NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 29 June 2021 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 April 2021**	Chair	**Paper**	2	To approve
4.	**9.05**	**Matters arising from previous Trust Board meeting held 27 April 2021 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 2 2021/22	Director of Finance & Resources and Director of Nursing & Quality	**Paper**	60	To receive
	10.30	8.2 Operating and Financial Plan Update	Director of Finance & Resources	**Paper**	5	To receive
9.	**10.35**	**Business developments**				
	10.35	9.1 Integrated Care System developments white paper update	Director of Strategy	**Paper**	10	To receive
	10.45	9.2 South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) including Barnsley Integrated Care Partnership Group Update.	Director of HR, OD & Estates and Director of Strategy	**Paper**	10	To receive
	10.55	9.3 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) - Wakefield Integrated Care Partnership Update	Director of Strategy and Director of Provider Development	**Paper**	10	To receive
	11.05	9.4 Confirmation of Chief Executive's extended secondment to West Yorkshire and Harrogate Health Care Partnership.	Director of HR, OD & Estates	**Paper**	5	To approve
	11.10	9.5 Receipt of Partnership Board minutes	Chair	**Paper**	5	To receive
	11.15	*Break*			*10*	

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
10.	**11.25**	**Strategies and policies**				
	11.25	10.1 Customer Services Policy	Director of Nursing & Quality	**Paper**	5	To approve
11.	**11.30**	**Governance matters**				
	11.30	11.1 Compliance with NHS provider licence conditions and code of governance - self-certifications	Director of Finance & Resources	**Paper**	5	To receive
	11.35	11.2 Serious Incidents Annual report	Director of Nursing & Quality	**Paper**	5	To receive
	11.40	11.3 Health and Safety annual report	Director of HR, OD & Estates	**Paper**	5	To receive
	11.45	11.4 Premises Assurance Model	Director of HR, OD & Estates	**Paper**	5	To receive
	11.50	11.5 Interim Governance Arrangements update	Director of Finance & Resources	**Paper**	5	To receive
	11.55	11.6 Changes to Board Committee Membership	Chair	**Paper**	5	To receive
12.	12.00	**Assurance and receipt of minutes from Trust Board Committees and Members' Council** - Audit Committee 18 June 2021	Chairs of committees/Members' Council	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		- Clinical Governance & Clinical Safety Committee 8 June 2021 - Equality and Inclusion Committee 1 June 2021 - Finance, Investment & Performance Committee 24 May and 28 June 2021 - Mental Health Act Committee 11 May 2021 - Workforce & Remuneration Committee 18 May 2021 - WYMHSC Committees in Common 11 June 2021 - Members' Council meeting 11 May 2021				
13.	**12.10**	**Use of Trust Seal**	Chair	**Paper**	5	To receive
14.	**12.15**	**Trust Board work programme for 2021/22**	Chair	**Paper**	3	To approve
15.	**12.18**	**Date of next meeting** The next Trust Board meeting held in public will be held on 27 July 2021	Chair	**Paper**	2	To receive
16.	**12.20**	**Questions from the public**	Chair	**Verbal**	10	To note
17.	*12.30*	*Close*	Chair	**Verbal**		To receive

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Minutes of Trust Board meeting held on 27 April 2021
Microsoft Teams meeting

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Non-Executive Director
	Mike Ford (MF)	Non-Executive Director
	Chris Jones (CJ)	Deputy Chair / Senior Independent Director
	Kate Quail (KQ)	Non-Executive Director
	Erfana Mahmood (EM)	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:	None	
In attendance:	Carol Harris (CH)	Director of Operations
	Andy Lister (AL)	Company Secretary (author)
	Tim Mellard	Lead Matron Trustwide Inpatient Services (item 5 only)
	Dr. Richard Marriot	Guardian of Safe Working Hours (item 10.3 only)
	Sean Rayner (SR)	Director of Provider Development
	Salma Yasmeen (SY)	Director of Strategy
	Claire Wilkinson	Matron Unity Centre Wakefield (item 5 only)
Observers:	Daz Dooler	Public Governor - Wakefield
	Csilla Fabian	Corporate Governance Manager (designate)
	John Laville	Public Governor – Kirklees (Lead Governor)
	Raymond Rowles	Member of the Public

TB/21/32 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. There were no apologies, 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/21/33 Declarations of interest (agenda item 2)

It was RESOLVED to NOTE there were no changes to the declarations of interest register since March 2021.

TB/21/34 Minutes from previous Trust Board meeting held 30 March 2021 (agenda item 3)

Kate Quail (KQ) requested an amendment to the minutes. KQ asked for the wording in paragraph two of page twelve (Diligent) to state:
"Kate Quail (KQ) reported she was on the IPR sub-group and questioned how the triangulation of information from a range of sources including service user and staff experience about risks worked, so that we understand the totality of risk by service".

This will replace the wording: "Kate Quail (KQ) reported she was on the IPR sub-group and questioned how more detailed service performance information and issues were identified and highlighted.

Action: Andy Lister

KQ confirmed the correct action was noted in the action log from 30 March 2021 and no further actions were required.

It was RESOLVED to NOTE the amendment and APPROVE the minutes of the public session of Trust Board held 30 March 2021 as a true and accurate record.

TB/21/35 Matters arising from previous Trust Board meeting held 30 March 2021 (agenda item 4)

TB/21/20 – Mark Brooks (MB) updated the Board that the information had been provided to the perinatal team as requested. To close.
TB/21/23a – Alan Davis (AGD) updated on RIDDOR (Reporting of injuries, diseases, and dangerous occurrences regulations) incidents. There are no Covid-19 related cases. In the main the incidents relate to violence and aggression. Each individual case has been reviewed in the Trust's Reducing Restrictive Practices and Interventions (RRPI) TAG (trust action group). A report is provided regularly to the Clinical Governance and Clinical Safety Committee (CGCSC). To close.
TB/21/25a – AM reported the Equality Impact Assessment (EIA) for the Green Plan forms part of the strategy and needs to come back to Board for approval. To remain open.
TB/21/25a – reusable PPE - Tim Breedon (TB) is taking this into the next regional meeting for an update.
TB/21/25c –MB provided a brief update on the action. Salma Yasmeen's (SY) team are working on the easy read version, health and safety risks regarding the use of digital equipment is being addressed and the updated EIA will be complete by the end of May. To be covered in the six-monthly report to Board.
TB/21/27 – RW reported Sean Rayner (SR) attended a meeting on the programme board. SR will take ownership of this action.

Action: Andy Lister

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

TB/21/36 Service User/Staff Member/Carer story (agenda item 5)

AM introduced Claire Wilkinson (CW) and Tim Mellard (TM) and their story, "a life in the day of a matron"

CW presented a typical working day as a matron:

9.00 am - coffee and check emails, catch up on incidents from overnight and the prioritisation of clinical follow up with the ward teams.

9:30 am – Matrons' operational call, matrons are committed to patient safety, staff safety and wellbeing, and providing staff with the support they need to provide the best possible care to service users, carers, and families. This daily meeting is a review of clinical and inpatient pressures with the general manager. Matrons can focus on the operational priorities for the day and highlight areas of concern. The peer support within the matron team is excellent and in line with Trust values, making sure matrons are ready for today and relevant for tomorrow.

10.00 am – CW visits the Unity centre and male acute ward. Violence and aggression incidents have taken place over the weekend, including assaults on staff. CW has one to one meetings with staff, including those assaulted. The Reducing Restrictive Practices and Interventions (RRPI) team are contacted, and bespoke support sessions are arranged for the ward later in the week.

12.00pm - CW gets lunch and goes back to the office for the Unity centre staffing meeting which takes place every Monday and Thursday to review resources across the unit. Where there are gaps in numbers, or skill mix, conversations are held with the staff bank, with a view to deploying staff across the wards, dependant on acuity and clinical need. CW states the Unity centre is aptly named as the ward teams, led by managers, all work together.

2.00pm – CW attends the safer discharge meeting which is built into the patient safety strategy and involves learning from incidents and working with community colleagues to improve outcomes from service user discharge. Current workstreams are Care Programme Approach (CPA) process, staying well plans, community referrals and in-reach, and leave and discharge follow up support.

3.00pm – CW goes to the Unity centre to meet the wife of a service user who has concerns regarding her husband's admission and care. CW assures her the team want a positive recovery for her husband and CW will address her concerns with the clinical team. CW feels the concerns relate to a breakdown in communications given the acuity over the weekend but acknowledges the wife doesn't want excuses, she wants to see improvement.

7.00 pm – CW has finished today's tasks and is ready for home. CW receives information there is a phone line fault that she now needs to deal with and realises her journey home may be delayed.

AM and other Board members thanked CW for her story.

TM reported the story reflects a typical day and summarises everything matrons are trying to achieve.

Carol Harris (CH) stated the Board could take assurance from CW's story that things discussed at Board are being checked operationally on a daily basis and leadership is in place seven days a week.

Dr. Subha Thiyagesh (ST) noted the challenging working environment and valued the insight into the role and queried the difference between TM's role and CW's role.

TM reported the lead matron role was identified to implement standardisation across the Trust following a CQC report. With an overview TM can influence culture and take the best elements

of practice from wards and standardise them across the Trust to the benefit of service users and carers.

RW thanked CW and TM for the story and asked about the impact of Covid-19 on the wards in relation to visiting and leave.

CW reported the impact has been significant for service users and as a matron she has supported the team to be adaptive around the regular changes in guidance. The team had to learn quickly, and CW noted that clear communication was key in a such a dynamic environment.

RW reinforced CW's and TM's values-based approach and summarised the Trust values. RW noted the matron roles are new. CW and TM are in these roles because they are the right people for the job.

RW gave context to the operational environment reporting in March 2021. There were over 350 incidents of violence and aggression against staff. 330 of those were in an inpatient unit and over 250 involved physical aggression and 24 incidents involved a weapon.

RW noted the tough work environment and the need for the Trust to support staff to help them continue to provide the level of service they do. RW thanked CW and TM for their hard work.

CW and TM left the meeting.

It was RESOLVED to NOTE the Service User/Staff Member/Carer Story and the comments made.

TB/21/37 Chair's remarks (agenda item 6)

AM asked the Board to note it was Charlotte Dyson's (CD) last Board meeting. AM praised CD's fantastic contribution to the Board as a Non-Executive Director and in her roles as chair of the Clinical Governance Clinical Safety (CGCS) Committee and as former Deputy Chair and Senior Independent Director.
CD has been a member of the Board for six years and will be very much missed. CD was key in transforming the Trust's linked charities and the branding of "EyUp!".
AM thanked CD for her commitment, enthusiasm, and energy during her time as a Non-Executive Director.

It was resolved to NOTE the Chair's remarks.

TB/21/38 Chief Executive's report (agenda item 7)

<u>Chief Executive's report</u>

- RW firstly added thanks to CD for her positive support and challenge during her time as a Non-Executive Director.
- RW asked for his report and attachments to be taken as read.
- Prevalence of Covid-19 continues to fall but West Yorkshire and South Yorkshire continue to have higher prevalence rates than other parts of the country.
- Public Health colleagues report there now appears to be a break in the link between prevalence and serious illness and death following the vaccination programme.
- The Government road map out of restrictions has four tests. Progress of the vaccination campaign, effectiveness of the vaccine, the capacity of the NHS to deal with Covid-19 related surges in pressure and Covid-19 variants of concern.
- In Europe the "Kent" variant is causing substantial pressure.

- In India the situation is very difficult. Public Health England describe the variant first identified in India as a current variant of interest. Travel to and from India is now restricted.
- This is a good example of why we can't become complacent about Covid-19.
- There is a national relief effort, but it is recognised that a number of members of staff and their families have contacts with India and those staff are being supported.
- RW noted the information about suicide in his report. Current evidence suggests there has not been a significant increase during the Covid-19 pandemic, but the Trust will remain vigilant with proactive prevention measures given the economic impact of the pandemic.
- There is a significant increase in children and young people needing help and support, and self-harm has increased.
- Child and Adolescent Mental Health Services (CAMHS) are linking with councils and schools around an emotional wellbeing offer and this is a Trust priority with our partners in our places and systems.
- Staff and services continue to perform well, , and the Trust continues to improve.
- The accreditation of the RRPI team is a good example of this, as well as the number of innovations staff are delivering.

A discussion around the staff survey results followed. RW noted the staff survey results are linked to the actions of workforce strategy, and these will be discussed later in today's board meeting.

A query was raised in relation to progress against the eight actions on inequalities and what progress is being made in the Trust to support people with learning disabilities (LD).

RW reported in each of the places our LD teams are supporting primary care and acute organisations in different ways. In Calderdale and Wakefield there is specific work around supporting health checks which is producing positive results. There has also been targeted support for vaccination clinics for people with a learning disability. Further work has taken place with acute teams and matrons to identify people with Very Important Person (VIP) passports and digitise this information so that records are ready if they need to go to hospital.

In Calderdale and Huddersfield, and Mid Yorkshire acute trusts, work has taken place to prioritise people with a learning disability on waiting lists.

Carol Harris (CH) reported in Barnsley the LD team, community health team and mental health teams have come together to look at how services can be maximised and work better together across the neighbourhoods and teams. Learning from Calderdale is being used to improve access for people on waiting lists with learning disabilities.

RW reported the Trust had conducted an assessment against the eight inequalities measures and for each place we are involved with we had to provide a map of what each place was doing for the eight measures. That assessment has come to the Executive Management Team (EMT) and there is also benchmarking work being progressed around data for ethnicity and other protected characteristics and access to Trust services.

TB reported the Equality and Inclusion Committee (EIC) is where the action plans are monitored. Current key focuses are the engagement toolkit and data collection and analysis. These will help us understand our local populations and issues in relation to access to services.

Salma Yasmeen (SY) reported substantial work is taking place looking at CAMHS waiting lists and access to services in deprived areas. Charities are conducting insight work in communities. This will be brought together with the data to help inform priority areas. We are looking to develop something that can be used by every service.

AM requested two actions to be allocated to the EIC:

What are we doing for people with learning disabilities outside of our specialist services including our workforce?

Action: Equality and Inclusion Committee

Monitor the eight urgent actions in relation to inequalities.

Action: Equality and Inclusion Committee

Erfana Mahmood (EM) noted from the section 106 agreement, money has been received from Barnsley council and asked how this could be used to benefit the Trust?

RW stated the agreement is specific about what the money can be used for by the council. There are provisions for green space and woodland around the Mount Vernon site, for example, before any development can begin. The money received by the Trust from the sale of Mount Vernon will be invested in Barnsley.

Alan Davis (AGD) confirmed the Mount Vernon sale was completed yesterday.

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

TB/21/39 Risk and Assurance (agenda item 8)
TB/21/39a Board Assurance Framework (BAF) strategic risks (agenda item 8.1)

Mark Brooks (MB) highlighted the following updates and changes:

- Controls and assurance have been updated as proposed.
- The inclusion of target dates has been increased.
- Workforce risk 4.1 has been changed to Amber as agreed at the last Board meeting.
- The front sheet highlights where most EMT discussion took place around the appropriateness of risk ratings:
- 1.1 – commissioning function and how this progress over the next 12 months.
- 1.4 – Digital solutions and digital inclusion.
- 3.1 – Future financial arrangements are uncertain beyond September 2021.
- 3.3 – Resources and the impact of the white paper.
- 4.1 – Clinical workforce is driving the Amber rating.
- 4.3 – Staff wellbeing measures are good, but we have greater ambition.

EM queried where bullying and harassment, in particular for BAME colleagues, was shown in the BAF?

MB reported it is covered in general terms under strategic risk 4.2 and is covered in more detail in the Organisational Risk Register (ORR).

A discussion followed in relation to Amber gradings being reflective of being off trajectory, but some Amber risks had numerous controls and assurance. The process for getting Amber risks back on trajectory was raised.

RW reported the BAF shows where we have concerns. For 4.1 we have controls and actions to recruit and retain enough staff and working in the right culture. If we believe despite this we cannot recruit and retain enough staff then we have to make a strategic decision about what we do, i.e. restriction of beds or services. If things are persistently amber strategic decisions need to be taken.

MB reported that national staff supply is not within our direct control. We have investment but there are concerns as to how we can fill all roles given local and national staffing numbers.

AGD noted there are clear links between the BAF and the workforce strategy. There is a national shortage of doctors, nurses, and allied health professionals. We need to look at the supply issue in a different way, considering international recruitment, new role development and staff retention.

Chris Jones (CJ) noted amber gradings represent the high-risk challenges. If risks cannot be managed how are they being mitigated, more discussion could take place around mitigation. The BAF informs the Board about risk, it doesn't mean we have to manage all risks to yellow, because this isn't always possible.

RW noted the relevance of the group reviewing the workplan for the Board. They should look at scheduling the right conversations based on what the BAF is highlighting as areas of risk.

Action: Board Workplan Group

The Board also needs to consider if the Workforce strategy is mitigating the strategic risks.

Action: Trust Board

It was RESOLVED to APPROVE the updates to the Board Assurance Framework as NOTED and ACTIONS for future discussion around strategic risk and mitigation.

TB/21/39b Corporate / Organisational Risk Register (ORR) (agenda item 8.2)

MB highlighted:

- New risks have been added regarding the Covid-19 vaccination programme
- A change in the NHS capital regime has added a risk recommended by the Finance, Investment and Performance (FIP) Committee
- A new risk in relation to clinical staff shortages
- A new risk if the 'great place to work' actions are not delivered
- Workforce committee is looking at merging the workforce risks
- Three risks are recommended for closure:
    - Decommissioning of services leading to redundancies
    - Tender activity
    - Provision of the right IT equipment for staff to perform their role
- The total level of risk is increasing, this is expected given we have added more risks.
- MB asked for Committee chairs to comment about their allocated risks.

Mike Ford (MF) reported he had nothing to add from Audit Committee and noted the summary page and heat map appears to be missing. (AL circulated during the meeting).

CD reported Covid-19 risks had been discussed at Clinical Governance Clinical Safety (CGCS) Committee including the risk regarding Child and Young Adult Mental Health Services (CAMHS).

KQ noted the Mental Health Act (MHA) Committee had no current allocated risks.

Sam Young (SYo) updated the Workforce and Remuneration Committee (WRC) had reviewed allocated risks and these were now more specific and detailed.

AM noted one equality risk was allocated to the Equality and Inclusion Committee (EIC). This has been discussed at the committee and is an area of focus.

CJ noted the capital risk has been added from Finance Investment and Performance (FIP) Committee to make sure the Trust can access sufficient capital for all its needs. The financial forecast is also uncertain due to only having interim financial planning arrangements and review of the risk has shown the relevant foresight is in place.

MB explained the capital allocation for 21/22 was in place and sufficient for our needs. The challenge may come if the Trust wants to conduct major capital investment in the future, as it will need to be prioritised by the Integrated Care System (ICS). Under previous circumstances if we had our own financial resources and/or access to borrowing, we could spend to that amount. Under the current capital regime, we need to spend within the ICSs capital envelope.

AM asked for clarity of what had changed in the risk description for 1157.
TB noted the Workforce Disability Equality Standard (WDES) has been added to the description. AM will pick up outside of the meeting. Changes need to be reflected in the risk report.

Action: Mark Brooks

In relation to risk 1368 KQ asked if care, education, and treatment reviews (CETRs) are recorded as control measures. KW reported in eight out of ten cases admission is prevented where a review is done. CH agreed to check with the team and update.

Action: Carol Harris

It was RESOLVED to NOTE the updates to the Organisational Risk Register with the comments made.

TB/21/39c Consultation on the System Oversight Framework and Trust Response (agenda item 8.3)

MB introduced the item and asked to take the paper as read and reported a response was required by 14th May 2021.

Comments from Board members to go to MB by the end of next week.

It was RESOLVED to AGREE to invite COMMENT on the proposed Trust response to the consultation outside of the meeting.

TB/21/40 Business developments and collaborative partnership working (agenda item 9)

TB/21/40a Integrated Care System developments – white paper update (agenda item 9.1)

SY highlighted the paper sets out the approach that both ICSs have taken to respond to the white paper. It is still going through parliamentary processes. The South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) recruitment process for a chair is underway.

RW added there are four ICSs in the North East, Yorkshire and Humber and each has been contributing on the thinking around ICSs and the future. A paper has been produced that sets out how the four ICSs and the region should work together. This will be published in the next few days.

EM asked about public engagement and was there to be one accountable officer?

