous year, the attendance of members followed by renewed terms of reference. The only changes were to the membership.

DDe, JL and BB had all been added to the group following approval at May's Members' Council meeting.

No comments or questions were raised.

It was RESOLVED to RECEIVE the annual report for 2019/20 and APPROVE the updated Terms of Reference for the Nominations Committee.

MC/20/27e   Members' Council Co-ordination Group Terms of reference (agenda item 7.5)
AM reported the changes to the terms of reference were minor and related to membership. JL was now the chair, BB was a member as deputy lead governor, AJ had been appointed as a public member from Calderdale.

It was RESOLVED to APPROVE the updated Terms of Reference for the Members' Council Co-ordination Group.

MC/20/27f   South West Yorkshire Partnership NHS Foundation Trust Annual Report and Accounts 2019/20 (agenda item 7.6)
MB introduced the item by explaining that the recommendation was to inform the Members' Council of what had been done this year as it had been slightly different due the impact of Covid-19. The annual report and accounts would be formally received at the Annual Members' Meeting in September. MB summarised the following points:
- The Trust had achieved all of its year-end targets.
- The Trust had a duty to submit an annual report, annual accounts and quality account.
- The Trust was the first in the country to lay its annual report and accounts before parliament.
- The quality account deadline had been extended and the account would not be subject to audit this year.
- The salient points of the annual report had been audited as required.
- The Members' Council was obliged to receive the annual report from the external auditor Deloitte.

Paul Hewitson (PH) from Deloitte:
- PH started by explaining as an external auditor he was answerable to the governing body of the Trust, the Members' Council.

- This was an annual presentation to the governing body of the Trust and the conclusions that the external auditors have reached about the Trust.
- This year it had only been an annual report and accounts audit, due to the quality account deadline being amended nationally and not requiring audit.
- PH explained that his responsibility was to perform an audit on the annual report and accounts to look at the key risk areas and test those risks to make sure the financial arrangements were true and fairly stated. There was also a review on whether the Trust was demonstrating value for money
- The audit also reviewed if the Trust was a 'going concern' and this could have been difficult due to the uncertainty around financial planning, but due to the financial position of the trust there were no issues in relation to this.
- Some initial work was carried out before the quality account audit was suspended. Some limited testing of early intervention in psychosis and inappropriate out of area placements had taken place, and, while this work was not concluded, no issues were identified in either.
- PH stated Deloitte submitted reports to the Department of Health & Social Care and the National Audit Office as all NHS Trust figures got added together nationally for the government accounts.
- PH explained that the statement "All opinions were unmodified" meant that no issues were identified, and this was the best possible outcome from an external audit.
- The external auditor had to identify the areas most likely to give rise to a material misstatement in the financial statement. The ISO 260 report that had been circulated covered this in detail, but PH stated he would give an overview summary.
- The first thing of note was the 'modern equivalent asset design' which meant had the Trust valued its estate correctly. The perspective on this was not looking at what a Trust had but what it would cost to replace it to get the same level of service using current building methods. The controls were deemed satisfactory. There was a 'material uncertainty' identified but this was in relation to the valuations having taken place 31st March 2020 and the Royal Institute of Chartered Surveyors reporting that any valuations at that time had a material uncertainty due to Covid-19. This has applied to every other trust across the board.
- The other identified risk was in relation to the management override of controls. This refers to management being in a strong position to influence the financial statements to their own gains or to hide issues.
- PH reported they had found a weakness in the journals review mechanism. There had been one in place previously but because it had never highlighted any issues it had been replaced with other controls, which the external auditor was not totally satisfied with, but there was no evidence of management influence or nefarious activity in any way.
- PH summarised the audit findings. The draft report and accounts had been submitted to parliament within timescales.
- The Trust finance team had done an excellent job of preparing the accounts and engaging with the audit.
- There was one identified uncorrected misstatement in relation to the value of plant and equipment. This would have increased net assets by £273,000 and could have increased reserves by the same amount. This was due to a difference in the valuation date and the year-end date which meant an estimate had to be made as to how much the value could have changed. This was a very small issue in the context of everything else.
- The Annual report and annual governance statements required very little adjustment from the first draft.
- Accounting policies were in line with what would be expected.

