South West Yorkshire Partnership NHS Foundation Trust

# Minutes of Trust Board meeting held on 28 July 2020
# Microsoft Teams meeting

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| **Present:** | Angela Monaghan (AM) | Chair |
| | Charlotte Dyson (CD) | Deputy Chair / Senior Independent Director |
| | Laurence Campbell (LC) | Non-Executive Director |
| | Chris Jones (CJ) | Non-Executive Director |
| | Erfana Mahmood (EM) | Non-Executive Director |
| | Kate Quail (KQ) | Non-Executive Director |
| | Sam Young (SYo) | Non-Executive Director |
| | 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 |
| **Apologies:** | Members | |
| | Subha Thiyagesh (ST) | Medical Director |
| | Rob Webster (RW) | Chief Executive |
| **In attendance:** | Carol Harris (CH) | Director of Operations |
| | Andy Lister | Company Secretary (author) |
| | Sean Rayner (SR) | Director of Provider Development |
| | Salma Yasmeen (SYa) | Director of Strategy |
| **Observers:** | Julie Warren-Sykes | Assistant Director of Nursing, Quality and Safeguarding |
| | Ben | Service user (for item 5 only) |
| | Bob Clayden | Publicly elected governor, Wakefield |

## TB/20/43 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. Tim Breedon was representing Rob Webster (RW) in his role of Deputy Chief Executive in RW's absence.

AM welcomed governor Bob Clayden to the meeting and also Ben who was presenting today's service user story. AM also welcomed Julie Warren-Sykes who was supporting Ben in his presentation and then remaining to observe the rest of the meeting.

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/20/44 Declarations of interest (agenda item 2)

The Chair reported that Salma Yasmeen (SYa) Director of Strategy was no longer a Board member for the Prism charity in Bradford and the register would be amended to reflect that change. There were no further declarations over and above those made in the annual return in March 2020.

**It was RESOLVED to NOTE the change to Salma Yasmeen's declaration of interest and that no further declarations had been submitted.**

## TB/20/45 Minutes from previous Trust Board meeting held 30 June 2020 (agenda item 3)

- TB/20/35a – Tim Breedon (TB) identified there was an action requesting further clarity. The point being made in the action was in relation to a significant number of care home interventions and these swabbing tests not being included in Trust numbers. TB reported the matter was already clarified at the time and the minute was incorrect. It was agreed that the final sentence "TB stated that in future reporting, further clarity would be provided as to what the numbers included" would be removed from the minutes at page 7 along with the associated action.

**Action: Andy Lister**

- Charlotte Dyson (CD) reported that a conversation had taken place at June Board where Chris Jones (CJ) and CD were going to have a discussion about Child and Adolescent Mental Health Services (CAMHS) and this hadn't been logged as an action. CD asked that it was noted that she and CJ would be discussing how to manage CAMHS between Clinical Governance and Clinical Safety Committee (CGCS) and Finance, Investment and Performance (FIP) Committee. CD identified that this conversation was documented at page 18 of the minutes under Finance, Investment and Performance Committee.

**Action: Andy Lister**

**It was RESOLVED to NOTE the amendments and APPROVE the minutes of the public session of Trust Board held 30 June 2020 as a true and accurate record, subject to those amends.**

## TB/20/46 Matters arising from previous Trust Board meeting held 30 June 2020 (agenda item 4)

The following items from the action log were reviewed:

- TB/20/35a – the first action was identified as the clarity issue from TB noted above and could be removed.
- TB/20/35a – the second action referred to the table on deaths in the Integrated Performance Report (IPR). TB clarified that the Covid-19 incident reporting table showing patient deaths still included deaths that had been registered in error by community teams, but that this would be amended through incident reporting and would be reflected in the next IPR. These should have been linked to primary care services. TB reported it would take some time to cleanse the data and that is why there was a discrepancy. AM clarified that only one Trust inpatient had died from Covid-19, but not whilst in our care, and the other death shown in the table should have been linked to primary care.
- TB/20/35a – the third action related to data on self-harm. TB reported that work was continuing on this item and it was being monitored. He would update further in the IPR section of the Board meeting later. This item was in relation to the monitoring of carers in relation to self-harm.
- TB/20/35a – the fourth action related to the above item needing to be a focus of the Equality and Inclusion (EI) Committee in September. AM confirmed this would be picked up in EI agenda setting in August.
- TB/20/35a – the sixth action related to availability of advocacy on wards through tablets. The action specifically related to providing further details to the next Mental Health Act (MHA) Committee meeting in August. Kate Quail (KQ) confirmed that a piece of work was

taking place in relation to this action and was coming to the next MHA Committee meeting. AM confirmed therefore the action could be closed for the Board.

- TB/20/37d – Mark Brooks (MB) reported that NHS England and Improvement (NHSEI) self-certification had been sent as agreed. The action could therefore be closed.
- TB/20/24b – the action related to the annual review of the West Yorkshire Mental Health, Learning Disability and Autism Collaborative (WYMHLDAC) Committees in Common that had been delayed due to Covid-19. It was discussed at the July Committee meeting last week and there were notes to that effect in the Committee assurance section coming to the Board today. The revised Terms of Reference would come to the Board for review in September and therefore the action could be closed.
- TB/19/97a and TB/19/97c actions needed their timescale revising to go to September strategic Board.

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

## TB/20/47 Service User story (agenda item 5)

The Chair introduced the item and thanked Ben for joining the Board with support from Julie Warren-Sykes:

- Ben grew up in Calderdale around a lot of domestic violence and abuse. At age 11 he was taken into care with his brother and sister following his mother abandoning them. Within a week he had been arrested for the first time, which resulted in his first conviction for section 5 public order. On the same night he was separated from his brother and moved to foster parents.
- Ben reported from then on there was a stark change in his behavior and his mental health deteriorated.
- Over the next few years he turned to drink, drugs and crime and was “missing” most of the time and sleeping rough at the age of 12 and 13. Ben was moved to a children’s home in Manchester where he tried to take his own life. Following this, Ben was admitted to Barton Moss secure unit in Salford Eccles.
- Ben was supposed to receive a psychological assessment however, after three and a half months, this had not taken place. Ben felt that he had not received the interventions that he needed at the time.
- Shortly after this he was one of the first people to go to Medway secure training centre. On leaving, Ben’s behaviour resulted in a 16 month sentence to Wetherby Young Offenders Institution.
- Following further unsuccessful placements, Ben was admitted to a mental health ward. Ben decided to write a book about his experience and called it “51 moves” which refers to the number of times he was moved whilst in care, 51 times to 37 different placements having received 33 convictions before he was 18. Ben self-published the book and it received 25 “five star” reviews.
- From being in care Ben moved to working in care on a specialist unit which was a 12-week assessment unit for children who had been sexually abused or exploited for the purposes of terrorism. Ben received an invite to Buckingham Palace in 2015 for his work with children and families. From there he worked all over the country, spoke at universities and Whitehall.
- In 2013, Ben founded the “every child leaving care matters” which was included in the Labour Party manifesto and aims to stop children in care being disadvantaged.
- Following another breakdown, Ben was placed on ward 18, Dewsbury (an inpatient ward with our Trust) for 7-8 weeks and whilst on the ward, he learnt to paint. When he left, he auctioned his paintings and made £1080. He gave half of this money to ward 18 for them to buy canvasses for other service users to paint with. Ben also wrote another book titled ‘A Mental Year’ based on his journal from his time on Ward 18.
- Ben reported he had just been discharged (that day) from his current Community Psychiatric Nurse (CPN) who he reported had been absolutely amazing and he was now moving from the enhanced team.