RW confirmed in each ICS there will be one accountable officer. Where there are currently numerous Clinical Commissioning Groups these will transform into broader place-based

arrangements. A governance mechanism is needed where places can hold money and deliver against local place-based plans. Work is required in this area and is being developed by the ICSs.

SY confirmed public engagement was happening in all the Trust places in preparation for the next stage.

RW noted that, as a Foundation Trust with many members and governors, we are built on engagement and we need to use that to feed into the new arrangements. Both ICSs are very committed to this, even though it is not prominent in the white paper.

It was RESOLVED to NOTE the update on the local ICS approaches to respond to the White Paper.

TB/21/40a South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 9.2)

AGD asked to take the paper as read and highlighted:

- AGD noted there is a return to business as usual
- SY added the Mental Health Learning Disability and Autism (MHLDA) Alliance memorandum of understanding (MOU) is going through partner boards and is being supported.
- The Trust is establishing its role within partnership collaboratives in the South Yorkshire region.

RW noted from the Integrated Care Partnership Group in Barnsley work is looking at how provider collaboratives will work in places with a focus on community-based services.

It was RESOLVED to NOTE the SYB ICS update and NOTE the MHLDA Alliance and programme update.

TB/21/40b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 9.3)

SY asked for the paper to be taken as read, highlighting:

- Continued focus on a joined-up response to Covid-19.
- Movement towards planning, recovery and reset.
- Work on learning disabilities continues in each of our places.
- Work streams are strengthening clinical leadership across the system.
- Working with partners continues in preparation for the changes coming through the white paper.

Sean Rayner (SR) updated:

- The West Yorkshire adult secure lead provider collaborative is to review options with NHS England about what a “go live” for 1st July 2021 may look like.
- The team working on the Learning Disability Assessment and Treatment Unit (ATU) reconfiguration gave the final report for a “go live” date to the West Yorkshire Committees in Common. There is more work to do, but it is effectively now in a “go live” position.

A conversation followed querying the strength of partnerships in Kirklees and SY reported partnerships in each place are at different levels of maturity.

RW noted Jo Webster now has a formal role on Wakefield council, as an example of differences in maturity. He went on to note the role of the Trust may be different in each of our places.

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 developments in Calderdale, Wakefield, and Kirklees.

TB/21/40c Receipt of Partnership Board Minutes (agenda item 9.4)

AM asked for the minutes to be received and noted updates from partnership boards.

It was RESOLVED to RECEIVE the minutes of relevant partnership boards.

TB/21/41 Performance reports (agenda item 10)
TB/21/41a Integrated performance report (IPR) month 11 2020/21 (agenda item 10.1)

TB highlighted the following points:

Covid-19

- Significant Infection Prevention and Control (IPC) activity continues across the Trust, from a work-based perspective nothing has changed.
- Personal Protective Equipment (PPE) is in good supply.
- Fewer than 0.1% of results from staff lateral flow tests are positive.
- The vaccine roll-out has gone well, and further work is taking place around uptake from specific groups.
- The command structure of gold and silver now meets once a week. The Trust is ensuring the learning from the command structure is being absorbed into everyday work.

Quality

- There is concern around under-18 admissions to adult beds.
- The Medical Director (MD) and Director of Nursing (DON) regional call expressed the same concerns. It has also been referenced nationally by Amanda Pritchard, Chief Operating Officer of NHS England; and Chief Executive and Chief Operating Officer of NHS Improvement.
- Staffing pressures remain challenging.
- Incident levels remain within the usual parameters.
- Prone restraint continues to be a focus.
- The Reducing Restrictive Practice and Interventions (RRPI) team has achieved a strong accreditation from the British Institute of Learning Disabilities for their restraint reduction programme.
- Self-harm levels continue to be monitored.
- Safeguarding remains critical, maintaining attendance at local panels.
- The Care Quality Commission (CQC) action plan is being fully progressed.
- There is high demand and acuity in the system, and we need to maintain vigilance on early warning signs.
- The Serious Incident accreditation process has gone through the Royal College of Psychiatry on first submission which is a great achievement.

AM noted clinical supervision targets have now been met, which is positive.

A discussion followed about the potential of bladed articles getting onto wards. TB reported there is a clear policy about what can/cannot be brought onto wards. The challenge is where

people don't want to surrender things and the vigilance of staff. Search procedures have been recently reviewed, as have banned items.

CH reported there is a banned items list. People are more distressed, and wards are more acute. In the forensic unit a boss chair has been purchased, to detect concealed items. This is less intrusive than a physical search and has proved very successful. Detection wands are also being used. These will be rolled out in acute wards in due course.

CD noted the impact staffing is having on achieving clinical Care Programme Approaches (CPAs), which is an area of focus for the CQC action plan. This was discussed in Clinical Governance and Clinical Safety (CGCS) Committee

CJ felt that TB had articulated some emerging risks and noted they are Amber in the BAF, which shows we have highlighted the right things. CJ asked for assurance that quality of supervision was being maintained as well as quantity.

TB reported a key focus of the CQC improvement plan is the FIRM risk assessment process. In reference to supervision, the first part is making sure it's happening, the next is the quality. We now have an identified lead for this with audit and checks in place through clinical supervision.

RW commented that issues around inpatients' acuity and demand have been discussed at executive management team (EMT). This needs to be a priority within the priority programmes work. There is a request from the National team that Out of Area (OOA) beds are to be eliminated that may be hard to achieve in the short term.

RW noted the LD target is green when the three previous indicators are red and asked for clarity about the figures.

Action: Tim Breedon

NHSI national Indicators

MB reported there was nothing further to add from discussions already held. There were no comments or questions.

Locality

CH highlighted the following points:

Trust-wide CAMHS (child and adolescent mental health services)

- Waiting numbers for Autistic Spectrum Condition (ASC) and Attention Deficit and Hyperactivity Disorder (ADHD) diagnostic assessment in Calderdale have significantly increased.
- The CAMHS Tier 4 business case is under consideration by those CCGs who are looking at waiting list initiatives.
- In the last month there has been an increase in referrals into crisis pathways and eating disorder pathways.
- Eating disorders in CAMHS are seeing staffing pressures, options are being looked at to maximise capacity.
- Access to tier 4 CAMHS beds remains a challenge.

Barnsley General Community Services

- There is an operational risk in Urban House. It is a nurse-led service, but it has been difficult to recruit into the nurse prescriber role as it is defined, which presents an ongoing delivery pressure.
- Mobilisation work for the new BREATHE contract has now started.
- Improvements are being made in the integration of physical and mental health services in Barnsley.

Forensics

- Staffing levels remain challenging and are under constant review.
- Staff wellbeing remains a focus.
- There were noted improvements from the results of the staff survey.

Learning Disability (LD)

- Consultant psychiatry provision has been difficult recently. Contingency measures are in place, but this is not a long-term solution.
- The Quality Monitoring Visit report is now with the team and the outcome is being reviewed.

Trust-wide Inpatient Services

- Acuity remains high and there is a high demand for beds.
- Use of OOA beds is being kept to a minimum, although there has been an increase in numbers over the last month.
- Psychiatric Intensive Care Unit (PICU) beds are under pressure.
- The patient flow team is now fully recruited into a seven-day service.
- There are higher levels of occupancy and acuity on the wards.
- Difficulties have been compounded by staff absence.

Mental Health Community Services (all areas)

- Reducing OOA beds work takes place in the community to find alternatives to admission.
- There have been developments in the trauma-informed personality disorder pathway where the intensive treatment teams have improved gatekeeping.
- CPA review work continues. Performance across the west teams has now exceeded the target.
- There is increasing demand in Single Point of Access (SPA) teams.

CH noted the seclusion room problem still exists, but the level of damage has reduced. A group from estates and service have established a set of standards for seclusion. No recent incidents have resulted in a seclusion room not being available.

KQ asked for an update about the autism friendly environment work. CH updated that sound boards had been ordered and work was now ongoing to repair previous damage with the specialist that has been recruited into the unit.

Estates have been very quick in getting repairs completed and making the environment specific to the individual. Actions are in progress.

AGD noted the work is a partnership between estates and operations. AGD will visit the centre to check the report book. We have spent £0.5m on Horizon in last two years. We need a wholesale look at it, rather than the piecemeal approach that has been used. Everything we install meets the appropriate standards. The seclusion rooms reflect the standards, but they are not standing up to the task.

AM asked that the next estates report to Board includes an update on seclusion rooms and the autism friendly environment work programmes.

Action: Alan Davis

Priority Programmes, Communications, Involvement and Engagement

AM noted today's discussions around a new priority programme to look at acuity.

Action: Salma Yasmeen

SY noted the community transformation work funded by both ICSs is ongoing as part of priority programmes.

AM asked about progress on our sustainability work. AGD noted it was part of the 'great place to work' priority programme, and this work is progressing.

Finance

MB highlighted the following points:

- This has not been a typical financial or operational year.
- The Trust has received and spent more money than in the past.
- Initially there was a planned deficit of £2.1m.
- Partly as a result of national funding changes the Trust has produced a surplus of £4.6m, a £6.7m difference to the original projection at the start of the year.
- We have performed better than anticipated on OOA beds which has also contributed to the improved position.
- Additional income has been received from local commissioning sources and, national sources and policy or guidance from the centre was updated towards the end of the year. For example incremental annual leave accrual for up to five days per individual has been funded nationally.
- Non-NHS income that wasn't received as a result of Covid-19 has been compensated for and we received a contribution for the "Flowers" adjudication.
- Cumulatively, this means we have spent less than our income.
- Our cash balance is over £50m at the end of the year, up significantly on the previous year.
- The capital plan although lower than target has spent £5m.
- In March 2021, 14 days is the average time to pay invoices.

A discussion followed about transparency disclosures and a number of invoices from Dell.

MB noted the invoice amounts were likely to be in relation to delivery timescales but would double check and confirm the position to MF.

Action: Mark Brooks

RW gave thanks to MB and his team for all the work that has taken place throughout the year including switching financial systems in the year. It is testimony to the skills of the team. RW referenced the planned income and actual income profile in the paper being partly the reason for the shift in our financial position. If there is an opportunity for things to change, it should be that resources become available earlier in the year rather than notified later on. Board members noted this issue was apparent in previous years with the Provider Sustainability Funding at the year end.

Workforce

AGD highlighted:

- Vaccination clinics are now being reduced
- 83% of staff have had their first dose
- There remains a difference between different BAME groups' and white colleagues' uptake. Opportunities are being created for people to have access to first and second doses.
- An absence exercise has taken place across the region. We will need to reset some of the targets in the workforce strategy.

SYo queried if there is management of staff returning to work as infections fall.

AGD reported a risk assessment will be completed before staff return. The return to work must be safe. Before staff return to work there have to be conversations with individuals too. There

are mixed feelings amongst staff and managers. We know that agile working has been a strategy for the Trust for some time and how we will work in future, using lessons we have learned. We have a digitally enabled workforce.

RW asked that the workforce strategy looks at sickness levels and how we maintain the step change seen. What is it that CAMHS and Calderdale/Kirklees/Wakefield are doing to maintain these positive levels?

AGD noted we need the ability to make reasonable adjustments. Work is an important part of people's wellbeing.

SY noted the recovery and reset work is considering estate and the benefits it can bring. The reasons behind the low sickness levels need to be identified.

Action: Alan Davis

ST reported the Trust needs to have conversations with different groups. There may be anxiety about returning to work and a blended approach is required. Flexibility has improved sickness levels and the feeling that working from home is accepted.

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

TB/21/41b Safer staffing report (agenda item 10.2)

TB highlighted the following points:

- This is the routine six-monthly report that has been through CGCSC.
- Fill rates remain similar.
- An issue remains around skill mix dilution to maintain staff/patient ratios.
- The response to the pandemic has had a significant impact on staffing.
- Although the challenge has eased, we still have vacancy pressures.
- There is a need to understand how we are performing against identified need. The Trust is piloting "Safe-Care". This is a unique daily staffing software matching nursing staffing levels to patient acuity, in real time, allowing informed decision making on staffing levels.
- CGCSC identified the report included everything needed in the data but wasn't highlighting key points in the narrative.
- Visibility of key messages from staff working on the frontline is required, as heard in the Board story at the meeting today.
- There is to be a refocus of the safer staffing group, not just to the numbers but the impact of the numbers in front of them.

It was RESOLVED to NOTE the report and the assurance taken by the Clinical Governance & Clinical Safety Committee. In the future reports will cover lived experience of staff.

TB/21/41/c Guardian of safe working hours annual report on safe working hours: doctors in training (agenda item 10.3) (taken at 12:30pm)

Dr Richard Marriot (RM), the Guardian of safe working hours, highlighted the following points:

- The numbers of exception reports have stayed low.
- There has been an impact on the rota's from the pandemic.
- Gaps have been covered well in light of the challenge.
- RM and Professor Curran continue to meet trainees and receive feedback on work pressures.
- Trainees are happy with the rota's, hours and education delivered through MS Teams.

AGD reflected on the triangulation of the staff survey results and how the Trust ensures we are gaining the right information.

RM reported new induction trainees are encouraged to speak up about any concerns. The junior doctors' forum and discussions at other meetings appear to be providing a good level of feedback.

ST thanked RM for his work and being the independent person trainee doctors can go to. ST assured the Board that she is confident feedback is coming through and any concerns raised by trainee doctors are being addressed.

AM suggested a future Board story from a trainee Doctor.

Action: Andy Lister

IT was RESOLVED to RECEIVE the Guardian of Safe Working Hours' annual report on safe working hours: doctor in training and CONFIRM their assurance that the Trust has met its statutory duties.

TB/21/41d Serious incidents report Q3 (agenda item 10.4)

TB noted the report has been reviewed by CGCSC. The Committee considered:

- the low number of no-harm incidents in Kirklees
- Incidents in CAMHS
- Trends around green incidents

TB noted the full report needed to be circulated.

Action: Andy Lister

RW asked about triangulation with the safer staffing report and this report and is there a correlation.

TB noted one aspect was acuity and if this was impacting on people having the time to record incidents, and the second is the changes made in Datix (incident management system) around recording of green incidents. There is now an enhanced risk scoring matrix available. This asks people to look at the risk and the consequence and not just the severity. The correlation between incidents and staffing is being explored.

CD updated from CGCSC that the triangulation of the information is important, and this had been highlighted during quality monitoring visits.

It was RESOLVED to NOTE the comments of the Clinical Governance and Clinical Safety Committee on the quarterly report.

TB/21/42 Strategies and Policies (agenda item 11)
TB/21/42a Workforce Strategy (agenda item 11.1)

AGD introduced the item and highlighted the following points:

- The Strategy has been part of a large engagement process which started in 2019.
- Staff messages are key to this document.
- The Strategy needs to be responsive; the pandemic has shown that and needs to be a live document.
- The Equality Impact Assessment (EIA) will use the workforce equality report.
- We will be updating the measures and process as we go through the reset phase of the pandemic.

SYo noted the strategy has been through Workforce and Remuneration Committee (WRC) and discussion held about it being a good working live digital document.

CJ likes the way it's presented, and it reflects the feedback staff have given. Metrics are about survey results, should we have some aligned to quality improvement for service users. "More staff" is also about having the "right staff". "Zero approach to vacancies" could be a difficult message to uphold.

MF noted in the Trust objectives there is "healthy resilient and safe" workforce and this needs to flow through the strategy. In the staff survey there is reference to immediate managers, and should there be more focus on them in the strategy?

RW noted the strategy is a good piece of work and connects to the national strategy. RW welcomes the focus on measures of progress which need to be consistent and timely. The Board need to look at what are the highest priority issues we want to measure and how does this link to the numbers we have to provide for the workforce plan?

AGD noted acceptance of vacancies has become tolerated. If we can't recruit into positions, we need to look at the alternatives. The 'great place to work' programme is all about immediate managers. We are looking to put every immediate manager (500 staff) through a training programme in the next eighteen months.

The strategic workforce plans show the details of what we want to do and how we model this. Ultimately, we want a more flexible workforce with four dimensions, our substantive staff to work more flexibly, a more flexible workforce, smaller but more active bank and agency workforce.

AGD noted if the Trust wants to be outstanding, outstanding trusts excel in staff engagement, team working, immediate managers and health and wellbeing. This is our ambition. Our results from the staff survey are not far from outstanding trusts, we need to raise some profiles of our work and offers to make sure staff know what is available.

AM asked if the Board were happy to approve the strategy and can this be done without an EIA?

AGD noted it will be a comprehensive EIA and ready for WRC on 18th May 2021. RW asked that the final targets for the workforce strategy are tested against the EIA to make sure that any issues that arise are addressed in the actions that we are taking.

Action: Alan Davis

The Board approved the strategy in principle, the WRC should receive the EIA in May and then come back to Board for sign off.

It was RESOLVED to APPROVE the Workforce Strategy 2021–2024 in principle subject to the comments made and its development into a digital format.

TB/21/43 Governance Matters (agenda item 12)
TB/21/43a Draft Annual Governance Statement (agenda item 12.1)

MB highlighted:

- The statement has been through EMT, Audit Committee and RW for comments.
- The finished article needs to be ready for the May Board.
- Any comments to AL by the end of Thursday.

It was RESOLVED to REVIEW the draft Annual Governance Statement and COMMENT accordingly as requested.

TB/21/43b Going concern report for annual accounts (agenda item 12.2)

MB highlighted the following points:

- The requirements have been simplified
- The evidence required is limited this year

CJ queried if the change in status of CCGs affects our going concern declaration?

MB reported that these changes are not effective until April 2022, so not for the forthcoming year. He also expects existing contractual arrangements to transfer into a different commissioning body and as the funding comes from public finances, he does not believe this will impact on the going concern statement the Trust is required to make

It was RESOLVED to APPROVE the preparation of the 2020/21 annual accounts and financial statements on a going concern basis by adopting the following statement:

'After making enquires, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.'

TB/21/43c Committee Membership Changes (agenda item 12.3)

AM introduced the item and highlighted the following points:

- This report sets out the forthcoming committee membership changes that are to take place in May 2021 and August 2021, in advance of the Audit Committee report.
- Charlotte Dyson leaves the Board at the end of April 2021 and Natalie McMillan joins on 1st May 2021.
- TB is stepping down later in the year.
- SYo will not be seeking re-appointment at the end of July 2021.
- The paper recommends changes to Committee memberships at two stages, May 2021, and August 2021.
- From 1st May 2021 it is proposed that:
    - Natalie McMillan (NM) will assume chair of CGCSC, become a member of WRC and attend Finance, Investment and Performance (FIP) Committee as a supernumerary Non-executive director.
    - CH will replace SY as a member of the MHA Committee.
    - SY will assume lead director status for EIC.
- When SYo steps down at the end of July, it is proposed her replacement will become Chair of WRC and become a member of the Audit and MHA Committees. At this point NM will become a full member of FIP.
- AM noted a question had been raised around the new Director of Nursing and the heavy committee burden they would take on from TB.

It was RESOLVED for Trust Board to RECEIVE the attached proposals from the Chair as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through committees meeting the requirements of their Terms of Reference and APPROVE the proposed changes to the Membership for the:

- **Audit Committee;**

- **Mental Health Act Committee;**
- **Clinical Governance and Clinical Safety Committee;**
- **Workforce and Remuneration Committee;**
- **Equality and Inclusion Committee;**
- **Finance, Investment & Performance Committee.**

TB /21/43d Audit Committee Annual report 2020/21 including updated terms of reference for Trust Board Committees (agenda item 12.4)

MB introduced the item and highlighted the following points:

- All committees have conducted a thoughtful and thorough review of their effectiveness

MF reported he is impressed with everything the Committees have done in light of the year that has taken place. Evaluation surveys did not receive a full return, but all matters have been discussed at relevant Committees.

TB noted it is proposed that in future the EIC will have "involvement" in the title, so it will become the Equality, Inclusion, and Involvement Committee.

It was RESOLVED to RECEIVE the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:

- **committees meeting the requirements of their Terms of Reference;**
- **committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and**
- **committees can demonstrate added value to the organisation.**

- **APPROVE the update to the Terms of Reference for the:**
  - **Audit Committee;**
  - **Mental Health Act Committee;**
  - **Clinical Governance and Clinical Safety Committee;**
  - **Workforce and Remuneration Committee;**
  - **Equality and Inclusion Committee;**
  - **Finance, Investment & Performance Committee**

It was RESOLVED to APPROVE the change of title to Equality, Inclusion and Involvement Committee.

TB/21/43e Compliance with NHS provider licence conditions and code of governance self-certifications (agenda item 12.5)

MB introduced the item:

- MB reported this is a key component of the AGS and although it no longer needs to be submitted to the regulator it does need to be placed on the Trust website.
- This year the impact of the pandemic has been taken into account.