PH concluded his summary and offered to take any questions.

TW asked what Provider Sustainability Funding (PSF) was.

PH explained this was a sum of money that the Department of Health and Social Care (DHSE) made available to NHS Trusts if they met certain criteria. The reason this had been mentioned in the report was because if a Trust didn't meet the target for PSF they didn't get the money.

Therefore, there was the incentive for a financial director to manipulate the financial statements to meet the targets to get the PSF monies, but there was no evidence of this whatsoever from the audit.

TW referred to PH's comments about the journals and queried whether this had been a considered decision by the Board or whether the system of considering journals had been allowed to drift?

PH responded by saying this was a query likely to be answered by Mark Brooks (MB) but from his perspective the finance team felt they weren't finding anything through this and their system of reconciliation, reviews and tight budget controls gave the finance team and the Board sufficient assurance, but from the auditors perspective this was not sufficient to mitigate the risk.

MB added that in reality the risk was seen to be low and there were a number of compensating controls, there were a lot of account reconciliations after the event and what PH was referring to was that the Trust was not doing this before the event, proactively, it was being completed after the journal had been entered.

The Trust had been comfortable with this historically but would soon be moving to a new accounting system in October / November 2020 and this system required approval before journals were entered on the system. MB also clarified that as an extra control he had no access whatsoever to the accounting system and that was intentional so that he could not input to the system.

BB queried as PH had made the observation did the Trust then make a recommendation about what should be done to resolve the issue?

MB confirmed this was the case and the new system in October would resolve the matter. In the interim any sensitive or unusual journals would be checked prior to being entered on the system.

It was RESOLVED to RECEIVE the Deloitte report on the Trust Annual Report and accounts for 2019/2020.

MC/20/27g   Quality report and accounts (agenda item 7.7)
TB clarified that the timescale for the quality account had been moved to December 2020 and as already discussed would not be subject to audit this year. A revised report was planned to go to Trust Board in September. The same process had remained in place in respect of consultation and discussion.

The Members' Council Quality Group was taking place on 10 August 2020 and this would have sight of the first draft of the report. Partners would also be consulted and asked to comment on the draft report.

BC queried whether completing this work later in the year increased any risks to the Trust. TB responded to say that there would be no increase in risks to the Trust as the report was retrospective.

It was RESOLVED to RECEIVE the update on the 2019/20 Quality Account.

MC/20/27h   Customer services annual report and accounts (agenda item 7.8)
TB reported that normally this report would have been reviewed by the Members' Council Quality Group (MCQG), but this was not the case due to Covid-19. The report would, however, be going to the next MCQG meeting.

TB continued that the Customer Services annual report contained some useful information on changes that had been made to the complaints process and improvements that had been made in relation to timescales.

DDe reported he had looked at the complaints report and queried if the process was differentiating between a formal complaint, an informal complaint and a comment. Was there anything that governors could be looking out for in their areas to try and help resolve issues?

TB reported that any issue reported to a governor should be reported into the Trust so that it could be addressed. In terms of the report, any formal complaint that had been registered had been through the process of attempted informal resolution before it became a formal complaint. A local resolution was always the preferred process.

It was RESOLVED to RECEIVE the Customer services annual report and accounts.

MC/20/27i   Serious Incident annual report 2019/20 (agenda item 7.9)
TB reported that this report showed the Trust's performance against incident reporting. A presentation had been attached to help break up the content of the report. This report would also go to the next MCQG meeting.

BC queried that in previous years the aim had been for zero suicides but from the paper the rate of suicide showed a very flat line and as such was a change of approach required to make more progress?