- He had a psychological assessment booked that afternoon that he reported he had been waiting 20 years for.

AM thanked Ben for his story and for telling it so clearly and succinctly. AM clarified that Ben was now 37 years of age and thanked him for his generosity in his donation to ward 18. AM then asked if any Board members had any questions or comments.

TB thanked Ben for his story and complimented him on how well it had been delivered. TB asked how challenging it was for Ben when he started his work with children given his history and how he overcame it.

Ben described the job as tough, but said that he enjoyed it and felt that he could empathise with the children he was working with. Ben took pride in his high standards and said that the organisation modelled their induction standards on that basis.

SYa thanked Ben for his story and asked if he could give the Board any advice as to how we could have supported his mental health and wellbeing to prevent him becoming an inpatient.

Ben stated this came back to his most recent CPN. He reported if he had been with her for the last twenty years he would have been in a very different place. She had been very supportive and maintained regular contact which had not always been his experience with previous CPNs.

SYa summarised that this showed the importance of relationships between the service user and their key worker with which Ben agreed.

CH thanked Ben for his story and asked if he would be interested helping the Trust with children in care pathways. She also asked if Ben had been back to ward 18 and told them about the story.

Ben said that he would happily help children in care pathways and that he had delivered the canvasses to ward 18, but the occupational therapist had not been available at the time.

CH told Ben she would share what she had heard with the matron for ward 18 and would be in touch with him regarding the pathways work.

**Action: Carol Harris**

MB reported on the Teams message board that both books had five star ratings across the board. CD added how it highlighted to her the importance of partnership working and thinking about the whole person and the support across all areas, including education, housing, community support and safeguarding.

AM concluded by saying the story showed the importance of getting the right team around a person and putting them in the centre. It is also important to work with partners to ensure service users get early intervention when required. AM wished Ben well with his psychological assessment and thanked him again for providing his story.

**It was RESOLVED to NOTE the Service User Story.**

## TB/20/48 Chair's remarks (agenda item 6)

Chair's remarks

AM highlighted the items on the agenda for today's private Board meeting:

- Any risks that were considered to be commercially confidential.

- Any business developments from both Integrated Care Systems (ICSs), South Yorkshire and Bassetlaw and West Yorkshire and Harrogate, that may be commercially confidential.
- Any verbal updates on ongoing serious incident (SI) investigations
- Any matters in relation to draft financial and operational planning.
- A board discussion on race equality work following private conversations with the Black, Asian and Minority Ethnic (BAME) staff network. AM confirmed this would be partly heard in public but a further discussion would be held in private to enable free and frank discussion before agreeing further action.

AM noted the Trust was reaching the end of the process for appointing a new Non-Executive Director (NED) for the Board. A recommendation would be made to the Members' Council on Friday for a decision and any members of the public were welcome to attend.

AM noted that this was Laurence Campbell's (LC) last Board meeting having been a NED since 2014. She noted he had been an enormous asset to the Board and made a fantastic contribution over the years having chaired the Audit Committee, as a qualified accountant, with real skill and judgement. LC was known for his calm and thoughtful probing and constructive challenge whilst reflecting Trust values. AM finished by thanking LC for all his contributions to the Trust and the Board and that LC would be missed

**It was resolved to NOTE the Chair's remarks.**

## TB/20/49 Chief Executive's report (agenda item 7)

Chief Executive's report

AM updated that RW had written a paper and TB would provide any further comments. TB stated there was some additional information to share since the writing of RW's report:

- RW cited the move from national to local approach around Covid-19 outbreak management.
- TB updated there were now local Director of Infection Prevention and Control (DIPCE) calls within both of the ICSs which had been particularly helpful in keeping a focus on the health and social care aspects of outbreaks, of which there had been few. The focus of conversations had been around workplace outbreaks.
- Our geographical area was of significant national interest as a result of workplace outbreaks as opposed to health and social care settings.
- The flu vaccination programme will now be doubled in size from previous years with a 30 million target, which was significant in terms of workload.
- If a vaccine became available for Covid-19 it could not be administered together with the flu vaccine. This would put significant challenge into the system.
- There would be an increase in the requirement for asymptomatic testing from September 2020 (yet to be announced) which would put workload pressure into the system.
- RW had made an important point in that he was taking some leave and that staff are encouraged to take leave.

AM highlighted that RW had noted the 2.8% doctors pay increase but it was important the Board noted this did not apply to junior doctors, only specialty doctors and consultants. Junior doctors were in the middle of a four-year pay deal, and nurses were in the middle of a three-year pay deal. AM asked for questions or comments.

CD noted the learning disabilities mortality review (LeDeR) programme had been discussed on 23rd July 2020 at the Executive Management Team (EMT) meeting and asked if there were any significant risks that had come out of the LeDeR report that the Board needed to be aware of.

TB stated that the LeDeR report provided some similar messages to previous years and that EMT would look at the report and recommendations and ensure there were plans in place to

manage the recommendations that applied to the Trust. The report would be reviewed as part of the CGCS Committee agenda in September.

**Action: Tim Breedon**

AM noted there was a significant disparity for learning disabled service users from a BAME background in the report, and it raised the importance of maintaining the focus on health inequality in all the work we do. There was also a focus on the three main causes of death including epilepsy and sepsis, as well as other underlying health conditions, which highlighted the importance of maintaining a focus on physical health too for people with a learning disability.

TB agreed and commented that, as always, there were a lot of important recommendations in the report, including for primary and acute care, and the Trust had been linking in with partners on those items.

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

## TB/20/50 Risk and Assurance (agenda item 8)

TB/20/50a Board Assurance Framework (BAF) (agenda item 8.1)

- MB provided a reminder to Board members that it had been agreed that a new BAF would not be produced until after discussions at the Board strategy session in September.
- This was to allow for more clarity around further changes that needed to be made as a result of Covid-19 in relation to our priority programmes and strategic risks.
- The existing BAF had been updated where possible. A review had taken place at EMT and it was not felt to be appropriate to make any changes in the risk ratings at the moment.
- Potential considerations the Board may have to take into account when it came to the review in September, including some of the things we had learnt since the outbreak of Covid-19 and how they impacted on our strategic risks, were included in the documentation.

MB then asked for any questions / comments:

CJ reported he was interested in how we might use performance data to review some of the assessments and assurance levels. CJ referenced strategic risk 1.3 as an example "Differences in the services may result in inequitable services offers across the Trust."