It was RESOLVED to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to compliance with the conditions of its Licence.

TB/21/43f Data Security and Protection Toolkit (DSPT) (agenda item 12.6)

MB introduced the item:

- This is an annual process.
- Appropriate controls and assurances are in place around data protection.
- The audit has been completed by the Trust internal auditor.
- This the first substantial assurance audit since MB has been with the Trust and asks the Board to recognise the work undertaken.

RW added his thanks and asked if it affected our risk in relation to cyber security. MB agreed to review the risk and take this into account.

Action: Mark Brooks

It was RESOLVED to APPROVE the Trust submits the final assessment of the DSPT of "standards exceeded".

TB/21/44 Assurance and receipt of minutes from Trust Board Committees (agenda item 13)

AM asked the Non-executive director chair of each Committee to provide an update:

Audit Committee (minutes 26th February 2021)
MF highlighted the following points:

- Overall the draft annual Head of Internal Audit Opinion is showing significant assurance.
- Data quality for commissioner reporting audit has received limited assurance, and this is being reviewed.

Clinical Governance Clinical Safety Committee (minutes 9th February 2021)
CD had nothing further to add from today's discussions.

Finance, Investment and Performance Committee (minutes 25th January 2021)
CJ highlighted:

- Received the final finance report for 2020/21.
- Received the national community services benchmarking data, some work to be conducted by the internal benchmarking group.
- A paper on provisional mental health investment standard and recovery funding.
- A performance report on perinatal services.
- The above performance report was used as template as to how to receive performance reports in the Committee in the future.
- Adult Secure Lead Provider update.

West Yorkshire Mental Health Services Collaborative Committees in Common (minutes from January 2021)
CJ highlighted:

- Agreed the Memorandum of Understanding.
- Discussion around learning disability challenges and service improvements.
- Detailed update on ATU transformation plan.
- A presentation on the mental health and wellbeing hub for NHS staff experiencing issues after Covid-19.
- Discussion in relation to investment in core team structure.

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

TB/21/45 Trust Board work programme (agenda item 14)

AM noted this is accepted in draft and a small working group has been extended to May 2021. Future iterations to include strategic board meetings.

Trust Board RESOLVED to RECEIVE the draft work programme.

TB/21/46 Date of next meeting (agenda item 15)

The next Trust Board meeting held in public will be held on 29 June 2021.

TB/21/47 Questions from the public (agenda item 16)

No questions were received.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 27 APRIL 2021 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 27 April 2021

Min reference	Action	Lead	Timescale	Progress
TB/21/34	Kate Quail (KQ) requested an amendment to the minutes. KQ asked for the wording in paragraph two of page twelve (Diligent) to state: "Kate Quail (KQ) reported she was on the IPR sub-group and questioned how the triangulation of information from a range of sources including service user and staff experience about risks worked, so that we understand the totality of risk by service". This will replace the wording: "Kate Quail (KQ) reported she was on the IPR sub-group and questioned how more detailed service performance information and issues were identified and highlighted.	Andy Lister	June 2021	Minutes amended as requested.
TB/21/35	Action TB/21/27 to be allocated to Sean Rayner for progression.	Andy Lister	June 2021	Amended as requested.
TB/21/38	E and I Committee to review what the Trust is doing for people with learning disabilities, including staff, outside of Trust specialist services.	Equality and Inclusion Committee	June 2021	TB to verbally update in the meeting.
TB/21/38	E and I Committee to monitor the eight urgent actions in relation to inequalities.	Equality and Inclusion Committee	June 2021	Completed. Will now be a standard agenda item.
TB/21/39a	RW noted the focus group for the workplan for the Board. They should look at scheduling the right conversations based on what the BAF is highlighting as areas of risks.	Board Workplan Focus Group	July 2021	

TB/21/39a	The Board needs to consider if the Workforce strategy is mitigating the strategic workforce risks.	Trust Board	August 2021	
TB/21/39b	AM queried how the wording had changed in relation to risk 1157. The ORR needs to show what has changed. AM to take outside of the meeting.	Mark Brooks	June 2021	AL has e-mailed AM the wording changes.
TB/21/39b	In relation to risk 1368 KQ asked if care, education, treatment reviews are recorded as control measures. KW reported in eight out of ten cases admission is prevented where a review is done. We don't mention it. CH agreed to check with the team and update.	Carol Harris	June 2021	This was discussed with the team: CETRs are part of the process for children with diagnoses autism and/or Learning disabilities. We working to embed a multi-agency / multi professionals meeting for all young people at the point of admission; sometimes there is no time to co-ordinate this before needs escalate. CETR added as a control for a small, defined group of children. Multi-disciplinary / professional meeting added as an action
TB/21/39b	Risk heatmap to be circulated to Board members	Andy Lister	April 2021	Heat map circulated during meeting
TB/21/41a	RW noted the learning disabilities indicator in the IPR for the 18-week target was showing as green when the last three indicators are red and not in line with the Trust target. TB to review and bring back to Board.	Tim Breedon	June 2021	Verbal update to be given in meeting
TB/21/41a	KQ raised autism friendly environments and it would useful to receive an update in relation to progress. AM asked for the next estates update to Board to include seclusion and autism friendly environments.	Alan Davis	July 2021	
TB/21/41a	AM noted today's discussions around a new priority programme to look at acuity.	Salma Yasmeen	August 2021	

TB/21/41a	A discussion followed about transparency disclosures and a number of invoices from Dell. MB noted the invoice amounts were likely to be in relation to delivery timescales but would double check and confirm the position to MF.	Mark Brooks	June 2021.	It is unclear why Dell raised this many invoices. One purchase order was raised and there were six deliveries. The actual number of devices received reconciled to the number invoiced.
TB/21/41a	SY noted the recovery and reset work is considering estate and the benefits it can bring. The reasons behind the low sickness levels need to be identified.	Alan Davis	July 2021	
TB/21/41c	Following the Guardian of Safe working hours item AM suggested the Board may wish to receive a Board story from a junior doctor	Andy Lister	June 2021	Noted for future Board story
TB21/41d	TB noted the Serious Incident report for Q3 20/21 had a front sheet only and the report itself was not present on Diligent	Andy Lister	May 2021	Q3 serious incident report circulated to Board members
TB/21/42a	Workforce Strategy EIA to be completed, go to WRC on 18th May 2021nand come back to Board for approval.	Alan Davis	July 2021	
TB/21/43f	MB to review the Trust cyber risk in light of the significant assurance audit for the Data Protection and Security toolkit.	Mark Brooks	July 2021	This remains under review. The general view is that the overall risk level has not changed significantly.

Actions from 30 March 2021

Min reference	Action	Lead	Timescale	Progress

TB/21/23a	MB noted the question of what level of depth Board members should know and understand compared to the role of operational teams and management. This could perhaps be discussed at the next time out strategy session. AM noted to explore further in a strategic Board the point at which information comes to Board from the operational domain.	Andy Lister	August 2021	
TB/21/23a	RW queried if the locality report needed more structure and to be monitored by FIP. CJ noted the difficulty is determining which performance elements to focus on. The question of how the Trust Board sees emerging risks, before they are a problem, and an escalation process, is the next challenge. CJ liked RW's idea of using what is going on in the Trust to highlight ideas for FIP to focus on and would take this to FIP for discussion.	FIP	June 2021	FIP has agreed to use insight provided by the Benchmarking Group, and other committees to identify emerging performance risks for more detailed review. These will be built into the work programme as appropriate.
TB/21/25a	CJ reported that the Trust needs to understand how it will offset residual carbon emissions.	Alan Davis	June 2021	The Trust is currently not using carbon offsetting to reduce admissions. This will only be considered as part of any final approach to be a carbon neutral organisation.
TB/21/25a	AM reported we needed a Board that drives this agenda and have a governance group in place within the Trust. AM stated she does not feel a further Board committee was a requirement. There is a need to review governance arrangements.	Alan Davis	July 2021	Still under review.
TB/21/25a	AM asked for an EIA to be completed for the Green Plan.	Alan Davis	June 2021	April Board update - EIA is being finalised and will be completed for by end of May 2021. To be returned to Board when complete. Verbal update required on sustainability strategy progress.

TB/21/25a	In response to AM's query about reusable PPE TB reported there had been talk in nursing forums, but this was in its infancy and no information had been received from the centre. TB will make an enquiry through the chief nursing officer.	Tim Breedon	June 2021	April Board update - No information regarding reusable PPE has been received – to raise further query through regional Medical Director/Director of Nursing network.
TB/21/25c	MB and SY to look at infographics to present simple headlines about the strategic objectives in relation to the digital strategy	Mark Brooks/Salma Yasmeen	October 2021	PC has met with PF to determine next steps. The strategy is now with the comms team to proof, design and finalise. An infographic based 'plan on a page' is in development. Once these are produced a dedicated intranet/website section will be developed in advance of a launch to staff through multiple communication channels. Agreed at April to Board to form part of six-month Digital Strategy update in October.
TB/21/25c	Look at work from the Digital Strategy EIA, in relation to implementation and the health and wellbeing of staff in relation to Digital resources.	Mark Brooks	October 2021	This work is being conducted currently and expected to be completed by the end of June. Agreed at April to Board to form part of six-month Digital Strategy update in October.
TB/21/27	RW noted the core psychology commissioning issue and suggested this was escalated through the partnership arrangements. This will be dealt with through the collaborative arrangements and may need to be picked up in the MHLDA Committee in Common at some point.	Sean Rayner	July 2021	April Board - Action allocated to Sean Rayner to progress. Discussions are in place and an update to follow.
TB/21/29	Small working group to be established to review the Trust Board workplan.	Angela Monaghan	May 2021	Superseded by action TB/21/39a

Actions from 26 January 2021

Min reference	Action	Lead	Timescale	Progress

TB/21/08b	RW noted as work through our systems changes, there should be more public health support and insight into the work the Trust does. Dr Andy Snell, consultant in public health in Barnsley, has demonstrated the benefits of having this expertise embedded in a trust, with access to data to effectively manage services. As we work through the changes in our systems, we need to know how we are going to access the public health intelligence and information needed to plan Trust services effectively.	Salma Yasmeen/ Mark Brooks	June 2021	

Actions from 29 September 2020

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	July 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. 18.01.21. Further guidance has been developed for members of the public and how to join public meetings. This will be circulated with papers each month. Board meetings are now promoted on social media on a monthly basis. 19.03.21. The discussion relating to the recording and publishing of Board meetings will continue after the response to Covid-19. 26.06.21 There has been a national consultation on recording of meetings through the company secretary network. The majority of Trusts are following our current practice of informing all the parties the meeting is being recorded to support the minutes and will be deleted once the minutes are approved. The minutes are therefore the formal legal record of the Board meeting. Some Co Secs have highlighted risks with recordings and the Freedom of information act. Recordings become disclosable and require editing dependant on the request which is a complex and time consuming process, whereas minute extracts can be provided easily. It is recommended we continue with current practice at this time.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 7

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 are nearing the end of the first quarter of 2021/22. We have yet to receive confirmation of our financial planning and service requirements for the second half of this financial year, outside of the Mental Health Investment Standard and associated targets. COVID restrictions have eased but the roadmap set out by the Government has been delayed due to the Delta variant and its potential impact. During this uncertain period, we continue to operate in line with our strategic and operational priorities and the context within which we operate. This report updates The Brief attached at **[ANNEX 1]** which itself outlines priorities and actions for all Trust staff. The Brief provides continuity of communications alongside The View, the weekly Coronavirus update and the virtual Chief Executive Huddle open to all staff. Since publication of The Brief, we have seen: • **A delay in the Government's easing of restrictions.** This is due to the Delta variant which has become prevalent in England. This variant is more transmissible and more likely to evade the vaccines after a single dose. Therefore, the Government's fourth test for easing restrictions has not been passed. • **A national campaign delivered locally to ensure that people come forward for their second dose of vaccine in light of the Delta variant.** In addition, all adults in England are now able to access the vaccine and second doses have been brought forward to eight weeks rather than twelve weeks. We continue to promote the importance of vaccination to our staff, service users and families. • **The Government has restated its commitment to bring forward plans on the reform of social care by the end of the year.** This will require support from the Treasury and must address capacity, finance and affordability questions.

	• **Health inequalities have continued to be prioritised** by our systems and by the Trust. I was encouraged by the number of sessions and conversations at the NHS Confederation Conference 2021 which were dedicated to issues like race equity and tackling inequality. • **The Trust submitted its service, workforce and financial plan for the first half of the year.** This was discussed at the last Trust Board meeting and focusses on our contribution to the recovery of services and the addressing of backlogs. For example, our community services in Barnsley are helping the system deliver better access to care as part of the NHS Innovation Accelerator (NIA) Programme. This sees more money and resources put into services across the Borough. • **The CQC launched its strategy for the future.** This is based on lighter touch regulation of organisations and an approach to quality based on data and intelligence. A briefing on the strategy is attached from NHS Providers at **[ANNEX 2].** • **The annual learning from deaths of people with a learning disability report (LeDeR) was published.** This showed substantial numbers of avoidable deaths nationally for people with a learning disability, and persistent problems around do not resuscitate orders and access to care. Work on people with a learning disability and/or autism is being progressed in our Integrated Care Systems (ICS'), and we are not seeing the repeat of national patterns on additional deaths. There is also some positive work across the West Yorkshire and Harrogate (WY&H) ICS being shared, such as vaccine clinics, improved health checks and priority waiting lists, informing a wider strategy. A briefing from NHS Providers on the LeDeR report is attached at **[ANNEX 3]**. • **The Government published its latest guidance on the creation of ICS' in advance of its Bill being laid before Parliament.** This guidance is very much in line with our expectations and we have been involved in its design and production. It requires the recruitment of a chair and chief executive for the statutory body by the end of September 2021. A briefing from NHS Providers on the guidance is attached at **[ANNEX 4]**. • **Amanda Pritchard, Chief Operating Officer for NHS England & NHS Improvement visited WY&H ICS** to look at the work we are doing on integration. We showcased our collaboration in places and across the system. • **Services remain under pressure in the Trust and more broadly.** We are seeing for example, record attendances at Accident & Emergency departments, record calls to the Ambulance Services requiring support for people with mental ill health, and significant pressure on our beds for adults and children. During this period it is more important than ever to support the wellbeing of staff. All of our wellbeing offers remain in place supplemented by the mental health hubs in our ICS' and national helplines. Staff sickness remains relatively low for the Trust.

	• **It was good to see Professor Marios Adamou recognised in the Queen's Birthday Honours 2021** as well as our partners in the Kirkwood Hospice. This is my last Chief Executive's Report until I go full time into my ICS role. This will be an interim measure pending final recruitment processes, for which I will need to apply. I wrote to staff earlier this month with my personal reflections on the last five years here at the Trust, this is attached for information at **[ANNEX 5]**. It has been a genuine privilege to be the chief executive of this Trust particularly during the pandemic. I would like to thank Board members for their enduring support over the last five years and look forward to continuing to work with them in my ICS role. Mark Brooks will be interim chief executive from 5 July 2021.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

27 May 2021

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

With **all of us** in mind.

Our mission and values

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

Our Trustwide perinatal mental health team celebrated the theme of nature for Mental Health Awareness Week by going for a socially distanced walk together and taking to people while they were out about their service offer.

With **all of us** in mind.

Our priority areas 2021/2022

NHS
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NHS Foundation Trust

Understanding equality, and addressing inequality through inclusive involvement

Improve health

- Play a full role in our Integrated Care Systems and associated places to contribute to outcomes in their 5 year plans
- Deliver improved integrated mental health community services with our partners in each of our places
- Deliver the changes required to be a high-quality lead provider of forensic services
- Continually improve and further integrate general community services in Barnsley
- 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 and support, locking in innovation
- Continually improve services for people who are acutely mentally unwell and improve the working environment for staff on our wards
- Transform our mental health wards for older people

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

#allofusimprove and be outstanding

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

With **all of us** in mind.

The national, regional and local context

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Rates of Covid infection are falling across England but are rising in some areas. Kirklees is now subject to enhanced guidance because of a rising infection rate. We need to keep up with the measures that have helped us to protect those around us and slowly ease lockdown restrictions.

The government's February white paper Integration and innovation: working together to improve health and social care for all set out a range of proposals on collaboration between the NHS and social care. The initial proposal is for the ICS to be comprised of an ICS NHS Body, which will subsume clinical commissioning group functions, and the ICS Health and Care Partnership, which will bring together wider partners to addresses the health, social care and public health needs of the system. We are a part of discussions nationally and in our ICS' on how this is being developed.

Join us for a panel discussion and Q&A on creativity and health in Calderdale, taking place on 16 June at 1pm on MS Teams.

We now have 2 metro mayors in our areas, with Tracy Brabin being elected West Yorkshire Mayor earlier this month. She joins Dan Jarvis who is the elected mayor for South Yorkshire.

West Yorkshire and Harrogate ICS is setting up a new citizens' panel to help shape communications around restoring planned care services. Details on how to get involved can be found on the intranet.

We are in the process of submitting a tender to continue running Yorkshire Smokefree services in Wakefield.

Coronavirus updates

NHS
South West Yorkshire Partnership
NHS Foundation Trust

As of 24 May there were **24** members of staff absent or working from home due to coronavirus, a significant reduction on where we were earlier in the year.

A **new variant** of the coronavirus has emerged, which are more easily transmittable. Originally discovered in India it is now being seen in areas across the UK. **Kirklees is now subject to enhanced guidance because of the rising infection rate there.** Details are on the intranet. The vaccine is so far effective against new variants.

Most of our staff have now had their first **coronavirus vaccine**. If you have make sure you have your second, as this is the best way to achieve maximum protection. If you haven't yet had your first dose you can still book to have it through the national booking system. Take a look at the intranet for more details.

Coronavirus (COVID-19) staff vaccinations began on 12 January 2021 at the Trust. Read how we used data and insight to provide tailored support and communications to staff, to help listen to any concerns or feedback and remove barriers.

Many people are experiencing **long-COVID**. This is where people who have had the virus show long term symptoms. This can include fatigue, brain fogs, generalized pain, high temperature and psychological problems. Our occupational health team has set up a pathway to help staff suffering with long-COVID. Details can be found on the intranet.

With **all of us** in mind.

Improving Health
Our performance in April

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **2** suicides for patients with an open referral
- **57%** of people completing IAPT treatment and moving into recovery
- **15.8%** of people accessing IAPT are from a BAME community
- **96.8%** of service users with a CPA followed by within 7 days of discharge
- **93%** of inpatients have been screened using the cardio metabolic assessment and treatment tool, **51%** have been screened in our early intervention services

Barnsley's adult learning disabilities community health team will be moving from the Keresforth Centre to Mapplewell Health Centre on 5 July 2021. The service will be writing to patients about the move.

The service's telephone numbers stay the same.

A new **suicide prevention** page has been set up on the intranet summarising the support that is available for staff involved in serious incidents. Remember there is support available for #allofus.

On 7 May our lead peer support development coordinator, **Debs Teale**, spoke at an international World Health Organisation (WHO) webinar on how art and creativity can help people look after their health and wellbeing, and how health organisations can support social prescribing.

With **all of us** in mind.

Improving Care
Our performance in April

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **84** inappropriate out of area bed days
- **3** people under 18 admitted onto adult inpatient wards
- **93.8%** waiting list referral to assessment within 4 hours
- **95.5%** waiting list referral to assessment within 2 weeks
- **92.5%** waiting list assessment to treatment within 6 weeks
- **380** average contacts per day in mental health services
- **592** average contacts per day in general community services
- **155** average contacts per day in community learning disability services

95% of respondents in the friends and family test rated our general community services either good or very good; **81% in** our mental health services; and **65.9%** would recommend our CAMHS service.

Darryl Thompson has been appointed as our new director of nursing, quality, and professions replacing Tim Breedon when he retires. Darryl is current deputy director of nursing.

The Trust is carrying out a survey to find out what people who use our community mental health services think about their care. This is part of a national programme with the CQC to improve quality of care and service users' experiences. Service users will receive questionnaires direct.

With **all of us** in mind.

Improving Care
Our performance in April

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In April we had:

- 1,004 incidents – 683 rated green (no/low harm)
- 312 rated yellow or amber, 394 in March
- 9 rated as red, 12 in March
- 32% of incidents are recorded as either red, amber or yellow. Down from 35% in March.
- We had **6** serious harm incidents recorded, including 5 category 4 pressure ulcers, 1 slip, trip or fall; and there were **8** deaths awaiting confirmation of cause.