TB confirmed that the aim was to reduce the number of suicides and states that the report was for the previous year and so some of the work that was currently being undertaken should be reflected in next year's report. There was a strong piece of work linked to the West Yorkshire and Harrogate Integrated Care System (ICS), which featured in a separate report specifically about apparent suicide, and this came to MCQG and Members' Council.

AM reported that the zero-suicide target relates to people in mental health care, whereas the national figure was to aim to reduce overall suicide by 10%. Not all people who die by suicide are in touch with mental health services.

BC asked if the figures in the report reflected people in Trust care. TB confirmed this to be the case.

TB reported that around 30% of people who took their own life would be known to services and 70% were not. The work with the West Yorkshire and Harrogate ICS focused on people both inside and outside of services.

CI raised a query in relation to suicide and the wording and language of letters that were sent to patients prior to them being discharged from services. Were allowances made for people with dementia, literacy problems, memory problems?

TB responded that the decision to discharge someone from services was not taken lightly. There were policies and procedures to be followed around discharge including sufficient attempts to make contact with a person and ensure the person was clear about what they were being asked.

TB continued that the engagement work going on in the Trust was looking at what was right for individuals, not just groups.

TB agreed that there was scope for work to be done in respect of letters and the language used. AM clarified that a previous meeting had been arranged for CI to meet with Mike Doyle to discuss this issue. Given governor absence and then recent events, this had been unable to take place. TB agreed to set up a meeting with CI and Mike Doyle to review language in letters to service users. AJ also reported he would like to be involved in this work.

Action: Tim Breedon

Debs Teale (DT) reported the issue was about clear communication with service users and their individual circumstances and needs. DT was involved in 'Project Hope' with Salma Yasmeen which looked at communication with service users and staff. This looked for communication to be more open and honest. A trial was initially being carried out with Newhaven ward, but this should look to improve service user communication.

TW asked about the relationship between the Trust and local Healthwatch groups. TB responded that the Trust had a good working relationship with local Healthwatch groups and sits with them on a number of meetings from a Board perspective. A meeting is taking place with Healthwatch in the next couple of weeks to discuss their customer services appraisal of Trust services. Healthwatch are also involved in the sign off of the Trust quality account.

Paul Batty (PB) commented that Assertive Outreach Teams (AOT) used to deal with service users who were likely to disengage. The FACT (Flexible Assertive Community Treatment) model currently in use had the potential to lose those service users that were disengaging, especially those that were quiet and made very little contact.

TB reported that when transitions were made in the models of care it was important not to lose sight of any gaps and continue to evaluate things. The development of community forensic teams across the system was an ongoing piece of work with the forensic commissioners. This would be a useful point of discussion in the MCQG.

Action: Tim Breedon

Carol Harris (CH) reported that funding had been received for the pilot of a new community forensic team that would be starting in Wakefield. At the same time a review of the current, very small, forensic community team was taking place to look at how that would fit into the new model. The Trust would be the new forensic lead provider going forward and as part of that work would be looking at developing support for high risk people in the community.

AJ had noted that the top themes in relation to complaints were communication and staff attitudes. AJ referenced an incident in a neighbouring Trust where a young woman had died and there were problems around her care. Staff had written on social media about feeling despondent and didn't get enough praise, which caused significant issues.

A young nurse was "scapegoated" and was made to apologise. AJ asked if we were sharing any lessons in relation to incidents such as this and were staff advised in any way about the use of social media. It caused a lot of upset.

TB reported he was familiar with the incident and there was a social media policy in the Trust, and this was covered in the staff induction when people joined the Trust. It was also covered in the Information Governance Policy, but it may be prudent to give regular reminders about the use of social media and the associated risks.

Action: Tim Breedon

It was RESOLVED to RECEIVE the Serious Incident annual report

MC/20/27j   Consultation / review of Audit Committee terms of reference (agenda item 7.10)
LC updated that this item is something that was adopted some time ago having been cited as best practice by Deloitte. The Audit Committee terms of reference were therefore reviewed very twelve months and presented to the Members' Council.