CJ stated we had controls in place but we needed the performance data to show us whether or not the controls were effective in managing the risk. The performance data may give us a different picture. CJ queried that in light of what we knew about some of our services whether 1.3 should still remain as green.

MB agreed that this was likely to form part of the discussion at the September strategic Board. As had been discussed at the FIP Committee meeting, one issue that had been highlighted in recent weeks was the disparity in data available across different areas. MB noted that the Trust needs to consider what data we should and need to have, and what data might be available from public health and commissioners. He also added that to generate some of the reporting information required there would need to be increased recording of information.

CJ agreed but suggested there were some things about our services specifically that could give us greater insight into a particular risk but agreed that a review in September was appropriate.

AM had a similar query to CJ, using strategic risk 1.3 to illustrate the example, regarding whether health inequalities, and measures to reduce them, were sufficiently addressed in the

BAF. AM stated this should also be the focus of discussion in the strategic session in September.

AM noted the 2019/20 BAF was still being worked on until the strategic session in September and thanked everyone for their work in updating the document and keeping it current.

**It was RESOLVED to NOTE the Board Assurance Framework and the controls, assurances and progress to mitigate gaps against the Trust's strategic objectives for Quarter 1 2020/21.**

TB/10/50b Corporate / Organisational Risk Register (ORR) (agenda item 8.2)

- MB noted that the ORR had been reviewed regularly in depth since the Covid-19 outbreak.
- This quarter was the full update of the ORR and there was an emphasis on the Covid-19 risks and the impact of Covid-19 on our existing risks.
- MB reiterated that the ORR was regularly reviewed at EMT and had been updated to the NEDs every one to two weeks during the Covid emergency. MB invited Board Committee chairs to add any comments they wished to make.
- A legal risk had been added to the register and it was noted there were still quite a lot of unknowns as to what might happen during and post Covid-19 in terms of potential legal claims.
- There was more financial uncertainty for the remainder of this year and going forward in 2021/22. This issue had resulted in a slightly raised score of the impact of national funding risk.
- There were two 15+ risks, one of which was accepted as a 15+ risk as a result of the consequences of a "Cyber-attack" and the other was the potential impact of a demand surge on existing services and the Trust's ability to meet that demand and deliver services within the existing quality and safety standards.
- In the last three months the IT risk of staff not having appropriate access to equipment or licenses was much reduced given the work of the IT team in providing kit and adding licenses at the onset of the pandemic.
- The improvement in the testing process since the start of the outbreak had meant a reduction in risk for 1522 "Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19" and 1527 "The Covid-19 testing regime being delayed or inadequate, leading to sub-optimal utilisation of staff and sub-optimal care."
- There has been a notable increase in out of area (OOA) beds during July and this risk needs to be carefully reviewed if this position continues.
- There was a separate paper into the Board about being the forensics lead provider for the WYMHLDA collaborative. The risk remains the same as previous, but timescales are notably compressed given the pause in work as a result of Covid-19.

AM asked Committee chairs for comments.

LC reported from Audit Committee that, in relation to the cyber risk, a lot of great work had been done to mitigate the risk but the risk remained high. This had been accentuated by the increase in the number of staff working from home due to Covid-19. LC highlighted there was a paper on the digital strategy today and this could be discussed later in the meeting. The financial risk was significant due to the current level of uncertainty regarding funding arrangements and the potential risk relating to the forensics lead provider collaborative finances and that was an ongoing concern.

CD reported, as chair of CGCS Committee, that they had spent time focussing on Covid-19 risks to quality, care provided and patient experience. Risk 1528 related to the quality of care and CD asked if we had expressed sufficiently in our risks about the patient experience, and queried if the Board considered ways we were delivering service differently and thought about how that was impacting on patient experience and reflecting the risk around that.

AM added there had been a lack of service user and carer engagement in the development of new models of care during the Covid-19 period and acknowledged we were looking at how we address that. AM added that the actions that were in place for the Clinical Ethics Advisory Group (CEAG) were not really relevant to this and that was not what CEAG was there for. The risk was much more about making sure we capture the input from service users, carers, the wider public and also learning from their experience.

TB reported when the risk had been considered in CGCS Committee it was in the very early stages of Covid-19 but we now knew more about what had been done for service delivery by video, telephone and face to face contact and the Quality Impact Assessment (QIA) work had been put into place to assess the impact.

Risk 1528 was to be reviewed in CGCS committee in September 2020 to ensure that all new models of care included service user, carer and public understanding of the impact of different communication types on patient experience and quality of care.

**Action: Tim Breedon**

SYa assured the Board that there were several things that had taken place, Healthwatch reports from each our localities had been reviewed and ICSs had a done a large piece of work with the public to evaluate services. SYa would update actions for risk 1528 to include the review of Healthwatch reports and the ICS work that has taken place to evaluate services with the public.

**Action: Salma Yasmeen**

A standardised toolkit had been developed that would enable us to look at information and feedback from service users for each specific service. The toolkit was 80% standardised which would help to review the change and impact of those changes.

A large amount of work had taken place to help services evaluate their changes and the impact of change including the QIA and Equality Impact Assessment (EIA). This had been completed in line with the Trust change framework.

There was also a plan to enhance the engagement with service users, carers and communities by using volunteer groups, recovery colleges and Creative Minds and the peer support work that was emerging within the Trust, but this work was in its infancy.

LC asked about the effect of the new ways of working on our staff and their motivation. Many of our staff enjoyed interaction with people as a key component of their work and job satisfaction and so how did they feel about the change and how have we measured that?

CH reminded the Board that all face to face working hadn't stopped. Many services had continued face to face working on a risk level basis. When people had needed to see someone this had taken place.

There were also members of staff who had wanted to continue face to face work and as such had put themselves forward for this work. There was a benefit to staff being able to work more flexibly and this had been reflected in the sickness figures as people had more options.

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.

**Action: Alan Davis**

CJ stated that RW's report had concluded that we have a period of significant risk ahead of us. CJ wasn't sure the risk register reflected that, despite the increase in a couple of the risks and questioned if we had the overall balance right. CJ noted that it was then a question of how

we prioritise our response to the risk, as there were a lot of risk actions in the document which was a huge workload for colleagues already under significant pressure.

Risk 1530 had been discussed previously and related to an increase in demand. There was a question as to whether this was purely a mental health focus or needed to address community health pressures as well and if there was any evidence that our new ways of working would help us manage a surge in demand.

CH stated that the new ways of working increased our capacity to respond to an increase in demand in the community. We could cover a larger number of people with virtual clinics. We would use what we had learned during Covid-19 to respond to this scenario. There was a current issue with the demand in inpatient services, and the out of area bed usage reflected this. Work was ongoing to be more pro-active to prevent people becoming acutely unwell and requiring inpatient stays.

CJ queried if there was an expectation that CAMHS referrals would increase when the schools reopen in September.

CH reported the discussion had taken place and it was yet to be determined whether the surge would be for CAMHS services or for the CAHMS workers in schools, but it was believed it would be with the latter. As such preparations were in place to put in support where we were not the main provider. CH reported that CAMHS had achieved some real success in working virtually over the Covid-19 period and resources were being reviewed to increase capacity in the right places.