We had **157** restraint interventions in March, down from 179 in March. **93.7%** of prone restraints were of 3 minutes or less.

There were **7 confidentiality breaches** in April, down from 13 in March. The Trust has a duty that any information we hold is safe. Everyone has a part to play.

89.3% of people dies in a place of their choosing.

We had **50** falls in April, up from 40 last month. All falls are reviewed to identify measures required to prevent reoccurrence.

DTOC (delayed transfer of care) was **1.2%** in April.

CHECK-IN.
Looking after each other to prevent staff suicide

With **all of us** in mind.

Improving resources
Our finances in April

NHS
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NHS Foundation Trust

Performance Indicator		Year to Date
1	Surplus / Deficit	£0.6m
2	Agency Spend	£0.6m
3	Cash	£60.3m
5	Capital	£0.1m
6	Better Payment Practice Code	98%

In April a surplus of £0.6m has been reported which is favourable to our plan. The forecast position will be assessed by the end of the first quarter.

Agency spend remains at a consistent level. The most notable reasons continue to be for medical staffing covering vacancies, and in unregistered nursing to support both backfill of vacancies and safer staffing requirements.

We have experienced an increase in out of area bed costs in April as demand has increased.

Cash in the bank continues to be positive although this is forecast to reduce in year due to the higher level of planned capital investment.

The capital programme for 2021-2022 has been agreed as £9.6m. Of this £2.6m is on major schemes, £2.4m on IM&T and £4.6m on Estates (focusing on health and safety).

98% of invoices have been paid within 30 days. On average non-NHS invoices have been paid within 11 days from receipt.

A great place to work
Our performance in April

#allofus
our wellbeing at work

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **4%** sickness rate
- **2.6%** of absences are a result of stress, anxiety and MSK
- **15.6%** staff turnover

May 17 was **International Day Against Homophobia, Transphobia and Biphobia (IDAHO).** Staff across the Trust held discussions in team meetings about what we can all do to support each other and tackle discrimination. Staff also took to social media to share their stories and pledges.
June is Pride Month. Keep an eye on the Headlines for more information.

EyUp, our Trust charity, is offering staff **'Bee You'** journals which can help you support your health and wellbeing. This is being funded by NHS Charities Together funding and follows their successful roll out to CAMHS service users.

Our staff support group on **menopause** meets for the first time on 7 June. More information is available on the intranet. 1 to 1 support is also available.

Our staff networks came together virtually on 12 April to celebrate '**Staff Networks Day**'. All our staff networks were involved, and attendees made pledges on how to be better

With **all of us** in mind.

Remember there is health and wellbeing support available for **#allofus**.

Improvement and innovation

#allofusimprove and be outstanding

NHS South West Yorkshire Partnership NHS Foundation Trust

We use established QI (quality improvement) approaches for our improvement work.

The Wakefield Research Team has been nominated as 'Clinical Researcher of the Year' in the PharmaTimes awards. The partnership, which includes us, Mid Yorks, Spectrum, and Wakefield Council is nominated for the COVID antibody study.

Our services often use gardening and outdoor activity to help promote wellbeing with our service users. Our Beamshaw ward in Barnsley has built window boxes and in Fieldhead our acute wards have worked with Incredibly Edible to set up allotments so that patients can grow fruit and vegetables for people in need.

Emma Robinson, quality and governance lead, has been awarded a Chief Superintendent's Commendation for her work on the liaison and diversion service in Barnsley. She received the award for her "drive, commitment and enthusiasm" and for supporting the police to better understand mental health issues.

Yorkshire Smokefree has been asked to present two posters at the national stop smoking conference. One is for the digital use of the e-voucher for medication and one for the YSF marketing and media.

Remember to use the I-Hub to share you learning and ideas for improvement.

i-hub
Share, innovate, collaborate and improve

Managing risk

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We continually monitor risk through our Operational Risk Register. This assesses clinical, commercial, compliance, financial and strategic risks and identifies mitigations on how we can reduce and remove risk across the Trust.

The following are the major risks added to the register in April, and what is planned to mitigate them:

- Policies and procedures do not keep pace with COVID-19 vaccination requirements, which could lead to gaps in practice that result in an adverse impact on staff and patient safety. **This is currently being looked at by our clinical safety and governance groups. Any changes will be communicated out.**
- Insufficient numbers of staff receive the Covid-19 vaccination, including those identified as more at risk, leading to an increased risk of infection. **We are supporting all of our staff to ensure they have access to a vaccine and engaging through individualised approaches to support informed decision making. We are also updating the risk assessments to include the impact of the vaccine**
- The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans in any one year, impacting on ability to meet our strategic objectives and priorities. **We are looking at our existing strategies to see how they might be affected and are working with our ICS partners on capital priorities.**

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Covid-19 pressures are real and still with us. We cannot be complacent.

Safety comes first, always. New variants mean it is still important to maintain safety measures.

Always follow the rules for wherever you are, including wearing appropriate PPE.

Remember your second dose appointment, there is still time for a first jab too and support if you need talk

Be extra careful when handling other people's information and data. Treat it like you would your own.

Take a look at the intranet and familiarise yourself with the wellbeing and suicide prevention support available.

Apply for an EyUp 'Bee You' journal to help you with your wellbeing.

Your health and wellbeing is our priority – use the support when you need it.

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

8 January 2021

on the day BRIEFING

NHS Providers

Launch of a consultation on CQC's strategy for 2021 and beyond

Introduction

The Care Quality Commission (CQC) is approaching the completion of its 2016-2021 strategy, and has today launched their consultation for their strategy for 2021 and beyond. In the document, CQC sets out how it plans to develop its approach in line with a changing health and care landscape taking into account the context and learning from COVID-19, the development of system working and greater use of digital technologies. CQC has identified a need to transform and ensure its regulatory model is relevant and fit for purpose in an evolving system.

This briefing summarises the main points set out in the strategy document and NHS Providers view. We would greatly appreciate any feedback you may have to feed into our response to this consultation, and we would also encourage trusts to submit their own responses to the consultation. Please send any comments to Leanora Volpe, policy advisor, at Leanora.volpe@nhsproviders.org.

Key points

- The strategy identifies four key areas of focus, which set out how CQC plans to change its approach to regulation. A common thread runs throughout of reviewing health and care systems and how they are working together to reduce health inequalities.
- The strategy describes an intention to take a more dynamic approach to regulation, moving away from relying on a set schedule of inspections to a more flexible approach using all regulatory methods, tools and techniques to assess quality continuously. Local teams will have a more regular view of the services they manage and ratings will be updated more regularly.
- There will be an increased focus on people's experience of care, with a stronger emphasis on gathering the public's feedback in accessible ways, and using that feedback as part of CQC's overall insight into quality of care, and as part of the rating and published information about services that CQC holds.

- CQC will provide a clearer definition of what 'good' and 'outstanding' care looks like, based on what people say matters to them, which is accessible to everybody and underpins CQC's assessments of services.
- CQC will work with providers and other regulators to coordinate data collections, reduce duplication and workload and only ask for information they cannot get elsewhere. They will explore how to improve digital interfaces with services to make it easier for providers to submit data.
- CQC describe a series of changes to support providers to develop strong safety cultures where risks are not overlooked and staff can report concerns openly.
- As well as assessing individual services, CQC will hold local care systems to account for the quality of care in their area, and call out issues in services and systems as well as highlighting good practice. As part of this CQC will consider it unacceptable for providers not to collaborate as part of the system.

Four key areas of focus

The strategy identifies four key areas of focus, which set out how CQC plans to change its approach to regulation. Throughout the four themes, a common thread focuses on their ambition to understand how health and care systems are working together to reduce inequalities.

1. People and communities

The strategy describes an ambition to regulate according to how people experience services, with a closer focus on people's experience and outcomes of care. CQC set out an intention to change how they encourage and enable people to share their experiences of care, and transform how they use that feedback to build trust with the public and motivate people to share their experiences. CQC identifies a number of key actions to meet this ambition:

- They identify a need to improve their capacity and capability to get the most out of feedback, by identifying more and better ways of gathering experiences, and changing the way they record feedback so it can be used to quickly identify changes in quality of care.
- The draft strategy stated that it would not be possible to achieve a rating of good or outstanding without evidence of best practice in encouraging and enabling people to speak up, and acting upon it. This has been amended to a commitment to improve the way CQC assesses how services encourage and enable people to speak up and how they act on it – however the strategy states that it will not be acceptable for providers not to be doing this.
- Providing a clearer definition of what good and outstanding care looks like, based on what people say matters to them, which is accessible to everybody and underpins CQC's assessments of

services, and these definitions will be easy to understand and access. They will change the outputs they produce and how information is provided so that it is more relevant, up to date and meaningful for people using services.

2. Smarter regulation

The strategy describes an intention to take a more dynamic approach to regulating, including moving away from periodic inspections of services, and instead harnessing information from multiple sources on a more continuous basis to assess quality and update ratings. CQC set out an ambition to make it easier for services to work with them through open, ongoing and constructive relationships based on trust and a common drive to improve care. Key changes include:

- While acknowledging that site visits are a vital part of performance assessments and essential in some settings to observe the care people receive, CQC will aim to take a more dynamic approach to regulation, moving away from relying on a set schedule of inspections to a more flexible approach using all regulatory methods, tools and techniques to assess quality continuously.
- Continuing to use inspections when appropriate, in response to risk, when specific information is needed, to observe care, and as part of checks on the reliability of their view of quality.
- They will use the best information they can get to keep ratings and information about quality up to date, rather than relying on the outcome of periodic all-inclusive inspections. This includes a better understanding of people's feedback and experiences, coupled with a combination of targeted inspections, national and local data from other organisations, insight from their relationships with providers and partners, and providers' own self-assurance and accreditation.
- The strategy describes how a combination of IT systems that can handle large amounts of data, artificial intelligence and innovative data analysis methods will enable CQC to be alert and ready to act quickly in a targeted way where needed.

3. Safety through learning

The new strategy sets out a series of changes to drive providers to see safety as a top priority, with stronger safety cultures where risks are not "overlooked, ignored or hidden", and staff can report concerns openly with confidence that they won't be blamed. CQC want to see this approach reflected with leaders, staff and people using services involved. The strategy acknowledges that there is no national agreement on what we mean by safety in different sectors and services, and sets an intention to work with others to agree a definition and language for safe care, to create a better understanding of risk across health and care to help minimise harm. Key changes include:

- Assessments of safety will have a sharper focus on checking for open and honest cultures, with learning and improvement at their core.
- Looking for processes to show that leaders and staff are committed to involving people in their own safety throughout their health and care journey, and checking that people have the information they need to help them be equal partners in their care and play a part in their own safety.
- Increasing their safety expertise and expecting services to do the same, using training and insight to ensure staff are familiar with the most up-to-date safety concepts, and how system design can influence safety practice. They will challenge and highlight provider and system failures, and support services to learn and improve.
- Seeking to understand where there is a lack of support and expertise for safety, and work with others to develop solutions to ensure all services have support and leadership during difficult times and the right tools to provide safe care. They will use insight and independent voice to promote a conversation about safety across the health and care sector.

4. Accelerating improvement

In this theme CQC sets out how it intends to ensure equal and consistent access to improvement support for all health and social care services, through the establishment of an improvement alliance with key partners from across all sectors. This will enable access to shared learning, information, advice and support, empowering services to help themselves while retaining their own core regulatory role. Key changes include:

- Establishing and facilitating national sector-wide improvement coalitions with a broad spectrum of partners within health and care, including those representing people who use services, which would work collaboratively to improve the availability of support for improvement.
- Developing collaborative relationships with providers to help them find their own route to improvement, pointing them to sources of guidance, best practice and other organisations, rather than 'telling them what to do', enabling CQC to support services without compromising their core regulatory role.
- Being proactive in understanding changes on the horizon and working with health and care services to develop ways of regulating innovations and new technology effectively, including mitigating risks of technology creating or exacerbating inequalities in care.

Assessing systems

CQC has set out an ambition to adapt its approach in the context of accelerated system working, and to use its influence to look at how different parts of the health and care system work together to provide joined up care, and tackle inequalities.

The draft strategy in September 2020 described many actions as set out above which apply to both individual services and to local systems, signalling an intention to explore numerous metrics and indicators at both provider and at the system level. The final strategy reflects a number of changes, and CQC will expand their definition of what they consider to be a provider of care and what it means to carry on a regulated activity so that they can register all parts of an organisation that are responsible for directing or controlling care, so that they can be held accountable.

The strategy also describes how they will seek to ensure services in local areas are working together to improve outcomes:

- As well as assessing individual services, CQC will look at how services work with each other and in partnership with communities, to make improvements, including how effectively they involve people in designing and improving services, how they embed equality, diversity and inclusion, and corporate social responsibility in everything they do to benefit local health and wellbeing, society, the economy and the environment.
- CQC will hold local care systems to account for the quality of care in their area, and call out issues in services and systems as well as highlighting good practice. Likewise, CQC will consider it 'unacceptable for providers not to work as part of the system.'
- As part of their approach to regulating services, they will look at how they work with other services in the system, and with local people and communities, as part of their improvement.

NHS Providers view

We welcome the development of new strategy for CQC and the opportunity to engage with CQC's ambitious proposals, however this consultation does fall at a time of unprecedented pressure for trusts which may impact on their ability to engage at this time.

That said, we fully support CQC's intentions to take a more proportionate and risk-based approach to regulation, and to minimise burden where possible, supporting trusts to drive their own improvement. Trusts will also welcome the proposed move towards a more flexible, 'real-time' approach, based on developing constructive relationships with their local CQC teams, and less reliance on resource

intensive, 'set piece' inspections, although there will be a need to understand what fewer inspections means for those trusts keen to improve their ratings or to exit special measures for example.

Trust leaders will also welcome CQC's intention to develop a regulatory model which is more responsive to how individual organisations operate within the context of system working. There seems to us to be an important opportunity for better alignment of a new regulatory model between CQC and NHS England and NHS Improvement (NHSE/I) as they similarly seek to develop their approach to system oversight to a similar timeframe for roll out from April.

These proposals suggest the potential for an important evolution to CQC's approach. We look forward to working with CQC to understand what these changes to the overall model of inspections, insight and ratings will means for trusts' relationship with the regulator, and welcome the opportunity to respond to the consultation.

22 May 2019

on the day BRIEFING

NHS Providers

Third annual Learning Disability Mortality Review (LeDeR) report and NHS England and NHS Improvement LeDeR: Action from Learning report

Introduction and summary

The University of Bristol has published the third annual Learning Disability Mortality Review (LeDeR) report this week, which presents information about the deaths of people with learning disabilities and puts forward recommendations for action at a national level. Separately, NHS England and NHS Improvement have published LeDeR: Action from Learning, which provides an overview of actions taken in response to recommendations made in the second annual LeDeR report and action going forwards. This briefing summarises key points from each report, but for a comprehensive overview of findings and conclusions we encourage providers to read both in full.

Key points:

- The third annual Learning Disability Mortality Review (LeDeR) report highlights a number of concerns about the deaths of people with learning disabilities. These include system level issues, staff training, care coordination and communication, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders, and recognising signs of deterioration.
- The report makes twelve recommendations at a national level that cover: availability of data; identification of people with learning disabilities; listening to families; priority programmes of work needed; service and care coordination; transition from children's to adults' services'; and addressing bias.
- The report also states there is much that can and should be done at local level to reflect on the learning coming from the reviews of deaths, and to translate that into actions for improvement.
- NHS England and NHS Improvement's LeDeR: Action from Learning report states that CCGs, working with their local authority and NHS partners, have made significant progress towards completing LeDeR reviews in a timely way but there is still a long way to go.
- The national bodies have committed to invest an additional £5 million to address the backlog of unreviewed cases and increase the pace with which reviews are allocated and completed. Data on CCGs' progress of completing reviews will also be published on their website moving forward.
- They have also committed to national action to tackle the major conditions that cause death among people with a learning disability based on lessons learned from reviews.
- In 2019/20 the University of Bristol will be reporting more regularly about themed learning, and the learning into action collaborative will continue to co-ordinate national responses to the learning emerging from the LeDeR programme.

Learning Disability Mortality Review (LeDeR) annual report 2018

Deaths notified to the LeDeR programme

- 4,302 'in scope' deaths have been notified to the programme from 1July 2016 to 31 December 2018. In 2018, this was approximately 86% of the estimated number of deaths of people with learning disabilities in England each year.
- By 31st December 2018, the review process had been completed for a quarter (25%) of these deaths. One in 10 included a multi-agency review.
- Reviews were in progress for a third (37%) of the notified deaths by the end of December 2018. However, 38% of the deaths were still waiting to be allocated to a reviewer. The programme said this indicated continuing and significant problems with the timeliness with which reviews take place.
- The proportion of deaths notified from people from Black, Asian and Minority Ethnic (BAME) groups was lower, at 10%, than that from the population in England as a whole (14%). However, children and young people from BAME groups were overrepresented in deaths of people with learning disabilities.
- A quarter of people from BAME groups had profound and multiple learning disabilities, twice the proportion (11%) of white British ethnicity. Almost all also had at least one long term health condition.

The deaths of people with learning disabilities

- The median age at death for people with learning disabilities who died from 1 April 2017 to 31 December 2018 was 59 years, compared with 58 years in the 2016/17 annual report.
- The updated data suggests a disparity in the age at death for people with learning disabilities and the general population to be 23 years for males and 27 years for females, compared with 23 years for males and 29 years for females in the 2016/17 annual report.
- There was a rise in deaths through autumn and early winter.
- The proportion of people dying in hospital was 62% compared to 64% in the 2016/17 annual report; in the general population it is 46%.
- Deaths were reported to a coroner less frequently (31%) than people in the general population (43%). Once reported, a post-mortem or inquest was more likely for people with learning disabilities.
- Reviewers felt that the majority (79%) of DNACPR orders were appropriate, and correctly completed and followed. However, 19 reviews reported that the term 'learning disabilities' or 'Down's syndrome' was given as the rationale for the DNACPR order.
- A fifth of adults with learning disabilities were usually prescribed antipsychotic medication at the time of their death. Of these, 20 people were taking two different types, six were taking three different types, and one person was taking four different types of antipsychotic medication.
- The programme's data reinforces national and international concerns about the accuracy of the coding of the underlying causes of death in people with learning disabilities.
- A third (33%) of reviews reported one or more examples of best practice. These were frequently in relation to: strong, effective inter-agency working; person-centred care; and end-of-life care. Many involved the provision of 'reasonable adjustments'.

Indicators of the quality of care provided

- One in ten reviews noted that concerns had been raised about the person's death. These were commonly in relation to delays in diagnosing and treating illness, and the quality of health and social care received by the person.
- Delays in the person's care or treatment that adversely affected their health were reported in 12% of reviews. The delays were of various types including: delays in diagnosing and treating illness, delayed discharge from hospital, and delayed recognition of approaching end-of-life.
- Problems with organisational systems and processes were reported in 13% of reviews. The problems were wide-ranging and included: the coordination of care; information sharing; transition planning for those moving from children's to adults' services; policies for specialist referral; and staff resources and skills.
- Gaps in service provision that may have contributed to the death of a person were reported in 7% of reviews. Such gaps included: postural care and epilepsy expertise; access to cancer screening; and a lack of 'joined up' working and holistic assessments and support.

Assessment of the quality of care

- Almost a half (48%) of deaths reviewed in 2018 received care that the reviewer felt met or exceeded good practice. This is slightly more than the 44% we reported in our last annual report.
- Seventy-one adults with learning disabilities (8%) were reported to have received care that fell so far short of good practice that it significantly impacted on their well-being or directly contributed to their cause of death.
- The reasons varied but included: problems with clinical care; problems with medication or equipment; not summoning medical attention in a timely manner; a lack of coordination of a person's care and treatment; and poor quality end-of-life care.

Recommendations made by reviewers for local action

- A wide variety of recommendations were made by local reviewers, most commonly in relation to:
  - system level issues (e.g. the development of clinical care pathways; adjustment of standard operating procedures)
  - staff training
  - care coordination and communication
  - DNACPR orders
  - recognising signs of deterioration

National level recommendations

Availability of data

1 Consider designating national leads within NHS England and local authority social care to continue active centralised oversight of the LeDeR programme.

2 NHS England to support clinical commissioning groups (CCGs) to ensure the timely completion of mortality reviews to the recognised standard.