Minor changes had been made to the names of NHS bodies and minor changes to wording.

AM noted it was LC's final Members' Council meeting and gave thanks for all his work and contributions to the Trust and Members' Council.

It was RESOLVED to APPROVE the updated Terms of Reference.

<u>MC/20/27k   Recommendation of appointment of external auditors (agenda item 7.11)</u>
LC updated that BB had been involved in the process with the evaluation team representing the governors. The current external auditor's appointment had come to an end, namely Deloitte. LC noted this had been a very thorough process with input from the procurement team to manage the process. There had been initial discussion with team members followed by interviews with the four organisations that tendered for the work.

The scoring process was very objective and resulted favourably for Deloitte, both including and excluding the charitable funds audit which was demonstrated in the paper.

BB reported he was involved as a governor and was particularly interested in what the prospective auditors understanding was of role of the Members' Council, how they proposed to engage and involve the council, and how they would meet with governors. There was also a focus on what they brought to the Trust from outside knowledge perspective and their benchmarking.

BB reported that he was positively assured that Deloitte were the right company for the job. BB thanked the procurement team for a smoothly run process.

It was RESOLVED that the Members' Council APPROVE the appointment of Deloitte LLP as the Trust's external auditor for a period of up to five years (an initial three years with the option of extending for a further two years).

MC/20/28   Trust Board Appointments (agenda item 8)
AM reported she need to vacate the chair. Items relating to the appointment or remuneration of the Chair or Non-Executive Directors had to be chaired by the lead governor, John Laville. AGD would remain to support John with any questions about process.

<u>MC/20/28a   Re-appointment of Chair (agenda item 8.1) (confidential item)</u>
It was agreed that Charlotte Dyson would remain for this item as she has been involved in the process.

JL outlined the recommendation that was being put to the Members' Council for consideration. JL explained that the background and the process was included in the paper. JL explained he had experienced some technical difficulties earlier when the private discussion had taken place regarding AM's re-appraisal but had joined the meeting in time to hear CD say that as a Trust we were very fortunate to have AM as our Chair and very fortunate that she had considered re-appointment and JL fully endorsed that. JL opened the meeting up to comments.

CD clarified that the appointment was for a three-year term with a review after 12 months and AM's interim appraisal had been very positive, and this had been agreed by all governors in the earlier meeting.

It was resolved to CONSIDER and AGREE to the recommendation from the Nominations' Committee of re-appointment of Angela Monaghan as Chair from 1 December 2020 for a three-year term (with a review after 12 months from both sides). In the initial period she will remain on her current remuneration.

It was resolved to CONSIDER and AGREE to the recommendation that a remuneration review takes place at the Nomination Committee following approval of the interim appraisal. Any recommendation for progression to the top of the pay range will be made to the Members Council for approval in October 2020 with a view to being implemented on 1st December 2020.

MC/20/28b   Non-Executive Director appointment (agenda item 8.2)

JL introduced the item to consider the appointment of a Non-Executive Director. The purpose and the format was clear and JL stated the recommendation to the Members' Council was to approve the appointment of Mike Ford. The Nominations' Committee had to ensure the right composition and balance to the Trust Board. Mike Ford's (MF) background was financial and he met the candidate requirements and he had the relevant financial qualifications. The process was outlined in the paper and was conducted virtually.

JL reiterated that MF was the stand out candidate from his perspective, this view was supported by BB who agreed and stated that all four candidates were strong, but MF stood out for his transformational work that he had carried out with the BBC. AJ agreed with this assertion.

BC asked if MF's biography and photograph could be circulated to the governors prior to the next Members' Council meeting.

Action: Andy Lister

It was RESOLVED to APPROVE the recommendation from the Nominations' Committee to appoint Mike Ford as a new Non-Executive Director from 1 September 2020 for a period of three years.