KQ referenced the Covid-19 related risk 1531 which dealt with the impact of Covid-19 on people with protected characteristics. KQ questioned whether the risk needed to be broadened to include people experiencing deprivation and poverty and should this be part of the strategic Board discussion. AM added that this was a similar comment to those in relation to the BAF, and if it reflected those health inequalities.

TB reported that this was the focus of discussion in the Equality and Inclusion task group . The importance of our engagement approach was key. The next task group was in two weeks' time.

AM reiterated that in the Trust, working carers were considered to be a protected characteristics group.

Erfana Mahmood (EM) asked about Information Governance (IG) breaches and what the impact of new ways of working had been. The risk register showed that the risk was outside of the risk appetite and EM queried how we were looking to manage this.

MB responded that in quarter one there had been the highest number of IG breaches that the Trust had experienced for a couple years. Initial review suggested a number of issues had impacted on this.

The number of staff off work in April and May had resulted in roles being performed by different people. Absence and people working remotely meant people had not been peer reviewing to the usual standard, which had resulted in information being sent to wrong addresses.

A Bluelight alert (a Trustwide communication about safety) had been issued and awareness is being raised through the communications team.

One team had recorded eight IG breaches and specific work had been carried out with that team to reinforce the importance of IG. The risk was reflected appropriately and was currently outside of the risk appetite.

The controls in place were appropriate but there was always further work to be done. The Trust ensured that IG was taken seriously and incidents usually came down to basic human error. There had been significant improvements over recent years. The last two incidents that had required reporting to the Information Commissioners Office (ICO) had both resulted in no further action being taken.

Sam Young (SYo), as chair of the Workforce and Remuneration Committee, reported there had been a lot of learning from different ways of working. What came out of the staff survey would need to be reflected into the actions going forward.

SYo stated that at the Committee 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 Workforce and Remuneration Committee to review risk 1533 and give more clarity as to the true nature of the risk.

**Action: Workforce and Remuneration Committee**

AM drew the discussion back to CJ's point about overall risk and did the risk register reflect this correctly. AM stated there was no heat map or total risk score, with trends over time, included with the board papers, as there would usually be.

MB reported the heat map and scores had been omitted in error and would be circulated after the meeting.

MB confirmed a cyclical approach to reviewing risks had continued throughout the Covid-19 pandemic and had in fact increased in frequency. They had been subject to significant scrutiny at EMT, including the scoring, and in NED meetings, as well as in Trust Board Committees. Therefore the scoring of the risks had been subject to robust challenge and the members of EMT and Committees were confident the ratings were appropriate when they were decided.

The current risk register was completed three to four weeks ago and there had been some subtle changes since the papers were circulated due to the dynamic situation in relation to Covid-19. The out of area bed risk had increased quite substantially over the last two to three weeks. The financial risk had also increased significantly given previous comments regarding income uncertainty.

MB reported that, other than those items, he was unable to say where he thought scores were over and above what had been reported in the risk register but accepted that other Board members may have different views.

CJ responded to say that the risk from his perspective was the overarching risk that there were a lot of risks. That, added to the level of uncertainty and pace of change, was where RW had got his headline from. The question was how the Trust prioritised the management of risks and whether EMT spent some time debating that.

CJ continued that it could become very "process centric" to review a list of risk actions and was the Trust reviewing whether actions had actually been carried out. Was the expectation too much that people manage individual risks given the overarching organisational risk that was present.

TB reported that there was a forthcoming EMT time out session. The agenda would include risk prioritisation and management and refreshing objectives and strategies in light of Covid-19. This would then feed into the Strategic Board session in September.

**Action: EMT**

AM asked for the risk register appendices to be circulated.

**Action: Aimee Willett**

AM thanked MB and his team for the very thorough review of all the risks.

**It was RESOLVED to NOTE the key risks for the organisation subject to any changes / additions arising from papers discussed at the Board meeting around performance, compliance and governance. The Board had DISCUSSED if the target risk levels that fall outside of the risk appetite are acceptable or whether they require review.**

TB/20/50c Infection, Prevention and Control Board Assurance Framework (agenda item 8.3)

TB reported the item was to be taken as read and was self-explanatory. The internal work carried out had been reviewed by Care Quality Commission (CQC) and their response was noted within the paper.

LC asked for an explanation in relation to findings on page 3 – no gaps in assurance other than in domain 3.

TB explained that this related to the anti-microbial work that had been ongoing to make sure that the pharmacists link data to individuals. This had been occurring manually but the new electronic prescribing system would carry out this function which would make it easier to understand if people were using the right medication. The CQC in their review concluded we had no gaps in assurance, and this was something we identified ourselves and reported back to them.

**It was RESOLVED to RECEIVE the IPC Board Assurance Framework as assurance that the appropriate standards are in place and NOTE that the CQC have reviewed and confirmed that.**

## TB/20/51 Business developments and collaborative partnership working (agenda item 9)

TB/20/51a South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 9.1)

- AGD updated that the Health Executive Group (HEG) was in a transitional state from responding to the pandemic to working towards the reset and having a stronger focus on planning arrangements.
- There had been a good workshop around equality and inclusion. Experience had been shared from the West Yorkshire & Harrogate ICS within the South Yorkshire and Bassetlaw ICS.
- A single site for Covid-19 patients was discussed, there had been a large amount of work carried out on this and this continued.
- There was a stronger focus moving forward on the reset, how to increasingly restore clinical services and how to link in with the private sector and contractors.
- SYa updated in relation to the Barnsley ICS. The mental health, learning disabilities and autism programme board had been re-established as part of planning for recovery and there will be a further prioritisation process across South Yorkshire and Bassetlaw in regard to this programme.
- The integrated care partnership in Barnsley had resumed and was overseeing the re-prioritisation and five key critical priorities had been agreed, which were in the paper. One of these was financial sustainability across the system and an executive group including finance directors and operations directors was to be established to oversee efficiency improvements.

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

TB/20/51b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 9.2)

- SYa asked that the paper was taken as read. The ICS across West Yorkshire had allocated funding as part of delivering its ambitions and targets around reducing health inequalities. It had targeted BAME communities and those with protected characteristics.
- Voluntary Action Calderdale was one of the projects that had been successful in its bid. The Trust were key partners in this project and Creative Minds would be supporting it. It was focused on one of the most deprived areas in Calderdale.
- To help people who have experienced complex bereavement issues and associated mental health difficulties, a helpline had been set up.
- The Trust continued to lead the suicide prevention work on behalf of the ICS.
- The commissioned work on race equality being led by Professor Dame Donna Kinnair had started and was to conclude in autumn with recommendations

AM asked what the process would be to share to the outcome of the independent review of race inequalities by Professor Dame Donna Kinnair across the ICS and how individual trusts across the ICS would receive the recommendations.

SYa stated that she understood the final editing rights remained with the chair and that she would clarify how the Trust would receive a copy of the outcome.