Identification of people with learning disabilities

3 There should be a clear national statement that describes (referencing to relevant legislation) the differences in terminology between education, health and social care so that 'learning disability' has a common understanding across each sector and between children's and adults' services.

4 CCGs and local LeDeR steering groups to use local population demographic data to compare trends within the population of people with learning disabilities, and use the findings to take appropriate action.

Listening to families

5 The Department of Health and Social Care and NHS England to support national mortality review programmes to work with 'Ask, Listen, Do' and jointly develop and share guidelines that provide a routine opportunity for any family to raise any concerns about their relative's death.

Priority programmes of work needed

6 The Department of Health and Social Care, working with a range of agencies and people with learning disabilities and their families, to prioritise programmes of work to address key themes emerging from the LeDeR programme as potentially avoidable causes of death. The recommended priorities for 2019 include: i) recognising deteriorating health or early signs of illness in people with learning disabilities and ii) minimising the risks of pneumonia and aspiration pneumonia.

Service and care coordination

7 Guidance continues to be needed on care-coordination and information sharing in relation to people with learning disabilities, at individual and strategic levels.

Transition from children's to adult's services

8 Shortfalls in adherence to the statutory guidance in the Special Educational Needs and Disability Code of Practice in relation to identifying and sharing information about people with learning disabilities approaching transition, transition planning and care coordination must be addressed.

9 The Royal College of Paediatrics and Child Health to be asked to identify and publish case examples of best practice and effective, active transition planning and implementation.

Addressing bias

10 DHSC (working with agencies and Royal Colleges) to issue guidance for doctors that 'learning disabilities' should never be an acceptable rationale for a DNACPR order or described as the underlying or only cause of death on Part I of the Medical Certificate Cause of Death.

11 Medical Examiners to be asked to raise and discuss with clinicians any instances of unconscious bias they or families identify
12 The Care Quality Commission to be asked to identify and review DNACPR orders and Treatment Escalation Personal Plans relating to people with learning disabilities at inspection visits.

NHS England and NHS Improvement LeDeR: Action from Learning report

NHS England and NHS Improvement's response to third LeDeR annual report

- CCGs, working with their local authority and NHS partners, have made significant progress towards completing LeDeR reviews in a timely way but there is still a long way to go.
- An additional £5 million will be invested by NHS England and NHS Improvement in 2019/2020 to address the backlog of unreviewed cases and increase the pace with which reviews are allocated and completed.
- The money will be invested in developing a dedicated workforce to undertake reviews and develop systems and processes to embed mortality review and quality improvement activity across the health and social care system.
- Moving forward, data on the progress of CCGs completing reviews will be published regularly on the NHS England and NHS Improvement website.

Progress on second annual LeDeR report actions and 2019/20 action plan

- The report includes an update (see Annex 1 of report) on NHS England and NHS Improvement's progress on commitments that were attributable to them in the Government's response to the second annual LeDeR report.
- Seven actions have been completed and seven are ongoing. Completed actions include:
    - reviewing how local health care records exemplars could better integrate the approach to information sharing between health and care providers
    - writing to providers and employers about core skills framework and training responsibilities
    - NHS Improvement implementing and monitoring adherence to trust learning disability standards.
- Actions where progress is ongoing include:
    - testing and developing clear guidance on how the reasonable adjustment flagging system will support clinical practice – testing is currently underway
    - publishing Right Care Pathways for dysphagia, epilepsy, sepsis and constipation – guidance and pathways currently being reviewed
    - distributing additional best practice guidance on the MCA, learning disabilities and urgent care situations – guidance is in development and is due to be published in Autumn 2019.
- NHS England and NHS Improvement have developed an action plan (see Annex 3 of report) to ensure prompt and effective action is taken to address the learning identified about factors that can contribute

to premature mortality in the LeDeR 2018 report. Programmes include: cancer; respiratory, constipation, medication, DNACPR & cause of death; NHS Improvement standards; and health checks.

Conclusion and next steps

- NHS England and Improvement stated that the LeDeR programme is making progress but there is still a long way to go in making sure that reviews are completed in a timely way so that learning is translated into effective action.
- In 2019/2020 the University of Bristol will be reporting more regularly about themed learning, which is possible now that a higher number of reviews have been completed.
- The learning into action collaborative will continue to co-ordinate national responses to the learning emerging from LeDeR.

NHS Providers view

We welcome the continued focus on improving care for people with learning disabilities. There remain too many people with learning disabilities who are not receiving the care they need and should expect from the health and care system.

All providers understand the importance of making the right adjustments to meet the needs of people with learning disabilities and of ensuring individuals' needs are picked up early within every care setting. Delays in access to appropriate care, and a lack of available staff with the correct training and awareness of the needs of people with learning disabilities, are impacting on quality of care. Whilst the extra investment and commitments from NHS England and NHS Improvement are welcome, additional investment is required if learning is to be successfully acted upon and widespread improvement made to the care and treatment of people with a learning disability.

The LeDeR third annual report includes a series of useful recommendations for national bodies, trusts and other partners to act upon. Sharing best practice and learning from incidents, across the sector as a whole, is a vital part of improving the experience of people with learning disabilities. The health and care sector must work together to provide a more joined-up approach for people with learning disabilities.

Contact: Ella Fuller, Senior Policy Officer ella.fuller@nhsproviders.org

16 June 2021

on the day BRIEFING

NHS Providers

Integrated Care System Design Framework

NHS England and NHS Improvement (NHSE/I) published the Integrated Care System (ICS) Design Framework on 16th June 2021. This briefing sets out the operating model for ICSs from April 2022, after the enactment of the Health and Care Bill which will place ICSs on a statutory footing. It also acts as interim guidance for how ICSs need to continue developing and preparing for new statutory arrangements over the next ten months. The design framework will be supplemented by further information and guidance later this year to support detailed planning. For any questions on this briefing, please contact georgia.butterworth@nhsproviders.org.

Key points

- The ICS design framework sets out the next steps for how NHSE/I expects NHS organisations, working with system partners, to continue developing ICSs during 2021/22, in anticipation of establishing statutory ICS NHS bodies from April 2022. The framework sets out the core arrangements that NHSE/I will expect to see in each system, as well as some key elements of good practice. We expect further information and guidance to be issued later this year.
- As set out in the government's *Integration and Innovation* white paper in February, ICSs will be made up of two parts: the ICS partnership, and the statutory ICS NHS body. NHSE/I expects the ICS partnership to be a committee, rather than a corporate body. Its role will be to align the ambitions, purpose and strategies of partners across each system. It will be established by the relevant local authorities in collaboration with the ICS NHS body, and have a specific responsibility to develop an "integrated care strategy".
- The ICS NHS body will be a statutory body, whose functions will include planning to meet population health needs, allocating resources, and overseeing delivery. ICS NHS bodies will have a unitary board. The statutory minimum membership of the board will be confirmed in forthcoming legislation but is expected to be comprised of: a chair and at least two independent non-executive directors; a chief executive and three executive directors; and a minimum of three "partner" members, representing trusts, primary care and local authorities. Partner members will be expected to bring a perspective from their specific sectors, but not act as delegates of those sectors.
- The ICS NHS body will be expected to agree with local partners the membership and form of governance at place level. The design framework sets out five potential place-based governance arrangements: a consultative forum; a committee of the ICS NHS body; a joint committee of the ICS NHS body and one or more statutory provider; an ICS NHS body director with delegated authority; or a lead provider contracted to manage resources at place level.

- The design framework reiterates that all trusts providing acute and mental health services are expected to be part of one or more provider collaborative. Community and ambulance trusts and non-NHS providers should participate in these where it makes sense to do so.
- Providers will continue to be accountable for quality, safety, use of resources and compliance with standards, as well as the delivery of any services or functions delegated to them by an ICS NHS body. Executives of providers will remain accountable to their boards for the performance of functions for which their organisation is responsible.
- The final 2021/22 System Oversight Framework (SOF), which is expected to be published in the coming weeks, is expected to confirm ICSs' formal role in the oversight of organisations and partnership arrangements within their system. NHSE/I will retain its statutory regulatory responsibilities, so any formal regulatory action with providers will be taken by NHSE/I.
- NHSE/I also sets out the key features of the financial framework that will support system working, including some further detail on how resources will be managed at system level. It is envisaged that ICS NHS bodies will be given a duty to act with a view to ensuring system financial balance, and meet other financial objectives set by NHSE. This duty would also apply to trusts.
- The framework includes a roadmap to implement new arrangements for ICS NHS bodies by April 2022, including appointing leadership teams and ensuring a smooth transition of staff from CCGs.

Summary of the framework

Context

This framework builds on NHSE/I's renewed vision for ICSs in the Integrating care paper published in November 2020, which set out their four core purposes: improving outcomes; tackling inequalities; enhancing productivity; and supporting social and economic development. It also builds on the two-part statutory ICS model proposed in the government's white paper, Integration and Innovation: working together to improve health and social care for all, which stated that ICSs will be comprised of an ICS partnership – bringing together a broad alliance of organisations related to improving health and care – and an ICS NHS body – bringing together organisations that plan and deliver NHS services to improve population health and care.

The ICS partnership

Under the two-part statutory ICS model, each ICS will have a partnership, established by the NHS and local government "as equal partners". NHSE/I expects the ICS partnership to bring partners from local government, the NHS and wider organisations within the ICS together to align purpose and ambitions, and improve the health and wellbeing for their population, including influencing the wider

determinants of health. NHSE/I expects the ICS partnership to have a specific responsibility to develop an "integrated care strategy" covering health and social care for the whole population. NHSE/I indicates that the legislation for how partnerships should operate will not be prescriptive.

Membership of the ICS partnership will vary between systems, and may be drawn widely from health, care and other partners such as housing providers. They will be established by the relevant local authorities and the ICS NHS body. Partnerships will be able to use sub-groups, networks and other methods to convene parties to deliver the priorities set out in its shared strategy.

The ICS partnership chair will be jointly selected by the ICS NHS body and local authorities, who will also define the chair's role and accountabilities. NHSE/I provides some flexibility in this arrangement, by acknowledging that some systems may prefer the partnership and the ICS NHS body to have different chairs while others may choose to appoint one chair to sit across both. NHSE/I describes ten principles for ICS partnerships to consider, which include: distributed leadership; collective decision-making that seeks to find consensus; and a collective model for accountability.

The Department of Health and Social Care, NHSE/I and the Local Government Association will jointly develop guidance on the partnership, including on the role and accountabilities of the chair of the ICS partnership. This guidance will be consulted on before implementation.

The ICS NHS body

ICS NHS bodies will be statutory organisations that bring together all organisations involved in planning and providing NHS services within their footprint, to take a collaborative approach to agreeing and delivering ambitions for the health of their population.

NHSE/I outlines the specific functions that the ICS NHS body will be responsible for delivering:

- Developing a plan to meet the health needs of their population, having regard to the partnership's strategy. NHSE/I highlights a focus on recovery following COVID-19.
- Allocating resources to deliver the plan across the system, including setting principles for how resource (revenue and capital) should be allocated across services and providers. This will be a balance between enabling local decision-making and harnessing the benefits of scale.
- Establishing joint working arrangements with partners to deliver priorities, including joint commissioning (possibly at place) with local authorities under section 75 of the 2006 NHS Act.
- Establishing governance arrangements to support collective accountability. This will be underpinned by the statutory and contractual accountabilities of individual organisations.

- Arranging for the provision of health services in line with the allocated resources across the ICS. This will be delivered in several ways including: through contracts and agreements with providers; convening and supporting providers (working across the ICS and at place) to lead major service transformation programmes; and working with local authority and voluntary, community and social enterprise (VCSE) partners to put in place personalised care.
- Leading implementation of the NHS People Plan and people priorities in the planning guidance, with specific responsibilities from April 2022. NHSE/I also expects ICS NHS bodies to adopt a "one workforce" approach, developing shared principles across the NHS, local authorities, the VCSE sector and other partners.
- Leading system-wide action on data and digital.
- Working alongside councils to invest in local community organisations and infrastructure, ensuring the NHS contributes to social and economic development and sustainability.
- Driving joint work on estates, procurement, supply chain and commercial strategies.
- Planning for, responding to and leading recovery from incidents.
- Take on functions NHSE will be delegating including commissioning of primary care and appropriate specialised services. Specific public health functions may also be delegated.

Once an ICS NHS body has been established, NHSE/I expects that all CCG functions and duties will transfer over, including CCG assets and liabilities, such as commissioning responsibilities and contracts. NHSE/I is reviewing its own operating model, including how its functions and resources will be deployed in the context of the creation of statutory ICS NHS bodies.

NHSE/I expects the ICS NHS body's duties to include: supporting achievement of the triple aim, improving quality of service, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

NHSE/I will clarify in separate guidance how the statutory duties of CCGs will transition to ICS NHS bodies. NHSE/I will work with Health Education England to produce supplementary guidance and implementation support resources for ICSs on developing their strategic people capabilities.

Governance and management arrangements

This section sets out NHSE/I's expectations for ICS governance and management arrangements, with further resources to follow throughout this year. The final composition of the board and the process of appointing partner members (as described below) is subject to the parliamentary process.

The ICS NHS board

The ICS NHS body will have a unitary board, with all board members having shared corporate accountability for delivery of the functions and duties of the ICS and its performance. The board will be the senior decision-making structure for the ICS NHS body, and will be expected to facilitate finding consensus and manage areas of disagreement. The ICS NHS body should foster constructive challenge, debate and the expression of different views. If consensus cannot be agreed, the chair may make decisions on behalf of the board, and where necessary third-party intervention from NHSE/I or peer review may be needed.

The statutory minimum membership of the board will be confirmed in the legislation, but NHSE/I expects it to be comprised at least by the following roles:

- Independent non-executive directors (NEDs): This will include the chair plus a minimum of two other independent NEDs. These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body) This will include the chief executive, who will be the accountable officer for the funding allocations of the ICS NHS body, as well as a director of finance, director of nursing and medical director. These individuals will normally be full-time ICS employees.
- Partner members: a minimum of three additional board members, including at least:
    - One member from trusts and foundation trusts which provide services within the ICS;
    - One member from primary care providers within the ICS footprint; and
    - One member from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the ICS footprint.

Partner members will be expected to bring knowledge and a perspective from their specific sectors, but not act as delegates of those sectors. NHSE/I expects the partner member(s) from trusts and local authorities will often be the chief executive of their organisation. The appointment process of partner members and rules for qualification will be set out in the constitution of the ICS NHS body. The constitution, which may also include the appointment of additional members, will need to be agreed with NHSE/I.

The framework highlights the need for the board and its committees to ensure it considers the perspectives and expertise of all relevant partners, including those across the local health and care system covering physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the ICS partnership.

NHSE/I will provide further guidance on the composition and operation of the board, which will include a draft model constitution. Additional guidance on the management of conflicting roles and interests to enable effective joint working will also be published.

Committees and decision making

NHSE/I expects ICS NHS bodies to put in place arrangements for committees and groups to advise and feed into the board and to exercise functions delegated by the board. These arrangements should also enable the involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives.

Each board will be required to establish an audit committee and a remuneration committee. Other decision-making or advisory committees may be established by the board if they decide. It is expected that the legislation will give ICS NHS bodies flexibility in how committees are established, including how members are appointed and responsibilities delegated.

Place-based partnerships

The framework positions 'place' as central to the coordination and improvement of service planning and delivery, as well as addressing the wider determinants of health. The ICS NHS body will be expected to agree with local partners the membership and form of governance at this level, building on/complementing existing arrangements. The ICS NHS body will remain accountable for NHS resources deployed at place-level. At a minimum NHSE/I proposes that place-based partnerships should cover leadership from primary care, local authorities including directors of public health, providers across acute, community and mental health services, and representation from communities.

The framework sets out the following potential place-based governance arrangements:

- Consultative forum, informing decisions by the ICS NHS body, local authorities and others;
- Committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources;
- Joint committee of the ICS NHS body and one or more statutory provider;
- Individual directors of the ICS NHS body having delegated authority; and
- Lead provider managing resources and delivery at place under a contract with the ICS NHS body.

Supra-ICS arrangements

This section outlines functions where multiple ICS NHS bodies will need to work together to develop a shared plan across these systems. This includes, for example, the commissioning of specialised services and ambulance services. The governance arrangements to support this should be co-designed between the related providers and the ICS NHS bodies' clinical networks or alliances, and, where relevant, NHSE/I's regional teams.

Quality governance

NHSE/I sets the expectation for ICSs to build on existing quality oversight arrangements and work collaboratively with system partners to maintain and improve the quality of care. The ICS NHS body will have statutory duties to act with a view to securing continuous improvement in quality and will lead System Quality Groups (previously Quality Surveillance Groups). NHSE/I will provide support in line with the National Quality Board's guidance.

The role of providers

NHSE/I states that each ICS partnership and ICS NHS body must draw on the expertise and ambition of providers, given their critical role in the delivery, transformation, and improvement of services and outcomes within places and across and beyond systems. Trusts will be expected to work alongside system partners at place level to tailor their services to local needs and integrate pathways. They will have a role in agreeing how resources should be used and how they can best contribute to population health improvement as both service providers and as local "anchor institutions". There is flexibility in what this will look like locally and ICS NHS bodies will be expected to work with all providers to agree arrangements at different levels. In future, the ICS NHS body may delegate "commissioning" functions to providers for certain populations, which builds on the NHS-led provider collaboratives model for specialised mental health, learning disability and autism services. Trusts will increasingly be judged against their contribution to the objectives of the ICS alongside their existing duties, including delivering their agreed contribution to system financial balance.

NHSE/I also sets out the important role of primary care (including Primary Care Networks), independent sector providers and the VCSE sector in ICSs. NHSE/I expects primary care to be represented in all levels of ICS decision-making and by April 2022, the ICS will need to have a formal agreement for embedding the VCSE sector in system level governance arrangements.

Provider collaboratives

From April 2022, all trusts providing acute and/or mental health services are expected to be part of one or more provider collaborative. NHSE/I now states that community trusts, ambulance trusts and non-NHS providers should participate in these collaboratives where it makes sense for patients/the system. Provider collaboratives will be expected to agree specific objectives in line with the ICS's strategic priorities and help facilitate the work of alliances and clinical networks. The ICS NHS body and provider collaboratives will be expected to define their working relationships and governance arrangements, which will include their participation in committees through partner members as well as other local arrangements.

NHSE/I will publish additional guidance on provider collaboratives this summer.

Clinical and professional leadership

NHSE/I states that all ICSs should develop a model of distributed clinical and care professional leadership. This should build on clinical leadership within clinical commissioning groups, although the specific model will be determined by ICSs locally. Such leadership should be fully involved in decision-making, supported with sufficient resources and reflect the health, social care and VCSE sectors. ICSs will be expected to use forthcoming guidance to support a self-assessment of their clinical and professional leadership model, and implement mechanisms to measure progress and performance. The ICS NHS board will be expected to sign off a model and improvement plan.

NHSE/I will provide best practice guidance describing features of an effective professional leadership model for ICSs in due course.

Working with people and communities

The ICS will be expected to agree how to involve people and communities in developing plans and priorities. The framework reiterates seven principles for how ICSs should work with people and communities, including working with Healthwatch and the VCSE sector as key partners. The ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities. As part of this, ICSs should develop arrangements for:

- representation on the ICS partnership and in place-based partnerships; and
- gathering intelligence about the community's experience of, and aspirations for, health and care.

NHSE/I expects there will be a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning services.

NHSE/I will provide more information in guidance on the membership and governance of ICS NHS bodies and in the implementation support resources for how ICSs work with people and communities.

Accountability and oversight

As set out in the planning guidance for the first half of 2021/22, NHSE/I regional teams will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive. NHSE/I clarifies that providers will continue to be accountable for the quality, safety, use of resources and compliance with standards, as well as the delivery of any services or functions commissioned from or delegated to them, including by an ICS NHS body. Executives of providers will remain accountable to their boards for the performance of functions for which their organisation is responsible. If a provider executive sits on the board of the ICS NHS body, they will also be accountable for the ICS NHS body and ensuring its functions are discharged. When acting as an ICS body board member, they must act in the interests of the ICS NHS body and the wider system, not that of their employing provider.