MC/20/28c   Review of Chair and Non-Executive Directors remuneration (process and timescales) (agenda item 8.3)

JL explained where the Trust was paying Non-Executive Directors more than NHSE recommended remuneration it had been agreed these rates be frozen until they fell in line with the NHSE pay scales or on re-appointment.

AGD explained for the NED's there was a flat rate and Members' Council agreed we would hold rate until it fell in line with NHSE recommendations. The Chair's pay was slightly more complex. It had previously been on incremental scale and NHSE had now stipulated pay ranges.

The Chair's remuneration would be considered at the next Nominations' Committee and then the recommendation would come to Members' Council for approval.

It was RESOLVED to REVIEW and SUPPORT the process for the review of the Chair remuneration and NOTE the changes to Non-Executive Director (NED) remuneration agreed in November 2019.

MC/20/29 Members' Council business items (presentations) (agenda item 9)

MC/20/29a   Integrated Performance Report (IPR) (agenda item 9.1)

MB provided an update of headlines since the end of the last financial year and the first quarter of this year. MB presented the summary performance metrics and explained that anything highlighted in grey had stopped being recorded during Covid-19.

There were two reasons for this; nationally, recording had stopped to allow the response to Covid-19 and secondly, locally, metrics recording had been paused to allow for other priority work to take place during the pandemic.

- The Trust had been able to maintain good performance against a number of the metrics despite Covid-19.
- MB reported that admission of children and young people to adult inpatient wards had a target of zero, but there were occasions when this action was the least worst option for the individual concerned. There was a high level of safeguarding input in these circumstances to make sure it was as safe as it could be.
- MB noted the increase in information governance breaches. Some work into this had established that staff redeployment as a result of Covid-19 meant staff were not always performing familiar tasks, and the majority of breaches were incorrect addresses. This was

taken very seriously by the Trust and messages around the importance of information governance were being reiterated through the communications team.

- There were some temporary financial arrangements in place that were allowing the Trust to break even every month at the moment.
- The core level of sickness absence had decreased over the pandemic.
- The staff turnover rate had also decreased.

TB introduced the Covid-19 response and Quality sections of the IPR:
- A great deal of work had taken place in relation to the testing of both staff and patients.
- TB clarified that the Trust was in a very similar position to other mental health and community trusts in relation to positive tests for staff. This demonstrated that trusts responding in these areas of work had done so in a broadly similar way.
- There had been notable numbers of positive staff tests in acute trusts.
- Staff absence as result of Covid-19 had made an impact on staffing numbers. At the time of the report 138 were off work due to symptoms, household symptoms or shielding.
- 29 service users (inpatients) had tested positive for Covid-19.
- TB reported that Trust staff had carried out huge numbers of tests for other organisations and care homes, particularly in the Barnsley district where they had made a significant contribution to the Barnsley health system as a well as support around infection prevention and control.
- 884 calls had been received into the occupational health helpline.
- 1600 video consultations had taken place each week, but it was accepted that this was not a suitable medium for everyone and more face to face contacts would be reintroduced as the pandemic continued to decline.
- Gold, Silver and Bronze command structure had been in place.
- Sufficient personal protective equipment (PPE) had been available to staff throughout the pandemic. Mutual aid arrangements were in place across the system and work with partners.
- There had been a very effective digital response to the pandemic, enhanced by investment in the digital estate that had taken place prior to the pandemic.
- The Family and Friends Test (FFT) had been relaunched on 15th June and the responses from this had been positive.
- Safer staffing numbers (inpatients) had been positive during the pandemic, this was due to people continuing to work hard, employment of students to help fill absence and people returning to work who had recently retired.
- TB reported the weekly risk panel now included Covid-19 incident reviews. Early indications suggest that there was a rise in the level of self-harm but otherwise reporting levels remained similar to previous years. Self-harm incidents were being monitored closely.