**Action: Salma Yasmeen**

**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/20/51c West Yorkshire Adult Secure Lead Provider Collaborative - update (agenda item 9.3)

- Sean Rayner (SR) highlighted that the context of the paper was a revised timetable following Covid-19 which had been published by NHSE&I approximately two weeks ago.
- For our track of the collaborative, the go live date remained 1 April 2021 so the majority of the work would now be pushed into a shorter timeframe.
- Inevitably processes would become transactional and focus on contracting, finance, risk and benefits. This was understandable given the timeframe and the governance arrangements involved.
- SR drew the Board's attention to the reason why we were becoming the lead provider in the collaborative noted in section 4 of the clinical model paper, which highlighted the purpose was to "provide care closer to home in the least restrictive setting and care being individualised to a person's needs".
- SR highlighted the Board's requirements would be business case approval in October 2020 and the governance framework that would need iteration going forward as per section 11 of the report. SR was to bring the business case and governance structure for Lead Forensic Provider Collaborative to Trust Board in October 2020 for approval.

**Action: Sean Rayner**

AM stated it was a very good and detailed paper and clearly highlighted some of the risks we were facing. AM asked for any comments or questions.

EM posed a question about the risks. The report outlined that as the lead provider we would be carrying most of the risk and responsibility. EM queried how this would be managed through partnership working and if some of the risks in terms of delivery may sit with partners.

SR stated that behind this paper was a substantial amount of NHSE&I transitional guidance particularly in terms of quality and monitoring of those services provided by our partners on the collaborative.

On the financial and contracting side of the work a risk sharing agreement was required and there was a similar need on the CAMHS tier 4 project, which had similar financial risks, although maybe not as great in scale as this collaborative. We would be part of that collaborative in terms of signing the partnership agreement, albeit as a partner rather than the lead provider.

A framework was under development within which we would need to quality assure the services that the Trust was accountable for and make sure there was a line of sight on those risks to the Board.

EM asked if the framework would reflect financial risk as well or would the Trust have to carry all the financial risks?

SR replied that this was one of the key facets that the financial risk share would need to cover and this was beginning to be developed with partners.

MB started by saying this was a significant challenge. To put things in perspective, four months of due diligence work had been lost due to the pandemic and a business case was required to be agreed by all partners by October.

MB reported the Trust made a deficit on forensic services as did other NHS providers. Each Board for these organisations will need to sign up to a risk and gain sharing agreement. Potential benefits will need to be clear and evidenced in order to provide Boards with appropriate assurance regarding the financial implications on their own statutory organisations.

In the next couple of months intensive work was required, as it was not just about risk, but gain as well and how to make this a success with a series of services we can run more efficiently and effectively.

The aim was to have some basic financial due diligence completed by the end of August. A sub group looking at what a risk sharing agreement would look like had been established.

This contract was worth over £50 million. We do need to consider such matters as exceptional packages of care which can arise from time to time and can be very costly. We have all these factors to work through over the next few weeks to come to a position where we can ensure each Board is fully informed.

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

**Action: Sean Rayner / Angela Monaghan**

AM noted that this had been discussed at Committees in Common. There were significant issues to be addressed. There was a very strong collaborative partnership between the NHS providers which would help. It would be discussed further at Committees in Common before it came back to Trust Board.

**Action: WYMHLDAC Committees in Common**

CJ stated this was more complex than he had initially thought having read the report. CJ reported he had read into it there was a financial downside to be managed through the risk share but couldn't see the financial upside. He asked for focus on potential benefits and for consideration of reputational risk and the CQC perspective. For example when they inspect services is that going to appear on our reports, and how are we going to manage this?

SR stated, regarding the upside, evidence within West Yorkshire suggested that in relation to CAMHS tier 4 beds (young people detained under the MHA) there was a significant number of children placed in OOA beds and there were significant savings to be made. A similar approach is being assessed with regard to forensics. Further work around financial due diligence was required to provide assurance that financial upsides are possible.

In relation to the CQC, those processes would still be in place irrespective of the collaborative arrangements. The added layer that needed to be brought in was the additional commissioning arrangements we would have in West Yorkshire for all the collaboratives.
As lead provider we needed to make sure we receive early warning of any quality issues that were of concern. This was a risk we would have to manage and ensure our framework was fit to do this.

AM reported that the assurance and governance arrangements presented were quite complex with provider collaboratives and queried if there were any opportunities to streamline things without losing any control.

AM reported her understanding was that the mental health investment standard didn't apply to specialist commissioning and this had been discussed at Committees in Common. AM queried if this was something we should be taking up with NHSE&I and national mental health programmes.

MB reported it was national instruction and it didn't apply to forensic or learning disabilities. AM commented it seemed wrong the standard didn't apply to these specialised mental health services and we should continue to challenge this.

**It was RESOLVED to RECEIVE and NOTE the update on the Adult Secure Lead Provider Collaborative including the revised timetable, to NOTE the current governance framework, which will be kept under review and the Board apprised of any changes, to NOTE the requirements for Board Assurance as part of the Provider Collaborative approval process, outlined in appendix 1, and to NOTE comments made within the discussion.**

TB/20/51d Receipt of Partnership Board Minutes (agenda item 9.4)
**It was RESOLVED to RECEIVE the minutes from partnership boards.**

*Prior to item 10 Andy Lister (AL) confirmed the missing Appendix from item 8.2 had been circulated during the break to Board members by e-mail.*

## TB/20/52 Performance reports (agenda item 10)

TB/20/52a Update on arrangements in place for the management of Covid-19 (agenda item 10.1)

- AGD highlighted the understanding of our OPEL (operations pressure escalation level) compared to other organisations across the area. It was consistently under review and silver command was developing a more sophisticated model in terms of indicators which would determine whether we moved up or down the scale.
- A lot of work continued in relation to staff risk assessments and to date 2800 self-assessments had been completed. This was up 1300 since the report was circulated to Board.
- All BAME staff risk assessments are complete, a couple of shielding staff were outstanding, pregnant staff risk assessments are complete and the team were working through the older staff group.
- Around 68% of staff have now completed a risk assessment. Compared to other Trusts this put us in a strong position. The Trust is required to report our final position this coming Friday.

EM stated that the risk assessments had been positive and asked if there was any way of looking at these for volunteers or governors.

AGD reported that volunteers would need a risk assessment if they come into the Trust. There may be issues if there were a number of complexities and referrals into occupational health were required but the protection of anyone on our site was paramount and the Trust had a duty of care. AM clarified that governors were volunteers and so they would fit into that group.

KQ stated it had been a really good piece of work and was testament to a lot of hard work.

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

TB/20/52b Integrated performance report (IPR) month 3 2020/2 (agenda item 10.2)

TB clarified that each director would pick up their routine section of the IPR and anything from the Covid-19 section that related to them.