Approach to NHS oversight within ICSs

NHSE/I confirms that the oversight arrangements for 2022/23 will build on the final SOF, which was consulted on earlier this year and is expected to be published in the coming weeks. NHSE/I expects these arrangements to confirm ICSs' formal role in oversight, including leading oversight and support of organisations and partnership arrangements within their system. The newly formed NHSE will retain NHSE/I's statutory regulatory responsibilities, so any formal regulatory action with providers will be taken by NHSE. NHSE will work with each ICS NHS body to ensure "effective and proportionate oversight of organisations" that avoid duplication. However, the framework does not set out what the role of NHSE/I regional teams will look like or whether any functions/resources will be transferred to ICSs. NHSE/I envisages that ICS NHS bodies may over time decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues through system oversight. CQC, NHSE/I and DHSC are working together to agree the process and roles for reviewing and assessing systems, which will aim to avoid duplication and overlap.

Financial allocations and funding flows

ICS allocations

In line with the current direction of travel, NHSE will allocate funding to each ICS NHS body, which will decide how such funds should be spent. This will include budgets for CCG-commissioned primary and secondary care, as well as running cost allowances. This may also include the allocations for NHSE functions, including primary care budgets, specialised services, national transformation funding, the Financial Recovery Fund, and funding for digital and data services. Full capital allocations will be made to the ICS NHS body, based on the outcome of the 2022/23 settlement.

Increasingly, funding will be linked to population need. Allocations will be based on supporting equal opportunity of access and contributing to the reduction of health inequalities. NHSE/I's approach will continue to be informed by the independent Advisory Committee on Resource Allocation. Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHSE will allocate funding to ICSs taking into account the needs of their population and how quickly they move towards their target allocations. NHSE will not set allocations to place within the ICS. The ICS NHS body will have the freedom to set a delegated budget to place-based partnerships to spend ICS NHS resources, but it must focus on equal access for equal need and reduce health inequalities. The ICS NHS body should explain any variation from previous CCG budgets and enable pooling with local authority budgets.

Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with its priorities. Money will flow from the ICS NHS body to providers largely through contracts for "services/outcomes", which may be managed by place-based partnerships or provider collaboratives.

In conjunction with ICS leaders, NHSE will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS board and chief executive will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts.

Each ICS will have an agreed framework for collectively managing and distributing financial resources within the system's financial envelope to address the greatest need and tackle inequalities in line with

the NHS system plan, having regard to the strategies of the ICS partnership and the health and wellbeing board(s). Every ICS will be required to meet the mental health investment standard and the primary and community health services funding guarantee.

Financial and regulatory mechanisms to support collaboration

These measures build on existing financial and regulatory mechanisms to support collaboration, including system financial envelopes and changes to the SOF. NHSE/I envisages that further policy and legislative enablers will support these developments, including: a duty to collaborate; a duty on the ICS NHS body to act with a view to ensuring system financial balance and meet other financial objectives set by NHSE (this would also apply to trusts); and powers to ensure organisational spending is in line with the system capital plan.

The legislation will enable NHSE direct commissioning functions to be jointly commissioned, delegated or transferred to ICS NHS bodies as soon as they are ready to do so. Commissioning of primary medical services is currently delegated to CCGs, so will transition immediately into ICS NHS bodies when they are established.

NHSE/I will review the NHS provider licence in light of the new legislation and policy developments.

Data and digital standards and requirements

NHSE/I expects digital and data experts to have a pivotal role in ICSs. The What Good Looks Like framework is due to be published in the first quarter of 2021/22. This will set out a common vision to support ICS leaders to accelerate digital and data transformation with their partner organisations. From April 2022, ICSs will need to have smart digital and data foundations in place. ICS NHS bodies are expected to: have a named SRO with the appropriate expertise; implement a shared care record; and agree a plan for embedding population health management capabilities, among other things.

Managing the transition to statutory ICSs

In this section, NHSE/I sets out how CCG staff and functions will transfer into the ICS NHS body. This change process will be guided by NHSE/I's Employment Commitment[1] and a set of core principles, and will be managed by current ICS and CCG leadership, with increasing involvement of the new leaders who may be appointed on a shadow or designate basis, pending the legislation. Plans will be agreed with NHSE/I regional teams. NHSE/I sets out indicative outputs expected in every ICS during 2021/22, subject to legislation and other factors (including pending any potential changes to ICS boundaries).

NHSE/I will issue a set of guidance and resources to support this transition, including:

- Change and transition approach (core principles)
- Employment Commitment Guidance, including national support offer

After the legislation is introduced, NHSE/I will publish the following resources and guidance:

- HR framework (technical guidance)
- Appointments guidance for the statutory roles
- FAQs for staff
- Leadership competencies, job descriptions and proposed pay structure for ICS statutory roles.

NHS Providers view

Context

Overall, the ICS design framework begins to set out a clearer vision for how the two-part statutory ICS model – with the ICS partnership and the ICS NHS body – will operate after the enactment of the legislation. Trust leaders are fully supportive of NHSE/I's ambition to set out a coherent and flexible operating model for ICSs from April 2022. They are clear that an enabling policy and legislative framework is required for systems to design what works best for their local communities and circumstances. We will continue to engage with trust leaders to determine whether the right balance between permissiveness and clarity has been struck here, considering the implications for all trust types ranging across acute, community, mental health, ambulance and specialised.

[1] The Employment Commitment does not apply to those in senior/board level roles who may be affected by the new ICS board structure.

The framework also builds on the steps outlined in the 2021/22 implementation guidance, which set out how ICS leaders and their constituent organisations, including trusts, should prepare for new statutory arrangements in this "transition period" up to March 2022. The complexity of this endeavour should not be underestimated, as systems must prepare for legislative change without pre-empting the outcome of the Bill. The collective leadership of ICSs and their constituent organisations will also need to navigate a complex new array of policy frameworks, including adjusting to a new financial regime and oversight framework. We welcome NHSE/I's commitment to supporting the system through this coming year.

It is worth remembering that these imminent changes are taking place whilst providers remain under significant operational pressure to restore routine services affected by the pandemic, tackle the backlogs of care, and meet deferred demand across urgent and emergency care, mental health and community health services. We would strongly encourage NHSE/I to keep this context top of mind, especially in light of the expectation that ICSs will maintain momentum on improving outcomes and supporting recovery at the same time as embedding significant new planning and accountability arrangements.

Principles

We fully support NHSE/I's ambition to accelerate the current direction of system working and collaboration, and welcome the recognition of providers playing a central, leadership role in ICSs. Providers are the engine for transformation and delivery. They are responsible for employing the vast majority of NHS staff and spending the vast majority of NHS funding. However, we are increasingly concerned that the language around ICSs describes them as a separate entity to providers, rather than as genuine partnerships of all the organisations that contribute to health and care services and outcomes within the system. The model risks moving away from the founding spirit of partnership and ambitions of population health, to becoming a separate body managing those within it. This leaves the proposals vulnerable to the perception that the ICS NHS body will simply act as a larger commissioner divorced from providers, when the ICS should in fact remain a sum of its parts.

Similarly, we are also concerned that collective confidence in the ICS as currently structured could be undermined in several ways, which could hinder the opportunity and ambition of system working. For example, the founding principle of local ownership that has been central to driving improvements in collaboration and outcomes thus far could be undermined if the 'partner' members are not appointed in consultation *and agreement with* the relevant constituency. There also needs to be

parity between NHS and local authority representation. For example, if all relevant local authorities, who are already represented on the ICS NHS body by a 'partner' member, are involved in setting up the ICS partnership and selecting the chair, but no additional providers are, the ICS partnership composition could be a majority local authority decision which undermines the principle of equal partnership.

Governance

Well-functioning health and care systems need good governance and clear accountabilities. We continue to have some concerns about the proposed ICS governance arrangements:

- While we agree the board of the ICS NHS body will need to be formally accountable to NHSE/I and parliament, they should also see themselves as accountable to the communities they serve and the organisations within their footprint. NHSE/I should set this out explicitly in future guidance.
- In our view, it is crucial that non-executive directors form a majority on the board of the ICS NHS body in line with best practice drawn from all types of organisations led by unitary boards, including NHS trusts and foundation trusts. This will ensure effective challenge, risk management and assurance, which in turn will ensure the board can answer for the decisions it makes. We recommend this is explicitly defined in future guidance, rather than being locally determined as currently proposed.
- We would recommend that 'partner' members be referred to as non-executive directors drawn from the system as this would provide clarity around their status in decision making.

Given the nature of the ICS task, especially in taking decisions around contract values and funding allocations, there will likely be different views within its membership and it may legitimately be difficult to reach consensus. We welcome NHSE/I's recognition of this potential for disagreement, which we have been calling for to ensure the framework is not designed on the basis that system partners will always agree. Legitimate challenge is a sign of a healthy system. One of the core ICS tasks, as the framework acknowledges, is to manage reasoned dissent well, reconcile differences and build consensus.

Involvement of all provider types

We continue to emphasise the need for NHSE/I to ensure the views of the full range of provider types have sufficient access and input to the ICS NHS body decision-making process. We welcome the framework's statement that the board of the ICS NHS body must ensure it takes into account the perspectives and expertise of all relevant partners. We would urge NHSE/I to take this further and ensure that each ICS has a mechanism which enables the views of trusts to feed into the decision-

making process, and ensures trusts agree with the way the board of the ICS NHS body is set up and comprised, with recourse to a challenge function if they are unhappy. This parity in decision-making is absolutely critical if a collaborative approach to planning and delivering more integrated care, is to be implemented as intended.

Missed opportunities

Finally, there are a few missed opportunities in this guidance. While NHSE/I references its intention to develop its own new operating model, it remains unclear how the role of NHSE/I regional teams will change and how resources and responsibilities will be transferred to ICSs over time. This leaves the framework open to the charge that it is adding to rather than reducing bureaucracy as intended, especially in the context of the renewed emphasis on place-based partnerships and provider collaboratives.

In addition, the framework states that trusts will need to meet system financial objectives set by NHSE under the new legislation; providers will need clarity on what this will look like in practice. For example, it will be vital to know what these requirements will be, who is responsible for judging whether a provider or system is compliant, and the consequences for providers and systems for not meeting these objectives. Finally, while we understand this is an NHS-only framework, it will be important to keep wider system partners involved in this process and ensure they have buy-in within the plans and priorities of their ICS(s). This is not only important in the context of improving wider determinants of health and tackling health inequalities, but also in ensuring wider public services are fully involved at system and/or place level.

We look forward to continuing to work closely with senior leaders and colleagues at NHSE/I as the framework is implemented and further guidance is produced. We will continue to engage with our members on key proposals outlined within this new framework and ensure their views are fed back to NHSE/I.

NHS Providers press release

New ICS design framework offers clarity ahead of major reforms to health service but questions remain

Responding to the publication of a new Integrated Care System (ICS) design framework by NHSE/I, the deputy chief executive of NHS Providers, Saffron Cordery said:

"Today's ICS design framework sets out a much needed, clearer vision for how ICSs will develop further this year and how these new statutory bodies will operate when the health and care bill becomes law. We welcome the dialogue with NHSE/I throughout its development.

"The framework addresses many of the concerns outlined by our members, who fully support NHSE/I's ambition to set out a coherent, yet flexible operating model for ICSs from April 2022. Providers will particularly welcome recognition within the framework of their central, leadership role in ICSs and their commitment to delivering the best possible care for their local communities.

"But there are big challenges ahead as ICS leaders and their constituent organisations adjust to the complexities of system working.

"A key concern is that these NHS reforms- the most far reaching for nearly a decade- will take place against a challenging backdrop as trusts work to clear backlogs of care, restore routine services, and tackle pent up demand across urgent and emergency care, mental health and community health services.

"It is vital NHSE/I acknowledges the pressures and expectations trusts face as ICSs take a greater role in efforts to improve outcomes and support recovery while simultaneously embedding significant new planning and accountability arrangements.

"Trust leaders are keen to ensure ICSs remain a genuine partnership of all the organisations that contribute to local health and care services and outcomes within the system. They are increasingly concerned that the ICS model risks moving away from being a sum of its parts to a separate body managing those within it. There must be appropriate governance measures to ensure ICSs are accountable not only to NHSE/I and parliament, but also to the communities they serve and the organisations within their footprint.

"In the coming weeks and months, we will continue to work closely with senior leaders and colleagues at NHSE/I as the framework is implemented and further guidance is produced. Alongside this, we will continue to regularly consult our members on key proposals to ensure their views are reflected as this framework progresses".

Contact: Georgia Butterworth, Policy Advisor (Systems), georgia.butterworth@nhsproviders.org

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Dear colleague

You have received an update today that the partners in West Yorkshire & Harrogate have ratified my move to working full time as the lead chief executive for the integrated care system (ICS). From 5th July, I will no longer be working as the chief executive of the Trust. I had some personal reflections for you as I make a move that may become permanent in the future.

What you do matters. In the most profound and human way it matters. You are in a team of over 4,500 staff and volunteers that operates every hour of every day across the whole year.

We all help people fulfil their potential and live well in their community. In doing so, we have saved lives, we have made lives and when the time comes, ensured that people have died in the place of their choosing.

From Wetherby in the North to Sheffield in the South, Castleford in the East to Todmorden in the West and all points in between, I have seen you do this. In people's homes, in communities and in our health centres, offices and hospitals you have dished out kindness, care and compassion with a good dose of Yorkshire humour and grit.

This has been incredibly important. How we work together is as important as what we do together. It shapes the impact we have and demonstrates that we live the values we hold.

We work with some of the most vulnerable and the most brilliant people in society. People with a learning disability defying expectations placed on them. Boys who stammer making videos for parents and children to show life can be good and not to worry about what's to come. People with lived experience of suicidal ideation and enduring mental health providing peer support to others in the same situation and giving them hope. Carers planning holidays with frail partners with a logistical brilliance and determination underscored by love. Older people with co-morbidities defying labels to get out and see lifelong friends. Distressed parents of self-harming children, fearful that they will die or be damaged all too soon. Mums determined that their mental health struggles won't get in the way of being the best they can be for their new baby. People with labels they won't let define them – like young offender, asylum seeker, schizophrenic, sufferer, or victim.

These are the people you put first and in the centre. Behind the labels and expectations we see the potential and we seek to let it shine for however long it can.

Every one of you has a role in this. Administrators, clinicians, managers, leaders in every directorate and every service. Every one of you is able to make a difference and to "lead from every seat" in this organisation.

I knew all of this before the pandemic and thought we were an organisation that lived its values and treasured its people. Your contribution in the last 16 months has gone way beyond my expectations. In the darkest of times, we have seen the best of all of us.

I hope you can see that you have delivered this in the toughest period in the history of the NHS and for a generation. You have been magnificent.

Being your chief executive during the pandemic has been the biggest privilege of my life. I could not be more proud of you.

Thank you for letting me be part of your team for the last 5 years.

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Trust Board 29 June 2021
Agenda item 8.1

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 May 2021.
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 June is in line with developments agreed by the Trust Board, including a recently introduced section on monitoring progress against our strategic objectives. **Quality** • The majority of quality reporting metrics continue to be maintained during the pandemic • The number of restraint incidents has decreased in May to 106, a decrease of 33% from previous month • 3 avoidable pressure ulcers were reported in the month • The number of inpatient falls has decreased since previous month (from 50 to 39) • There were 8 information governance breaches reported in May **NHSI Indicators** • 3 young people under the age of 18 were admitted to an adult ward in May for a total of 22 days • Out of area bed usage increased to 204 days • Performance against national reported targets remains largely positive **Locality** • An increase in referrals in a number of services has been evident since the easing of lockdown measures e.g. CAMHS • ASD/ADHD services have seen a significant increase in referrals for assessment. • Work is underway in Kirklees and Calderdale to develop proposals for sustainable CAMHS neurodevelopmental pathways • Heightened levels of acuity are being experienced across many service lines, particularly ward based

With **all of us** in mind.

	• An integrated lymphoedema pathway is being developed with the hospice in Barnsley • IAPT waiting list initiative being developed with an emphasis on group work. **Priority Programmes** • Priority programmes for 2021/22 have been refreshed, with work being undertaken to describe the scope and pace for each of the priority areas • Work continues on the Adult Secure Lead Provider Collaborative with earliest revied 'go live' date of 1st August 2021 • Work is underway in each place to review and further develop integrated care partnership arrangements in line with potential implications of NHSE/I proposals • The first panel discussion bringing together representatives from the Calderdale system with the National Centre of Creative Health, Culture Health and Wellbeing Alliance and Arts Council England has taken place. • The Trust Strategic Recovery and Reset Group has been refreshed. Three recovery workstreams have been established: enabling working effectively, learning from the Covid-19 pandemic, and recovery and re-set of services. • A programme group to support the Community Mental Health Transformation is now meeting regularly • Older people's inpatient transformation has recently been added to the portfolio of change programme priorities by the Trust. **Finance** • A £0.7m surplus was recorded in the month, taking the cumulative position to a surplus of £1.3m. This is £1.3m favourable to our break-even plan. • Income was £0.1m higher than plan and operating expenses £0.6m lower than budget • Pay costs were £0.8m lower than plan with net whole time equivalent staff numbers 259 lower than budget. In total pay costs of £16.6m were similar to those incurred in April. • Agency staffing costs remained consistent at £0.6m in the month. • £0.2m of costs were identified as being reasonably incurred as part of the Covid-19 response, mainly as a result of staffing requirements. • Out of area bed costs were £251k, which represents the highest monthly cost value since August last year. There has been a sustained increase in acuity and demand leading to this position. • There also continues to be high spend on locked rehab placements in Barnsley (£0.3m) • The mid-year and full year forecast will be reviewed by the end of the first quarter.

	• Capital expenditure of £0.3m, has been recorded to date, with high focus on planning for this year's capital programme • The cash balance increased to £61.3m **Workforce** • As of June 22nd, there were 32 staff off work and not working Covid-19 related • Non Covid- 19 sickness increased slightly to 4.3% in May • 610 staff have tested positive for Covid-19 since the pandemic began. There were no positive results in May • Staff turnover decreased slightly to 14.7% in May, but remains below target **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 • Lateral flow testing for staff continues to be used • The Trust Opel level remains at 2 • Silver and Gold Command meetings have now been stood down • National guidance continues to be monitored, reviewed, and adopted • 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

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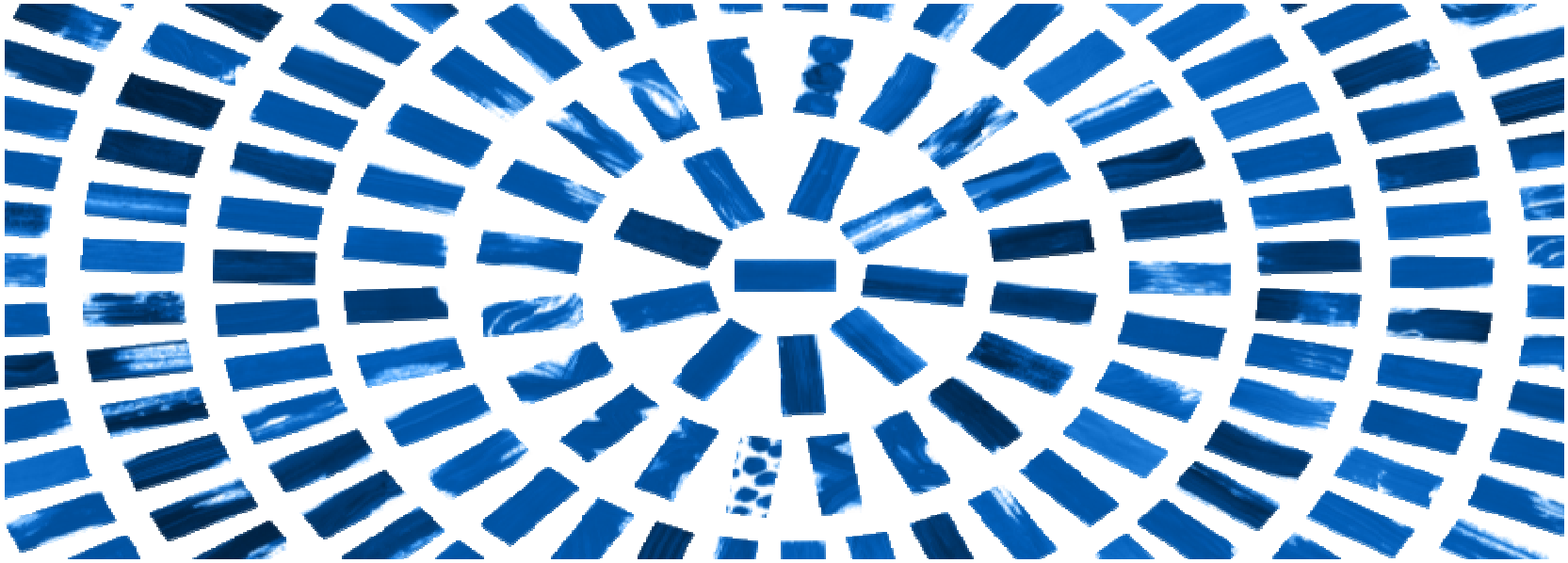
Integrated Performance Report
Strategic Overview



May 2021

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for May 2021. The development of the IPR will continue to evolve in the coming months following the discussion on targets and risks at the May strategy board session.