MB introduced the NHS Improvement metrics section of the IPR:
- MB updated that in relation to NHS Improvement metrics where numbers were highlighted in red these were as a result of the Covid-19 response. As an example, the maximum six-week wait for diagnostic procedures related to one service only which was reliant on our acute colleagues who had restrictions in what they could provide currently.

CH added that during Covid-19 Improving Access to Psychological Therapies (IAPT) had seen a reduction in clients who had completed treatment and were moving into recovery. This was as a result of the service becoming virtual and telephone based. Some clients did not want to work virtually and so wanted to wait until face to face meetings were available and others recovery scores had been affected by Covid-19 itself. There was a lot of work going on to restore services back to how they were prior to Covid-19 but the impact on recovery scores was expected to be seen for some time.

AGD provided some headlines in relation to workforce:
- Some focussed work had taken place around the reasons for sickness and absence and what had been identified was that there was increased sickness due to stress and anxiety, which the occupational health unit is monitoring.

- The health and wellbeing offer had been updated to include virtual contact and remote consultation. A health and wellbeing survey had been sent out to all staff and at the time of the meeting over 1800 responses had been received.
- AGD clarified that 123% staff fill rate related to the acuity of service users on the wards and demands on staff and did not mean that there was overstaffing taking place.

MB provided headlines in relation to finances and explained that there was a current artificial financial environment.
- Since Covid-19 had occurred previous planning arrangements and processes had been paused and normal financial arrangements had been paused.
- There was a current four-stage process of how the Trust was funded. This was originally in place from April until July but had now been extended until August.
- This gave every Trust the mechanism to break even. The Trust had also been paid a month's income early and so it had more cash available, and this had been put in place to allow Trusts to pay suppliers within seven days if possible. Compared to other Trusts we are in a strong position, paying 83% of suppliers within 7 days, whereas the national level was 36%.
- The Finance, Investment and Performance Committee was reviewing, according to guidance, what Trust money could be spent on and what could be reclaimed in response to the pandemic.
- The Trust continued to break-even at present, but the second half of the year was more uncertain as the details of the financial arrangements going forward had not yet been made available.

LH asked if the cost of remote working was being considered and if staff working from home were being compensated for increased energy bills.

MB responded that the cost incurred by NHS Trusts to enable staff to work from home was substantial. 3000 licences had been provided to allow home working, laptops had been made available, Microsoft Teams and other consultation tools had been provided.

AGD reported the conversations had been taking place with staff side in relation to the additional cost of working at home. The long-term arrangements, including chairs and equipment to be used to work from home were being reviewed. There were also tax allowances available for working from home.

LH asked if there was a target percentage of remote consultations that the Trust would like to continue with?

CH agreed that remote consultations would continue where it was the most appropriate option for the service user. A change process was in place including a quality impact assessment which would look at the impact of any changes made, but the focus would remain on what was best for the individual service user.

JL clarified that the staffing ratio of 123% was dictated by demand on the ward, therefore if the demand was 23% greater than anticipated the staffing was in place to support this.

TB confirmed that this was the case but also added that a Covid-19 cohort ward had been opened during this period which had to be staffed which had a significant impact on the numbers.

JL noted from previous meeting that the staffing rate figures always seemed to be over 100% and asked if there was a financial implication to this? MB confirmed this to be the case.

AM reported there were occasions when service users required two or three members of staff to support them, dependant on their level of acuity. Sometimes therefore extra staff were required to manage the acuity of a ward and the service users within it.

TB clarified that the planned staffing rates were reviewed on a regular basis and if there was a continued requirement that extra staff were needed the planned staffing levels would be reviewed.

DDo reported that a number of employees were beginning to struggle working from home due to the lack of work space available and asked if there were any plans to consider a rota to enable people to come in to work one or two days on a rotational basis?

CH responded that work was ongoing reviewing buildings and looking at what changes could be made to facilitate Covid-19 safe working environments. If people were struggling, efforts would be taken to make use of available space and facilitate people coming into work wherever possible. AGD added that working from home did not just present musculoskeletal issues but also wellbeing issues, and a working from home risk assessment was being developed to assess this.