- TB reported that at the last Board meeting it was agreed to look at the Covid-19 section as some of the headings and domains had become outdated given the dynamic nature of the pandemic response. Those domains had now been updated and TB was happy to take feedback in relation to those.
- The workforce information included in the summary on page 5 was noted and identified some positive trends.
- Testing – a significant number of staff had been tested, there had been a small increase in the number of positive tests but no positive patient tests at that time.
- There had been no need to bring a cohort ward into use during June. This was significant in terms of the pandemic changing and as previously mentioned the outbreaks tended to be outside of health and social care settings and are more work based currently.
- The positive increase in the number of compliments was noted.
- Safer staffing –TB reminded the Board that the information in the IPR relates to inpatient information (community metrics would be reported again from September). It was a generally positive picture but there were a number of students formerly employed by the Trust during this time and the “back to work” scheme had resulted in some higher than expected staffing fill rates.
- Incident reporting – moderate levels were up again, a lot of this was due to pressure ulcers and this had been monitored for last couple of months but there were no obvious themes or trends.
- Self-harm and suicide numbers continue to be under close review. There has been no change in the suicide figures but the number of self-harm incidents had gone up in the last 4-6 weeks.
- A task force in relation to the impact of self-harm had been set up to look at service users, our staff and the carers involved.
- The Infection Prevention and Control (IPC) team continue to manage guidance in relation to Covid-19.
- The Personal Protective Equipment (PPE) supply remains under constant review but the Trust is in a good place. A transparent mask source was being trialed for use with learning disability clients locally.
- Race equality – a revised delivery and governance structure, important messages and decision making processes are in place and the Equality Impact Assessment tool is available.
- There has been an increase in admissions under the Mental Health Act (MHA) which requires review by the MHA Committee to understand the reason behind the increase.
- Quality metrics were standing up well but acuity was significant and continues to be monitored.

LC noted incidents of non-compliance with social distancing was an increasing trend and asked how the Trust could respond to this.

TB suggested that there had been no upsurge in cases of Covid-19 and this perhaps created the perception it was not as important. TB added that the Trust continued to reinforce the messages about social distancing and hand washing, and the need to manage the cultural message regarding scrubs and PPE, and continues to promote the message that this has to be taken seriously. In the inpatient environment we still have to apply the 2m rule.

LC noted the CAMHS referrals to treatment times and queried if this was a new trend. CH clarified on the graph it had been highlighted that "waits for assessment" had been moved. The waits of Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) had been previously included in the figures. The graph now reflected the date after which these "waits" were removed and noted that the change from July 2019 was highlighted on the graph with the blue square on the blue line. LC questioned if this was an improving trend and CH confirmed it was.

CD reported she was pleased to see the review on self-harm following the discussion at the last Board meeting. CD asked for some assurance around training in relation to Reducing Restrictive Practice and Interventions (RRPI) and stated she could see we were within the expected levels, which was good but noted increasing acuity and pauses in training due to Covid-19 and queried how this was being managed by the Trust. CD then raised homelessness in the wider context and queried if there had been some positive management of this issue within our area.

TB responded that in relation to RRPI, originally the Trust had to suspend training due to Covid-19 but that training was now resuming as of 21st July. The refresher period had been expanded to maintain compliance.

Those not previously trained would be given priority, this related to both substantive and bank staff, and then to clear the backlog with people whose training would expire first. This had been the subject of national discussion in terms of management.

CH reported that more information would be reported through CGCS Committee on how we were working with homeless people in the community but there had been challenges in the inpatient setting. Some of the services that we would normally provide for the homeless had not been operating in the same way which had resulted in extended periods of stay. CH would provide a report to update the next CGCS committee.

**Action: Carol Harris**

KQ stated in relation to restraint the report mentioned bank staff but not agency staff. KQ stated that she believed there were no national standards for agency staff and that they may use different restraint methods to our staff which could be problematic. KQ queried if the Trust provided training for our agency staff.

TB reported that some agency staff were trained to the right level and there wasn't a national standard as KQ had pointed out, but there was some work being done by the ICS around this issue. The proposal was to have a system-wide approach that was quite ambitious because everybody was linked to their own system. As such, a set of value-based standards were being developed for everyone to work to which would provide some consistency across the system.

KQ then commented about IAPT and service users dropping out of treatment due to virtual treatments. KQ questioned the impact on recovery rates and asked if service users were re-emerging in services since having dropped out, and if there was an increase in anxiety and depression and if so how this was managed.

CH reported this was impacting on recovery rates and there had been a drill down in the Calderdale and Kirklees data (awaiting figures from Barnsley). In Calderdale and Kirklees the reporting showed a number of people had dropped out of treatment due to the virtual work and other factors which meant they did not want to engage with services at the time.

Covid-19 was having an effect on overall wellbeing, which had been having a negative impact on recovery rates. Face to face IAPT work had been stepped back up giving people the option to be part of a virtual group or wait for a face to face group. Staff were providing contact details so that service users could access support while they were waiting or those that had discharged themselves knew they could make contact to re-engage. There was also a regional helpline available.

Barnsley commissioners have been looking at renegotiating IAPT targets but this was ongoing and what remained important was continuing to provide the right level of service.

AGD updated on workforce:

- There were many positive workforce trends, staff absence was down but the Trust needed to examine why that was and look at the reasons for absence. Whilst absence overall has gone down for non Covid-19 related sickness there had been a 22% increase in stress and anxiety, nursing had seen a decrease, whereas Healthcare Support Workers had seen an increase and these figures needed to be explored. More detailed reports were going to be taken into the Operational Management Group (OMG) to look at this.

**Action: Alan Davis**

- Next week shielding was going to be paused and the Trust had been working on risk assessments and how to bring shielded staff back to work safely if they can't work from home.
- Staff turnover looked good but information suggested there was a pause in posts being advertised nationally. The Trust was looking at how to recruit and have a detailed campaign on recruitment. The last healthcare support worker recruitment drive had been very positive.

AM asked if there were any comments or questions.

SYo commented the number of staff receiving supervision within policy guidance was a downward trend and it was felt that this was really important currently.

TB agreed supervision was fundamental and there were issues around recording of supervision and there was a piece of work going back into CGCS Committee in September. Supervision had been on a downward trend prior to Covid-19 and it had improved but checks needed to take place to demonstrate this was continuing.

**Action: Tim Breedon**

CJ queried what the general approach was for home working going forward. AGD identified this was one of the big issues coming out of the reset and recovery work. Before Covid-19 happened the Trust had promoted agile working. The current position remains if staff can work from home they should do.

AGD commented that the learning was that some people may want to stay at home but it was not suitable to their role. For example, 60 shielded staff had been unable to have other work to do from home during Covid-19.

AGD stated returning to the situation where everyone was in the office for a full week at work was unlikely. What support mechanisms were required needed to be established. Leadership and supervision also needed to be looked at.

MB updated on national metrics:

- There are now some metrics not rated as green (meeting target). This included the 18-week referral time and six-week diagnostic time, largely because of capacity at acute hospitals and what services they were able to provide at the moment.

- The Trust has been able to maintain performance in other areas. MB acknowledged that this report didn't show the current out of area (OOA) bed issues which had increased in July.

CD queried what the position was with OOA beds and what the financial position was. MB reported there were 17 OOA beds last week, which was down to 12 last Friday. At those levels the spend was around £300k a month.