The majority of metrics identified to monitor performance against our strategic objectives have been populated, whilst others are in development with indicative timescales provided. Reporting against some metrics may take a little longer to develop and where appropriate, alternatives may be considered in the short term

With reference to key information relating to Covid-19, where possible the most up-to-date information is provided as opposed to the May 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
• Emergency Preparedness, Resilience and Response (EPRR)
• Quality
• National metrics
• Priority programmes
• Finance & contracting
• Workforce

It is likely additional metrics will be included at some stage of the year as a result of the introduction of the new system oversight framework. We will also need to consider how Trust Board monitors performance against the reset and recovery programme. Following an internal review of the IPR we are currently looking at various metrics that could benefit from the addition of an SPC chart. We are waiting for sufficient data to implement these. Our integrated performance strategic overview report is publicly available on the internet.

The following four pages highlight the performance against the Trust's strategic objectives.
EMT has now agreed to include community mental health transformation as an additional priority. An initial programme group meeting has been held and updates will be provided in future reports.

Improving health

Priority programme	Metrics	Threshold	Mar-21	Apr-21	May-21	Trend	Year end forecast	Notes
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		3	3	1			
	2.Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks) *	55%	74.6%*	Due July 2021				A weighted average is used given there are different targets in different places
	3.Proportion of people from BAME communities accessing IAPT		14.4%	15.8%	13.9%			BAME population 13%
Improve outcomes through our wellbeing services, physical health and services for people with mental health illnesses and learning disabilities	1a. Cardio metabolic assessment & treatment - Inpatient	80% screened 80% compliant	Reporting under development	**93% screened 80% compliant	**74% screened 54% compliant			For current inpatients (as at 22nd June) 74% of applicable patients have been screened using the cardio metabolic screening tool and of those 54% have been screened across all 9 domains. For current patients (as at 22nd June) within early intervention services, 57% of applicable patients on caseload have been screened using the cardio metabolic assessment tool. Of those, 37% have been screened across all 9 domains, with alcohol and diabetes being two domains where screening and appropriate actions are not being undertaken. This in part can be related to the availability of blood tests and results within the community setting.
	1b. Cardio metabolic assessment & treatment - Community (Early Intervention services)	70% screened 70% compliant	Reporting under development	**64% screened 51% compliant	**57% screened 37% compliant			
	2. IAPT - proportion of people completing treatment who move to recovery	50%	53.7%	57.0%	*55.6%*			May data is provisional and will be refreshed in July 2021
	3. % service users on CPA followed up within 7 days of discharge	95%	98/101 =97.0%	93/96 =96.8%	82/83 =98.8%			
	4. % of service users on CPA with a 12 month follow up recorded	95%	96.8%	96.8%	95.1%			Upward trend overall since April 20, targeted work continues to be undertaken with learning shared across teams
	5. % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 week	90%	82.5%	*83.0%*	*86.8%*			April and May data is provisional and will be refreshed in July 2021
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	TBC						Work taking place to define suitable metric, further update to be provided next month.

Notes:
* - quarterly data.
** - This metric identifies the number of current service users on CPA who have a diagnosis of psychosis that have been screened using the cardio metabolic assessment tool and the number of those screened that have all 9 elements of the tool recorded with appropriate action (smoking, diet, exercise, alcohol, substance misuse, weight, blood pressure, diabetes, cholesterol).

Priority programmes for 2021/22 have been refreshed. Several changes were made and agreed at EMT on 6th May 2021. Work is being undertaken on describing the scope and pace for each of the priority areas with consideration of the resourcing plan required and available.
Below we have set out progress against key milestones for areas of focus for work that has continued throughout May whilst the refresh is taking place. This only covers those priority areas that are being supported and managed as a programme of work. It does not reflect the breadth of improvement/change work happening on all priority areas or those that are being supported at a more local level in line with our integrated change framework.

Implementation deliverables	
	On Target to deliver within agreed timescales
	On Trajectory but concerns on ability/confident to deliver within agreed timescales
	Off Trajectory and concerns on ability/capacity to deliver within agreed timescales
	Action will not be delivered within agreed timescales
	Action Complete

Improve health (Salma Yasmeen and Sean Rayner)

Key Milestones		Comments:
1. Creativity & Health: To develop a series of three regional/national public panel discussions/ Q&As bringing together the leaders from the Calderdale system with the National Centre for Creative Health, Culture Health and Wellbeing Alliance and representatives from Arts Council England by July 2021.		**Creativity & Health:** The first public panel discussion took place on 16th June attended by representatives from the Calderdale system with the National Centre for Creative Health, Culture Health and Wellbeing Alliance and representatives from Arts Council England.
2. Active Calderdale: integrating physical activity into systems and processes: develop and pilot a motivational interviewing learning and development programme for professionals with a physical activity focus by end August 2021.		**Partnership working:** • Working with each place to review and further develop integrated care partnership arrangements in line with the potential implications of NHS E/I proposals. • Focus of work in integrated care systems is on providing ongoing Covid support and a joined up Covid response. • Working with each place to establish local recovery plans. • Established a SWYPFT programme group to support the community transformation which is now meeting regularly to share learning and coordinate SWYPFT activity.
3. Forensic Lead provider collaborative: NHSE confirmed on 14 June that the financial allocation issue will not be resolved in time for a 1 July go-live. Therefore, a 'go live' date will need to be reviewed. The earliest data is now 1 August, which remains dependant on securing appropriate funding allocation.		
4. Community mental health transformation: Recruitment into Wakefield, Calderdale and Kirklees posts are all planned to take place in mid May - June. Barnsley project lead post has been appointed and has commenced.		

Improve Care

Priority programme	Metrics	Threshold	Mar-21	Apr-21	May-21	Trend	Year end forecast	Notes
Continually improve patient safety	1. Incidents involving moderate or severe harm or death	Trend monitor	30	38	33			
	2. Number of c-diff avoidable cases	0	0	0	0			
	3. Number of pressure ulcers	Trend monitor	34	41	43			With regards to the recent reported increase in pressure ulcers, tissue viability nurses are providing additional training around Waterlow risk assessments and wound care management with the neighbourhood nursing teams. This is combined face to face/virtual, and they are also offering shadowing experience if required and where appropriate with the current Covid-19 restrictions. Each of the teams have set their own action plans around wound care management. Further focused work is being planned where necessary with individual teams.
	4. Safer staffing fill rates (%)	90%	116.2%	118.9%	119.8%			
	5. Number of children & young people in adult wards	0	3	3	3			Total of 22 days in May
	6. Staff absence due to Covid-19		13	0	0			No of staff still absent from work - Covid-19 positive
	7. Number of nosocomial incidences of Covid-19 in our inpatient units		137	139	139			Cumulative
Provide care as close to home as possible	1.Out of area bed placements (days)		82	122	204			Continued pressure and demand with the number of placements minimised. Targets being updated in light of the impact of the pandemic.
Deliver improvements particularly in CAMHS and forensic services	1.Numbers waiting over 4 weeks for assessment (CAMHS)		156	155	182			Some elements of the service seeing an increase in referrals and increase in numbers waiting as result of the additional demand
	2.Numbers waiting over 18 weeks for treatment (CAMHS)		132	140	128			
	3. Friends & Family test - CAMHS	80%	77.6%	65.9%	69.1%			55 responses in May
	4. Forensics staff sickness	<=5.4%	4.1%	4.4%	4.3%			
	5. Forensics staff turnover		Currently unavailable due to covid-19 response					Reporting currently under development. Data expected to flow from July 21.
	6. Race related incidents in forensics		8	5	10			There were a total of 46 race related incidents against staff reported from 1 November 20 to 31 May 21, occurring in Forensic BDU. Of these incidents, 45 were patient against staff and 1 was other against staff.
Safely deliver and restore inclusive services locking in innovation	1a. Waiting lists - Referral to assessment within 2 weeks (external referrals)	75%	95.7%	95.5%	94.6%			This mostly relates to SPA, Core, Enhanced and other general community mental health services
	1b. Waiting lists - Assessment to treatment within 6 weeks (external referrals)	70%	96.1%	92.5%	98.7%			This mostly relates to SPA, Core, Enhanced and other general community mental health services
	1c. Waiting lists - Referral to assessment within 4 hours (external referrals)	90%	91.0%	93.8%	93.2%			This mostly relates to IHBT and liaison services
	2a. Average contacts per day - Core mental health		281	263	238			Pre Covid-19 - 240 (October 2019 which is representative of the following 6 months)
	2b. Average contacts per day - intensive home based treatment team		112	117	121			Pre Covid-19 - 154 (October 2019 which is representative of the following 6 months)
	2c. Average contacts per day - Learning disability community		157	155	174			Pre Covid-19 - 89 (October 2019 which is representative of the following 6 months)
	2d. Average contacts per day - District nursing, end of life and community matrons		616	592	575			Pre Covid-19 - 710 (Average from September 2019 to January 2020)
	3. Access representative of community population		Data currently unavailable					New referrals compared to population health data to be reported in July 21.

Improve care (Carol Harris)

Key Milestones	
1. Recovery and stabilisation: identify and establish recovery workstreams with resources, work plans, structure, and governance in place to complete recovery activity for period May – September 2021.	
2. Care as close to home: Formal patient flow 7-day service, new target to in place by 31.04.21 Now completed.	
3. Care as close to home: Gatekeeping analysis commence by end Apr and be taken forward through May and has now been completed. Action plan is now in development to prioritise learning actions.	
Older People Inpatient Services Transformation Outline plan for inpatient consultation process to be agreed – July	
CAMHS improvement **4. Neuro waiting lists (Calderdale and Kirklees:)** Conversations are ongoing with Kirklees commissioners to agree resourcing for future service and business case with Calderdale for additional resources to the support the model.	
5. CAMHS Barnsley: Plan to reach agreement with commissioners regarding access KPIs depending on additional funding for 2021/22 by end of June 2021	

Comments:

Recovery and stabilisation

• Operational services are stabilising and moving into recovery phase. Focus is on maintaining core critical services and prioritising/addressing emerging and immediate impact (service and workforce) and commence/refresh insight and learning to inform activity of recovery workstreams.

• The strategic recovery and reset group has been refreshed. Three recovery workstreams have been established – enabling working effectively, learning from Covid-19 pandemic, recovery and reset of services. Each workstream is working on scoping and plan recovery activity and undertaking resource planning to support this.

Older People Inpatient Services (OPS) Transformation

OPS inpatient transformation has recently been added to the portfolio of change programme priorities by the Trust. Immediate actions include engagement with commissioners about proposed models and options and development of a plan for consultation.

CAMHS

• Negotiations of the resourcing for sustainable CAMHS neuro waiting list resources continue in Calderdale and Kirklees. Psychology recruitment and work to identify appropriate estate is being taken forward to mitigate against any potential issues caused by the time needed for the contacts to be established.

• CAMHS Barnsley – internal development work being undertaken to enable production of reports for new access KPIs as well as establishing baseline. Plan timeframe changed to early September with intention to report on access KPIs from Q3 onwards (subject to commissioners agreement & sign-off via contractual routes).

• CAMHS Barnsley & Wakefield – Continuation of higher number of referrals being received and accepted appropriately for CAMHS input. Barnsley CCG have asked for summary report regarding referrals.

Improve resources

Priority programme	Metrics	Threshold	Mar-21	Apr-21	May-21	Trend	Year end	Notes
Spend money wisely and reduce waste	1. Surplus/(deficit) vs target	In line with Plan	£963k	£636k	£675k		£4.6m	Favourable start to the new year
	2. Underlying surplus/(deficit)							Not currently calculated due to interim financial arrangements
	3. Cash		£56.6m	£61.3m	£60.3m		£56.6m	Positive cash position
	4. Performance against efficiency targets							Not currently calculated due to interim financial arrangements
Integrate digital approaches to the way we work	1. Number of 'did not attends'		3.8%	3.6%	3.7%			
	2a. Percentage of video consultations		3.8%	3.0%	3.1%			Slightly lower than national averages
	2b. Percentage of telephone consultations		38.0%	37.1%	36.8%			
	2c. Percentage of face to face consultations		58.3%	59.9%	60.1%			
	3. Prescribing errors (EPMA) (development required)		Currently unavailable due to Covid-19 response					10 wards are now fully live using EPMA, over the next month an evaluation of these wards will take place alongside a continuation of training. Further work to be undertaken to scope out implementation across other wards. Meeting taking place in July to identify an appropriate metric, further update to be provided next month.

Improve resources (Mark Brooks)

Key Milestones	
1. Digital: Agreement of new Digital Strategy by 31.03.21	
2. Digital: Electronic Prescribing and Medicines Administration (EPMA) live in 2 clinical areas by 31.01.21.	
3. Digital dictation: Development and approval of business case and specification for procurement of single supplier by 30.06.21 and completion of digital dictation tender and identification of preferred supplier by 30.09.21	
4. Trust Email platform accreditation (NHS Digital dependencies): Email accreditation penetration test completion June 2021, communications plan and review panel June/July2021 and accreditation achieved – July/August 2021	
5. Microsoft Licencing annual review: licencing review - May/June 2021	
6. IT Services re-procurement: approach planning prior to procurement – Q1/Q2	
7. Cyber Security: Annual Survey/Phishing Survey and evaluation of findings – Q2 and implementation of action plan – Q3	
8. Digital capital programme 21/22: detailed programme planning and mobilisation of planned expenditure.	
9. Electronic care records: Breathe Service SystmOne deployment – 1 July 2021.	
10. Information Sharing: Yorkshire & Humber Care Record onboarding (utilising Trust clinical portal) – Q1/Q2	
11. Business Intelligence & Performance Reporting • Development work to support new ways of working in Barnsley Community Services (NTS) and ensure suitable reporting outputs available – ongoing • In support of Covid-19, Health inequalities reporting established and the outputs being further developed via Business Intelligence solution – June 2021 (ongoing)	
12. Digital Inclusion: Technical Feasibility (in collaboration with WY&H ICS).	
13. H1 Financial Plan: development of financial plan for 21/22 by 06.05.21	
14. Finance: Confirmation of mental health investment standard (MHIS) monies and other investments by 30.06.21	
15. Financial Sustainability Plan: 3 year financial sustainability plan by 31.12.21 with review of previous financial sustainability plan scheduled to be completed by 31.08.21	

Comments:

Mental Health Investment Standard – largely agreed with commissioners. Discussions taking place regarding other investments including Mental Health Recovery.

Electronic Prescribing and Medicines Administration (EPMA)
10 wards are now fully live using EPMA.

Make SWYPFT a great place to work

Priority programme	Metrics	Threshold	Mar-21	Apr-21	May-21	Trend	Year end forecast	Notes
Support the provision of a healthy, resilient & safe workforce	1. Sickness absence	4.5%	3.9%	4.0%	4.3%			Non Covid-19 sickness lower than previous years
	2. Staff turnover	10%	10.3%	15.6%	14.7%			Slight decrease in staff turnover in May.
	3a. Clinical supervision	>=80%	81.3%	Due July 2021				Improved performance reported locally this quarter
	3b. Appraisal	>=95%	Data currently unavailable					Suspended due to Covid-19
	4. Incidents of violence and aggression against staff	Trend monitor	82	58	67			
	5a. Staff survey - % staff recommending the Trust as a place to receive care and treatment	80%	71.8%					Increased from 65.6% in 2019
	5b. Staff survey - % staff recommending the Trust as a place to work	65%	69.0%					Increased from 61.5% in 2019
	6. Cases of bullying & harassment		0	2	1			Alternative metric being considered
	7. Absence due to stress & anxiety and MSK		2.4%	2.6%	2.8%			
	8. Relative likelihood of appointment to roles band 5 and above for people from BAME backgrounds		1.14	1.16	1.29			Based on rolling 12 months. The indicator is calculated using a count of shortlisted applicants split by white / BAME, then looks at the number appointed split by white / BAME, this then gives the relative likelihood of shortlisting/appointed and the difference between the two calculates the rate. A figure below "1" would indicate that BAME candidates are more likely than white candidates to be appointed from shortlisting.
	9. Access to training for staff members from BAME backgrounds		Currently unavailable due to Covid-19 response					
Refresh and deliver our sustainability strategy and action plan	Dependent on what is identified in the updated sustainability plan							Requires further development.

Make this a great place to work (Alan Davis)

Key Milestones	
1. Healthy, resilient, and safe workforce: Establish and operationalise covid19 vaccine hubs	
2. Healthy, resilient, and safe workforce: Develop stratification model for delivering covid19 vaccine	
3. Healthy, resilient, and safe workforce: Deliver vaccine to workforce in line with stratification and supply	
4. Healthy, resilient, and safe workforce: source staff to work on the vaccination programme including the staffing of covid-19 vaccination clinics	

Comments:

• Current focus is on delivering our HR duties and legal obligations, and providing staff health and wellbeing, workforce, and HR support during Covid19 pandemic. Enhanced psychological support is also available through WY&H ICS. These sections are reported elsewhere in the IPR.

• The staff vaccination programme has now been decommissioned and a programme closure report approved by Silver command on 2nd June 2021. This report is scheduled for submission, as part of the priority programmes update in June, to EMT requesting formal closure of the programme. In place is support to access an evergreen provision of covid19 vaccination by new starters and existing staff who decide to come forward for vaccination.

Lead Director:
• This section has been developed to demonstrate progress being made against the Trust objectives using a range of key metrics
• More detail is included in the relevant section of the Integrated Performance Report.

Quality
• The majority of quality reporting metrics continue to be maintained during the pandemic
• The number of restraint incidents has decreased in May to 106, a decrease of 33% from previous month
• 3 avoidable pressure ulcers were reported in the month
• The number of inpatient falls has decreased since previous month (from 50 to 39)
• There were 8 information governance breaches reported in May

NHSI Indicators
• 3 young people under the age of 18 were admitted to an adult ward in May for a total of 22 days
• Out of area bed usage increased to 204 days
• Performance against national reported targets remains largely positive

Locality
• An increase in referrals in a number of services has been evident since the easing of lockdown measures e.g. CAMHS
• ASD/ADHD services have seen a significant increase in referrals for assessment.
• Work is underway in Kirklees and Calderdale to develop proposals for sustainable CAMHS neurodevelopmental pathways
• Heightened levels of acuity are being experienced across many service lines, particularly ward based
• An integrated lymphoedema pathway is being developed with the hospice in Barnsley
• IAPT waiting list initiative being developed with an emphasis on group work.

Priority Programmes
• Priority programmes for 2021/22 have been refreshed, with work being undertaken to describe the scope and pace for each of the priority areas
• Work continues on the Adult Secure Lead Provider Collaborative with earliest revied 'go live' date of 1st August 2021
• Work is underway in each place to review and further develop integrated care partnership arrangements in line with potential implications of NHSE/I proposals
• The first panel discussion bringing together representatives from the Calderdale system with the National Centre of Creative Health, Culture Health and Wellbeing Alliance and Arts Council England has taken place.
• The Trust Strategic Recovery and Reset Group has been refreshed. Three recovery workstreams have been established: enabling working effectively, learning from the Covid-19 pandemic, and recovery and re-set of services.
• Recruitment is now progressing across the Community Mental Health Transformation programme, including into programme manager posts.
• Older people's inpatient transformation has recently been added to the portfolio of change programme priorities by the Trust.

Finance
• A £0.7m surplus was recorded in the month, taking the cumulative position to a surplus of £1.3m. This is £1.3m favourable to our break-even plan.
• Income was £0.1m higher than plan and operating expenses £0.6m lower than budget
• Pay costs were £0.8m lower than plan with net whole time equivalent staff numbers 259 lower than budget. In total pay costs of £16.6m were similar to those incurred in April.
• Agency staffing costs remained consistent at £0.6m in the month.
• £0.2m of costs were identified as being reasonably incurred as part of the Covid-19 response, mainly as a result of staffing requirements.
• Out of area bed costs were £251k, which represents the highest monthly cost value since August last year. There has been a sustained increase in acuity and demand leading to this position.
• There also continues to be high spend on locked rehab placements in Barnsley (£0.3m)
• The mid-year and full year forecast will be reviewed by the end of the first quarter.
• Capital expenditure of £0.3m, has been recorded to date, with high focus on planning for this year's capital programme
• The cash balance increased to £61.3m.