LH asked whether patients detained under the Mental Health Act were being monitored in terms of the profiles of those patients being detained or restrained and their protected characteristics.

TB reported that the Mental Health Act Committee was monitoring protected characteristics through reports being brought into the Committee.

AM updated that the Equality and Inclusion Committee had a focus on groups with protected characteristics and how to improve data in this area.

It was RESOLVED to RECEIVE the update in relation to the IPR

MC/20/29b   Care Quality Commission (CQC) – action plan update and update on our inspection and annual report unannounced / planned visits (agenda item 9.2)
- TB introduced the item and reported that the Trust rating from the CQC was currently 'good'.
- An action plan was in place with some 'should do' and 'must do' actions.
- Four main themes were in the improvement plan; risk assessment, medications, care planning and record keeping.
- A collaborative improvement plan was in place using quality improvement methods.
- Five priorities within the plan which focus on risk assessment, care plans, reduction of incidents of violence and aggression against staff, safe medicines and treating service users with dignity and respect.
- Although some aspects had been paused during Covid-19 some of the improvement work had continued.
- TB referenced the Plan, Do, Study, Act (PDSA) quality improvement approach.
- The Trust was receiving monthly updates again and these would go through the Clinical Governance and Clinical Safety (CGCS) Committee in line with the usual process.
- 100% of our 'must do' actions were on track at the end of March 2020.
- 97% of 'should do' actions were on track at the end of March 2020.
- There would be oversight of the report and updates in the next Members' Council Quality Group.
- In summary, the Trust had seen some improvements and the work had been picked up again.
- TB reported that the quality monitoring visits had been paused as a result of Covid-19, but these would be starting again in due course. The quality monitoring visits included an accreditation rating, and this was going to be linked to the quality monitoring visit report for the future.

LH queried how as a Trust we were in the position where contemporaneous notes weren't being done, as this was basic care and putting the person in the centre. Were lessons being learned before we got to the position of using the PDSA cycle?

TB noted that one of the key themes during the CQC assessment was they couldn't always see where things had been recorded; they weren't on the right place in the system. TB clarified that this wasn't an issue across the system but an issue that had been identified in a couple of areas.

On closer inspection it had been established internally that the records had been made but weren't in the right place. There was a piece of work continuing in relation to this.

It was RESOLVED to RECEIVE the update in relation to the CQC action plan update

MC/20/30   Any other business (agenda item 10)
MC/20/30a   Annual Members' Meeting (agenda item 10.1)
- AL updated that the Annual Members' Meeting would go ahead as a virtual meeting on the 28 September 2020.
- The annual report and accounts would be presented as per normal practice. AL asked what the Members' Council would like to see or be included.
- One suggestion was for members to complete videos that could be presented to share their experience of Covid-19?
- The team were open to suggestions of what governors would like the day to include.

DDe reported as a new governor he had never attended an Annual Members' Meeting. DDe stated he was a former service user, volunteer and now employee of the NHS and had made a personal story/video on YouTube and would be happy to provide this.

BC asked about breakout rooms and whether this would be an option. Themes in rooms could be poetry, washing hands or what is like to be a governor. Would it be possible to have smaller groups facilitated within the meeting?

Action: Andy Lister

Ruth Mason (RM) suggested a gallery of artwork from Creative Minds. AM reported there had always been a performance in the past and this would be considered.

MC/20/31   Closing remarks, work programme, and future meeting dates (agenda item 11)
AM highlighted the Members' Council work programme needed reviewing to make sure any items highlighted as deferred by Covid-19 were picked back up and given a new date.

AM explained that the next meeting was on 30 October 2020 and was likely to be virtual. This would be also be the annual joint meeting with the Trust Board.

The Annual Members' Meeting would take place on 28 September 2020.