CH updated that a detailed discussion had taken place at the OOA partnership board and, while there had been a spike, the Trust had held the numbers from 12th July and were looking to get people back into area and strengthen the work on the pathways again. Only one person had been placed out of area since 12th July.

There had been an increase in acuity on the wards, and the length of stay and some discharge issues resulting in increased lengths of stay. Information was being scrutinised to establish whether these issues were Covid-19 related, pre-admission, in that people hadn't been receiving the normal services as a result of the pandemic, but information gathering was still ongoing. CH reported we were still managing a number of OOA beds, we had high levels of occupancy and were using leave beds and that the situation was still very challenging.

AM noted the percentage of clients in employment was rising and that was encouraging, noting the data quality issues.

CH summarised the locality section of the report:

- Barnsley general community – continued to deliver the refined service offer, recovery plans were in place and being worked on across the partnerships. There was already an increase in demand for face to face visits in neighbourhood nursing and community rehabilitation services and we were seeing more complex end of life pathways.
- The Trust had been able to open the stroke early support and discharge service which was now operational with clients on the caseload, providing priority face to face visits where required and also using virtual technology where appropriate
- The Health Integration team in Urban House were continuing to work closely with the Director of Public Health in relation to maintaining a safe environment.
- Standard operating procedures and clinical pathways for cohort wards for Covid-19 patients had been reviewed in light of new guidance.
- The Willow Ward had been accredited under the Royal College of Psychiatrists under the Quality Network for older adults mental health services (QNOAMHF).
- A workshop in West Yorkshire with local authority partners had taken place. With the three local authorities working together with the Trust some priorities had been agreed and action plans were in place for review in the next six months.
- Community teams are continuing to use technology for work and also supervision.
- The "virtual visitor" with the iPad on the ward was proving very popular and is something we were looking to continue.
- Forensic, learning disability and ADHD services had seen a reduction in referrals at the start of the outbreak but these were now returning to normal levels.
- ADHD and ASD services carried out a survey in relation to remote appointments and there had been some really positive results and we are looking at how we learn from those results.
- Forensics - the Covid-19 cohort ward was being held in case it was required again in the future.
- Barnsley mental health services – the crisis support arrangements were simplified at the start of Covid-19 working and, with the adult intensive home based treatment team (IHBT), they now provide an all age single point of access (SPA) function out of hours.
- Detailed discussions had taken place with Barnsley Clinical Commissioning Group (CCG) following the cancellation of the CAMHS procurement process. CAMHS had agreed a governance process which would then lead into discussions about ways of working in the future.

- CAHMS – ASD and ADHD "waiting for assessment" numbers continued to increase despite further commissioned activity work and the Trust submitted business cases to the CCG to obtain the resources to manage this. This will be looked at further in CGCS Committee.

**Action: Carol Harris**

AM passed on the board's congratulations to the stroke service in Barnsley, Willow ward and the team that implemented the virtual visitor work.

SYa updated on priority programmes:

- There had been a focus on improvements in our forensics services and CAMHS and that work would continue.
- Evidence of digital contact was still increasing and we were capturing evidence to support this.
- There was a focus on reset and recovery in each of our Business Delivery Units (BDUs) and that work continued.
- SYa asked to highlight the work from communications team and equality and inclusion team and the amount of work taking place. There was a summary in the report and the work had been both internal and external.

AM noted how good the communications had been and the engagement had been good, and the Board would continue to challenge and promote this work.

MB updated with the financial headlines:

- The financial arrangements to allow the Trust to continue to break even were still in place at least for another month until August. In June a requirement to have an increased retrospective top up payment was noted, the Trust was spending more money than we had in previous months.
- Pay costs in June were £1.6 million more than the average monthly pay last year. This was due to the pay award, investment in services through the mental health investment standard and the additional staff added for the Covid-19 response combined with low levels of turnover.
- There could be a financial challenge when the current financial arrangements end.
- The Trust is paying 83% of invoices within 7 days compared to 36% nationally.

CJ reported, as chair of FIP Committee, that the Trust continued to break even at the moment, which was the requirement, and had good sight on the extra costs and understood where they were. There were challenges due to not being funded for all our activities currently, but things were being well controlled. Some assumptions were made in the financial plan for this year and we have been really successful on one level but that may provide some challenges going forward.

AM reiterated a well done to the finance team on maintaining payments to suppliers within seven days.

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

## TB/20/53 Strategies and Policies (agenda item 11)

TB/20/53a Digital Strategy (agenda item 11.1)

- MB reported this was a deferred paper from March / April 2020 which provided updates from 2019/20 but also included comment on the Covid-19 response and he would take the paper as read.
- There had been progress on Windows 10 replacement and the e-mail platform change.

- There had been a presentation yesterday at FIP Committee on the progress on the business intelligence and the Trust dashboard which provides us with a wide range of information including internal benchmarking by teams.
- Progress on cyber security largely driven by the capital plan.
- SystmOne became more embedded last year.
- The Trust did well on our data protection and security toolkit.
- The Trust is working within both ICSs.
- The Digital Strategy is due a refresh and is to be updated in January.

AM commented this was an excellent paper showing great progress.

LC questioned what Microsoft Sharepoint was, what it did and asked if there was some text missing on page 6 of the report. LC also commented that digital developments for the clinical side of business would likely be developed outside of NHS trusts and asked therefore how we would get insight into what technology was best and how we integrate it into our strategy.

SYa responded saying there was an internal digital strategy group which had really strong engagement from clinicians. The group used themed conversations and received presentations from external companies demonstrating the evidence base of where they were using the new equipment, what the impact may be and what that may mean in terms of the Trust strategy.

Externally, members of the Yorkshire & Humber Academic Health Science Network, were involved in a significant piece of work with one of the national quality bodies where they were looking at learning and evaluation of digital progression.

The Trust is also part of conversations with the alliance for health service development across the Yorkshire and Humber region, which is a multi-million pound initiative which would inform policy at national and government level and again there was an opportunity to be part of research there as well.

MB stated SharePoint helped the Trust share information and it serviced the intranet. The Trust is very well represented within the ICS digital groups and like any network, it allowed us to see what was working in other organisations and nationally as well.

We were well placed in our access to benchmarking. All the Covid-19 staffing information that has been seen today was from Sharepoint and given its level of use, especially in relation to the intranet, it requires upgrade.

SYa clarified that the Trust was part of the Yorkshire and Humber shared healthcare record work taking place across the region, RW is the chair of that board and Paul Foster (PF) is linked in to South Yorkshire and West Yorkshire networks of Chief Information Officers (CIOs) and there is the opportunity for funding through these groups as well.

MB added a challenge is the level of recurrent funding now required given the increased number of laptops, licences and different platforms that had been invested in during the pandemic. The actual cost was not yet known as some products had introductory free periods before the payment started but MB estimated an additional recurrent cost of £1 -1.5 million each year.

AM asked for clarification on the missing wording at the bottom of page six page 6.

MB stated that the internal audit this year would include work on our digital strategy including how it compared to the others, if we were approaching it in the right manner and if we had a good process to evaluate performance against it. The work had just started and this would take place over the course of the year.

CD queried engagement and asked if there had been wider engagement than clinicians internally as this work needed to be led by the whole organisation.

SYa reported that the Trust was trying to use clinically-led change but there was representation across the board and it was an organisation-wide group.

MB referenced the level of engagement in the implementation of SystmOne and this represented the level of engagement that the Trust utilised with all its system changes.

CD asked how ambitious did the Trust want to be in relation to the digital strategy? It would be useful to know at the strategic board what, if any, constraints were preventing the Trust achieving its goals in relation to the Digital Strategy.

**Action: Mark Brooks**

AM reported it would be likely that the ambition of the Digital Strategy would form part of the conversation at Strategic Board in early September. AM reported the importance of having a digitally skilled and enabled workforce has grown since Covid-19, including the Trust Board. There had been an offer from NHS Providers to carry out bespoke Board development sessions on the digital agenda and this might be something that was worth looking at as part of this work. AM to liaise with MB regarding this.

**Action: Angela Monaghan**

AM reported that SYa had mentioned earlier the CIO network – it was confirmed that MB is the Trust CIO, and that, 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 it had been decided that an appointment needed to be made.

**Action: Tim Breedon / Subha Thiyagesh**

SYa reported that digital literacy was being picked up through the ICSs to look if there was a standardised way of doing it. Healthwatch organisations are interested in where there may be a digital literacy gap that contributes to health inequalities. The way in which the Trust is supporting people to work in an agile manner had been strengthened during Covid-19 and we were developing a best practice guide.

AM acknowledged that, on page 2, the report notes that the increase to three thousand virtual private networks (VPNs) to allow staff to work from home would not have been possible had the work not taken place in the last three years to improve the digital infrastructure. AM gave thanks and recognition for the team involved.

MB noted that the level of risk had been significantly higher three years ago and this had been well managed year on year through the capital programme.

**It was RESOLVED to NOTE the achievements made in respect of the 2019/20 milestones and the digital enabled reaction as part of the Trust's response to the pandemic.**

## TB/20/54 Governance matters (agenda item 12)

TB/20/54a Interim Governance Arrangements – update (agenda item 12.1)

MB updated to take the paper as read.

No comments or questions were raised, AM reported she thought this was a good summary of the current position in relation to governance matters which was under continuous review.

**It was RESOLVED to RECEIVE the update to the interim governance arrangements as outlined in the paper.**

TB/20/54b Board Development Proposal (agenda item 12.2)

- AGD updated that, having had some constructive discussion with the national leadership team around board development and building leadership for inclusion, they had put together a board development programme that the Trust was very interested in and was due to be part of pilot.
- A business case had been put together for it to be fully funded through the scheme if the Trust wanted to proceed.
- It had been initially agreed that the Trust would need sight of what the programme included, especially since Covid-19, but this had not yet been made available.
- As a result the Trust had decided to keep dialogue with the national programme but also explore other options.
- Conversations had been taking place with the Kings Fund.
- Inclusion would be at the heart of the programme whatever option was pursued.
- A firm proposal should be in place by September Board, either from the leadership academy or through our own bespoke board development programme.

**Action: Alan Davis**

**It was RESOLVED to NOTE the update in relation to the Board Development Proposal.**

## TB/20/55 Assurance and receipt of minutes from Trust Board Committees (agenda item 13)

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

**Audit Committee** – LC reported that one of the risks that had been discussed was around the need to prioritise activity. This was in line with discussions in today's Board meeting about initiatives, potential initiatives, strategic planning and reset and recovery. There was a large challenge around the increased volume of work required, and as such there was a new risk arising around the need to prioritise work and look at what we do first.

LC also cited the new finance and procurement system which, echoing the earlier conversation around the need for engagement, is not just a finance system so it was important the right feedback was fed in. SBS was a well-established system within the NHS but how it was implemented was very important and LC highlighted the need for inclusion across the Trust.

Minutes were received from 14 April 2020 and 2 June 2020.

**Finance, Investment and Performance Committee** – CJ updated that FIP Committee had taken place yesterday and most of the issues to be brought to the Board's attention had already been discussed. There had been a good presentation on internal benchmarking and productivity, noting that some of the work had been paused as a result of Covid-19, but was due to return shortly.

Minutes were received from 26 May 2020

**West Yorkshire Mental Health, Learning Disability & Autism Collaborative Committees in Common** – AM updated this had started to return to business as usual but not completely. A detailed status update had taken place on each of the collaborative's programmes. There was a very clear picture of what had been paused, what had been resumed, repurposed, continued or initiated during Covid-19 and starting to be clear on where the priorities were going to lie going forward.

There was an update on the ongoing work to reconfigure the assessment and treatment units (ATUs) across West Yorkshire and also on complex rehabilitation services. There was some good mutual aid work going on across the organisations in relation to ATUs and this was reflective of the positive collaborative work going on.

There was a detailed review of the Committee's effectiveness and also a review of the Terms of Reference now that the Committee had been in operation for two years and those would now go out to each of the trust Boards to approve.

There was a discussion around early learning since Covid-19 and a proposal in relation to the piece of work TB had mentioned earlier around a shared approach to RRPI which was seen as a priority. The Tier 4 CAMHS unit was in progress, it was currently on time and on budget.

**Workforce and Remuneration Committee –** SYo reported that many of the issues discussed in the Committee had been the focus of Board discussion and wished to highlight clinical excellence awards. There would be an even distribution of the funds to all eligible consultants this year, rather than the usual application process. There was concern expressed that a number of doctors were automatically excluded from this distribution, as they would not normally be eligible for clinical excellence awards. We have therefore asked AGD to go back and check if those that have been previously excluded remain so under the rules this year.

In relation to the Organisational Development Strategy and Workforce strategy there was to be a joint discussion between the Workforce and Remuneration Committee and the Equality and Inclusion Committee. The discussion was look at these strategies against the Equality strategy in October before it came back to board in November.

Minutes were received from 11 February 2020.

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

## TB/20/56 Trust Board work programme (agenda item 14)

The Board noted the changes to the work programme. AM noted there were some items that needed amending:

- The serious incidents quarterly report had been received.
- Annual reports deferred in June needed new dates for when they were going to Board.
- Check that health and safety, customer services, and serious incidents annual reports have been received.
- The equality and diversity and medical appraisal annual report were due in this Board meeting and so new dates were required.

- The Constitution and Scheme of Delegation were due to be taken today also and so they required new dates.

**Action: Andy Lister**

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

## TB/20/57 Date of next meeting (agenda item 15)

The next Trust Board meeting held in public will be held on Tuesday 29 September 2020.

## TB/20/58 Questions from the public (agenda item 16)

No questions were received. AL confirmed that no questions had been received and in the circulation of the Board papers on the Trust website a request had been made for members of the public and governors to submit any questions in writing prior to the meeting.

**Signed:** **Date: 29 September 2020**