DDo wished everyone a good weekend and praised everyone on the work currently being undertaken.

IHI quality improvement programme was available to be completed by governors and there were some places still available. Governors to contact the membership office if they were interested.

It was RESOLVED to RECEIVE the work programme for 2020/21.

Members' Council Meetings 2020/21
The dates for the Members' Council meetings in 2020/21 held in public were noted as follows:
- 30 October 2020 – 9.30am-14.30pm
- 29 January 2021, afternoon meeting

Signed: **Date: 30 October 2020**

Appendix

Poem by Carol Irving "A Moment in Time"

As she turns down the sheets, he is laughed at,

Screams, a waterfall, a cacophony of voices,

Blood ebbs and flows, sleep takes her leave.

Cries of men, abandoned to icy cold Atlantic waters

To God, to darkness, to lungs fill

Repeats and repeats echoing

She tries again to turn down the sheets

He is loading projectile words into five-inch guns on a war time destroyer

Someday man, sun downing, rejigs his suicide plan, locks himself in a bathroom

Yesterday he was the father, today I am not his daughter

Tomorrow he will hear his mother call his name from every cupboard door he opens

It is 3am, the world sleeps, she listens

Supplies him with mugs of hot sweet tea, garibaldi biscuits

A cold hand warmed lies into his, a strange yet familiar comforting confusion

Like a hand slipping into a glove and together, they try to turn down the sheets.

Trust Board 1 December 2020
Agenda item 13

Title:	Use of Trust Seal
Paper prepared by:	Corporate Governance Manager on behalf of the Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Mission / values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers / previously considered by:	Quarterly reports to Trust Board.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The Trust Seal has not been used since the report to Trust Board in September 2020.
Recommendation:	**Trust Board is asked to NOTE that the Trust Seal has not been used since the last report on 29 September 2020.**
Private session:	Not applicable.

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)	✖		✖	✖		✖	✖	✖		✖		✖	

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	!	!	✖ update	✖			✖			✖			
		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	✖												

Trust Board work programme 2020/21

SO		Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
		Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	**#**							✖ (KPI's)					
		Review of Risk Appetite Statement	**#**									✖			
		Annual report, accounts and quality accounts - update on submission		✖	✖**?**			✖ **(QA)**	✖ **(QA)**						
		Health and safety annual report			**#?**				✖						
		Patient Experience annual report			**#**			✖							
		Serious incidents annual report			✖										
		Equality and diversity annual report (included in new strategy)				✖**?**				✖					
		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		✖			✖				✖		✖		

Trust Board work programme 2020/21

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Policies and strategies													
	Constitution (including Standing Orders) and Scheme of Delegation *(January 2020)* *(deferred to April 2021)*	**#** (if req'd)						✖			✖ SOD			
	Digital Strategy *(January 2021)*										✖			
	Customer Services policy *(June 2020)*			**#**						✖				
	Estates strategy *(July 2022)*			**#**										
	Equality, Involvement, Communication and Membership Strategy *(NEW – will replace Communication, Engagement and Involvement, Equality and Membership strategies)*	**#** (if req'd)					✖ (update)		✖					
	Sustainability strategy *(June 2020)*			**#**					✖ (update)			✖		
	Organisational Development Strategy *(June 2020)*			**#**					**#**		✖			
	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* (March/April 2021)(Scheme of Delegation to look at which strategies can be signed off by committee rather than Board)
- Communication, Engagement and Involvement strategy *(to be merged with the Equality, Involvement, Communication and Membership Strategy)*(also to be taken as E and D annual report)
- Customer Services Policy *(next due for review in June 2020, extended to October 2020)*
- Digital Strategy *(next due for review in January 2021)*
- Equality Strategy *(next due for review in July 2020, to be merged with Equality, Involvement, Communication and Membership 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 Equality, Involvement, Communication and Membership Strategy)*
- Organisational Development Strategy *(next due for review in June 2020)*

Trust Board work programme 2020/21

- 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))*