Workforce
• As of June 22nd, there were 32 staff off work and not working Covid-19 related
• Non Covid- 19 sickness increased slightly to 4.3% in May
• 610 staff have tested positive for Covid-19 since the pandemic began. There were no positive results in May
• Staff turnover decreased slightly to 14.7% in May, but remains below target

Covid-19
• 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
• Lateral flow testing for staff continues
• The Trust Opel level remains at 2
• Silver and Gold command meetings have been stood down
• National guidance continues to be monitored, reviewed and adopted
• A range of staff wellbeing support offers continue to be available and used

Covid-19 response

This section of the report focuses on a number of components of the Trust's response to Covid-19 including testing, support to the system and PPE.

Managing the clinical response

PPE position

• Deliveries and stock levels remain good, ensuring sufficient supply to meet staff needs

PPE Levels	Approx days stock as at 16-Mar	Approx days stock as at 13-Apr	Approx days stock as at 11-May	Approx days stock as at 15-Jun
Surgical masks	31	31	42	42
Respirator masks	93	109	71	101
Aprons	25	23	19	20
Gowns	59	62	88	87
Gloves	21	22	18	20
Visors	26	46	46	33

Testing

KPI	As at 24th November 2020	As at 22nd December 2020	As at 19th January 2021	As at 17th February 2021	As at 23rd March 2021	As at 20th April 2021	As at 18th May 2021	As at 18th June 2021	Notes
No of service users tested (ward)	174	225	257	278	297	300	302	302	Symptomatic
No of service users tested positive (ward)	60	83	94	115	134	137	139	139	Cumulative
No of service users recovered	60	83	94	115	119	121	123	125	2 patients deceased

Patient testing & pathway/Outbreak response & management

Symptomatic patient testing is being undertaken and revised regime under review.
Outbreaks continue to be managed by the infection prevetion and control team. Last outbreak was in March 2021

Testing approach

Current position

Patients:

• Swabbing for symptomatic testing through Pillar 1 inpatient and through Pillar 2 if required for community setting.
• Inpatient asymptomatic COVID19 testing is undertaken through Pillar 1, taking place on admission, day 3 and day 5 and testing prior to discharge to adult care facility. Patient are also re-tested on their return if they leave the ward or unit over a 24 hour period.
• Also testing takes place for some patient on treatment pathways e.g.- planned operation/ treatment/ procedures.
• Outbreak and hotspot testing is provided through an internal testing route, with adequate capacity from local labs as required.

Staff

• Symptomatic testing - access via pillar 2 or through internal testing route. Testing staff per and post-operative and procedures as required
• Outbreak and hotspot testing is managed and provided through internal testing route, with adequate capacity from local labs as required
• Identified SWYFT staff are undertaking Lateral flow testing.

Lateral flow testing has been implemented, 100% test kits have been distributed and a system established to confirm usage. Current information suggests that low levels (below 1%) are showing as positive, this is being monitored. In addition all generally community staff who have previously not taken part in the Trust testing system are now undertaking a lateral flow test 3 x a week to be able to evidence a negative result when going into care homes. The national lateral flow system is being implemented across the NHS from July and the Trust is currently undertaking an option appraisal for a safe exit from our internal system.

Supporting the system

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

Emergency Preparedness

This section of the report identifies the Trust's repose to the Covid-19 pandemic.

Supporting the system

ICS stress test and outbreak support

• 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.

Covid-19 Vaccinations

• A total of 4,516 staff have received their first vaccination (88%) and 4,019 staff have received their second vaccination (78%)
• Covid-19 vaccination programme has now closed, with staff offered vaccination routes into the national system. Report provided to EMT regarding the operation and lessons learned from the programme.
• In addition to providing vaccinations for our staff we have provided 969 first vaccinations and 894 second vaccinations for partner organisations.

Standing up services

Emergency prepardness, resilience and response (EPRR) update inc OPEL levels

• Gold, Silver and Bronze command meetings stood down, with new reporting structures for Covid-19 related issues being absorbed into operational management group (OMG) & executive management team (EMT) to allow business as usual governance arrangements to manage the ongoing response and recovery
• The Trust OPEL Level remains at 2. Since the standdown of the command structure, this is now managed via weekly reports into the operational management group.
• Attendance at regional learning events and preparation everts for winter/Covid-19 2021 underway
• Strategic report regarding the response to COVID and lessons learned being drafted.

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	Improving Health	Responsive	CH	TBC	66.4%	63.0%	63.2%	63.2%	66.3%	72.9%	N/A
Complaints	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	8% 2/25	15% 4/27	7% 2/30	16% 7/43	11% 3/27	6% 2/35	1
Service User	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	90%	80%	80%	81%	81%	78%	1
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	96%	100%	95%	98%	95%	96%	1
Quality	Number of compliments received	Improving Health	Caring	TB	N/A	45	24	8	31	37	28	N/A
	Number of Duty of Candour applicable incidents 4	Improving Health	Caring	TB	trend monitor	39	36	24	35	31	Due July 2021	
	Duty of Candour - Number of Stage One exceptions 4	Improving Health	Caring	TB	trend monitor	3	4	4	4	3		N/A
	Duty of Candour - Number of Stage One breaches 4	Improving Health	Caring	TB	0	0	0	0	0	0		1
	% Service users on CPA offered a copy of their care plan	Improving Care	Caring	CH	80%	39.0%	41.3%	41.1%	40.4%	40.9%	41.8%	2
	Number of Information Governance breaches 3	Improving Health	Effective	MB	<12	12	12	13	13	7	8	2
	Delayed Transfers of Care 10	Improving Care	Effective	CH	3.5%	2.2%	1.8%	1.6%	1.8%	1.2%	1.1%	1
	Number of records with up to date risk assessment - Inpatient 11	Improving Care	Effective	CH	95%	54.0%	55.5%	53.0%	53.2%	61.6%	61.6%	N/A
	Number of records with up to date risk assessment - Community 11	Improving Care	Effective	CH	95%	51.9%	56.0%	63.2%	57.3%	51.8%	46.9%	N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	1042	946	953	1166	1029	1011	
	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	30	20	16	21	24	23	
	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	6	2	1	5	7	3	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Improving Care	Safety Domain	TB	trend monitor	7	5	8	4	8	7	
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	115.6%	114.3%	116.2%	116.2%	118.9%	119.8%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	90.9%	88.9%	92.7%	92.9%	94.6%	94.9%	
	Number of pressure ulcers (attributable) 1	Improving Care	Safety Domain	TB	trend monitor	33	33	29	34	41	43	
	Number of pressure ulcers (avoidable) 2	Improving Care	Safety Domain	TB	0	0	0	3	2	1	3	1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less 8	Improving Care	Safety Domain	CH	90%	90.2%	100%	90.0%	79.0%	93.7%	100%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	49	47	44	40	50	39	
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	189	166	185	179	157	106	
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	85.7%	82.8%	96.0%	100%	89.3%	90.3%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	0	0	0	0	1
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	1
Improving Resource	Single Oversight Framework metric	Improving Resource			2	2	2	2	2	2	2	2
	CQC Quality Regulations (compliance breach)	Improving Resource			Green	Green	Green	Green	Green	Green	Green	Green

** 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 (Category 2 and above) that has developed after 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 – Lapses in care - A pressure ulcer (Category 2 and above) that has developed after 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 damage3 - 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. Up to and including September 2020 the 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. Given the recent implementation of the FIRM risk assessment tool, from October 2020 onwards - Older people and working age adult Inpatients, we are counting how many staying safe care plans were completed within 24 hours and for community services for service users on care programme approach we are counting from first contact then 7 working days from this point.
14 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return and is monitored under the NHS oversight framework.

Quality Headlines

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

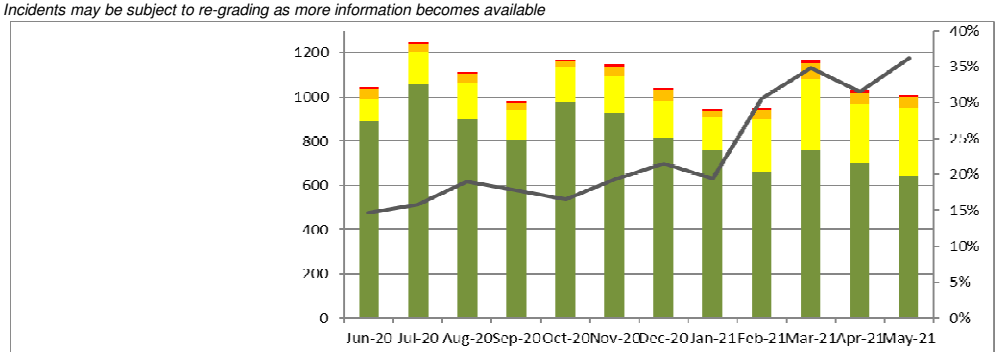
- Number of restraint incidents - the number of restraint incidents during May decreased from 157 to 106. Further detail can be seen in the managing violence and aggression section of this report.
- NHS Safety Thermometer - medicine omissions. It has been decided by NHS Improvement that the safety thermometers are to cease being used and they are currently working on a replacement.
- Number of falls (inpatients) – Total number of falls was 39 in May, which is a decrease compred to last month's data. 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 - no breaches in April
- % 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 achieve the standard. Work is ongoing to improve data quality. Further work is underway also to review the way that this is recorded and reported with the emphasis on people having the conversation with service users about copies of the care plans.
- Number of pressure ulcers (avoidable) - there were 3 incidences of avoidable pressure ulcers to report during May. With regards to the recent reported increase in pressure ulcers, tissue viability nurses are providing additional training around Waterlow risk assessments and wound care management with the neighbourhood nursing teams. This is combined face to face/virtual, and they are also offering shadowing experience if required and where appropriate with the current Covid-19 restrictions. Each of the teams have set their own action plans around wound care management. Further focused work is being planned where necessary with individual teams.
- Performance for CAMHS Referral to Treatment - The number of children waiting for CAMHS have increased. Although currently this has not had an impact on the 18 weeks performance, services have highlighted that sustained increases will negatively impact on the length of wait.

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. Our Patient safety specialists (Dr Kiran Rele, Associate Medical Director and Helen Roberts, Patient Safety Manager) join national and regional patient safety discussions/information sessions and sharing information into the Trust. NHS England have issued a document with priorities for patient safety specialists which has been aligned with our patient safety strategy.
Further work to map the role against existing resources is underway.
Duty of Candour - the CQC have issued an update the Duty of Candour guidance for providers. Guidance has been developed and will be circulated to staff via Headlines and BDUs in due course.

Safety First

Summary of Incidents June 2020 - May 2021

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



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Red (should not be compared with SIs)	11	11	10	7	7	13	9	8	10	11	9	10
Amber	48	41	37	32	25	42	51	28	42	70	54	51
Yellow	95	146	165	135	161	167	164	148	240	325	261	305
Green	893	1055	902	807	976	927	818	762	661	760	705	645
Total	1047	1253	1114	981	1169	1149	1042	946	953	1166	1029	1011
Percentage of total that are Red/Amber/Yellow *	14.7%	15.8%	19.0%	17.7%	16.5%	19.3%	21.5%	19.5%	30.6%	34.8%	31.5%	36.2%

Degree of harm analysis:

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 (06th June 2021).

Deaths: of the 7 deaths that were recorded for May 2021, there are 5 deaths that are classed as cause of death unknown/ unexplained/ awaiting confirmation. These are recorded 2 incidents at Core Team East – Wakefield and 1 each at Core Team North – Kirklees, Mental Health Liaison Team (RAID) - Calderdale and Kirklees, and Single Point of Access, (Calderdale). There was 1 suicide (incl apparent) - community team care - current episode recorded at Intensive Home-Based Treatment Team (Kirklees) and suicide (incl apparent) - community team care – discharged recorded at assessment and Intensive Home-Based Treatment Team / Crisis Team – Calderdale.

Severe: of the 3 severe harm incidents recorded for the month of May 2021, there were 3 pressure ulcer - category 4, incidents recorded across the neighbourhood teams in Barnsley.

Moderate: of the 23 moderate harm incidents reported in May 2021, 9 incidents were pressure ulcer category 3 incidents recorded across the neighbourhood teams in Barnsley.

There were also 9 self-harm incidents reported in the month of May. These were 3 incidents recorded at Ward 18, Priestley Unit, and 1 each at Nostell Ward, Wakefield 1 at Older People's Barnsley, Lyndhurst, Calderdale, Intensive Home-Based Treatment Team (Kirklees), Early Intervention Service (Insight) – Kirklees and Clark Ward – Barnsley.
There were 2 safeguarding adult incidents recorded for the month of May. These were recorded 1 each at Enhanced Team South 2 – Kirklees and the neighbourhood team in Barnsley.

There was communication issues (non clinical) incident recorded at mental health access team (IAPT) – Barnsley. 1 Medication incident recorded at Community Health Centre Admin Team. 1 slip trip and fall incident recorded at Intermediate Care – Barnsley.

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

Safety First cont…

Summary of Serious Incidents (SI) by category

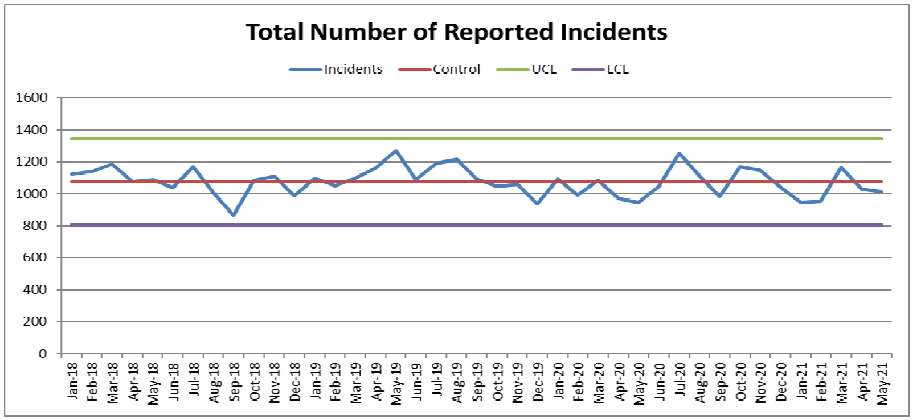
Please Note: initial reporting is upwardly biased, and staff are encouraged to report. Once reviewed and information gathered, this can change, hence the figures may differ in each report

• 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.
95% of incidents reported in May 2021 resulted in no harm or low harm or were not under the care of SWYPFT. For 2020/21 this figure was 92%. This percentage cannot be compared to previous reports as from March 2021, we have amended the way this is extracted from Datix. Previously this was based on severity and now uses degree of actual harm, which should be more accurate. This is the same percentage figure of April 2021
• Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
• All serious incidents are investigated using systems analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
• Risk panel meets weekly and scans for themes that require further investigation. operational management group continues to receive a monthly report, the format and content is regularly reviewed.
• No never events reported in May 2021

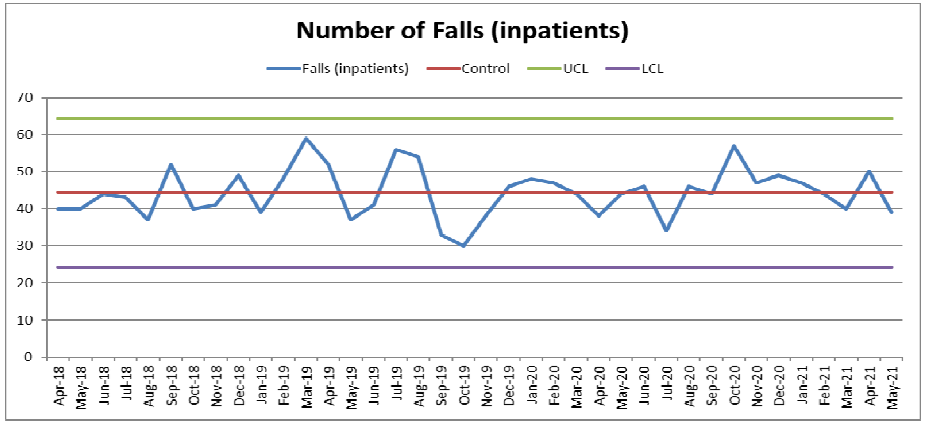
Following a decrease in incidents being reported in February 2021, the number of incidents reported in May 2021 is slightly lower but within the average mark of reporting. In April 2021 there were 1029 incidents reported compared with May 2021 which was 1011 incidents were reported. This is the average level of incidents being reported each month, before levels had considerably dropped in January and February 2021. Further breakdown of incidents do not indicate any BDU or team as under reporting.

Mortality

Learning: 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: Attended Hospital Mortality Statistics Masterclass facilitated by Professor Mohammed Mohammed on 24th May. This about acute hospital mortality statistics where they consider avoidable deaths
Structured judgement reviews: allocations are on track.
Reporting: The annual incident report will include data on learning from healthcare deaths. The quality accounts data is also being prepared.
Training: Structured judgement reviewer training for band 6 above took place on 14/5/21 and and a further session booked on 12/7/21.Please contact datix@swyt.nhs.uk if staff wish to complete the training. Attendees are required to complete a minimum of two structured judgment reviews in a year.



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.



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.

Safer Staffing Inpatients

High levels of acuity continue to be reported by inpatient areas across the BDUs. The requirement for increased observation levels, which in turn increases the demands on the regular workforce as well as the need for additional flexible staff, continues. Demand from the community and CAMHS teams has also increased adding to the pressure of the flexible staffing resource. The number of vacancies within the registered nurse group remains consistent and we continue to pursue multiple avenues to fill these vacancies. Within the healthcare assistant vacancies for inpatient services there continues to be a near full recruitment position.

Any incidents where the registered nurse cover has fallen below the expected establishment are supported by local escalation plans which remain robust in the face of the staffing pressures. Each incident where a preceptee registered nurse is left alone because of an emergency, i.e. sickness or clinical incidents, is looked at and assurances have been given around what support was in place for that incident.

The international recruitment program continues to gather pace, with a partner agency being appointed and initial meeting arranged with them. The Trust's internal coordinator has been appointed and an operational project board organised, with the first meeting set.

Further to learning from the initial roll-out, SafeCare is being refocused within the Unity Centre with a refreshed approach having analysed the interactive lessons learned together with the service. These lessons are being used as the bedrock for the rollout program within the Forensic BDU.

Again, no ward has fallen below the 90% overall fill rate threshold in May, which is consistent with the last three months. Whilst fill rates are a recognised indicator of our ability to staff wards to establishment, they are not a direct indicator of the challenges on a ward and acuity. For example, a ward staffed to 140% might still not be staffed to meet the clinical acuity on that particular shift.

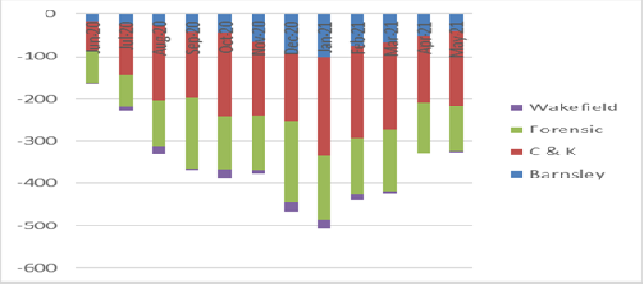
Unfilled shifts

Members of the Safer Staffing Group are exploring other, potentially more meaningful metrics to indicate safer staffing, one example being unfilled shifts. An unfilled shift is a shift that has been requested of the bank office (flexible staffing) and that could not be covered by bank staff, agency or overtime, despite all efforts made. This might offer an indicator as to the pressures on the wards for the remaining staff on shift. To maintain safe staffing, there will also be examples where a registered nurse shift will be filled by a healthcare assistant colleague. Although not exclusive, there are two main reasons for the creation of these shift requests:

1. Shifts that are vacant through short or long-term sickness, annual leave, vacancies, or other reasons that impact on the duty rosters.
2. Acuity and demand within the clinical area, including levels of observation and safety concerns.

All 31 inpatient areas within the trust are included in the figures below, with the individual areas populated as follows:

- Wakefield – mental health in-patient wards
- Forensic – all forensic beds plus The Horizon Centre (a specialist assessment and treatment service for people with a learning disability
- C&K – all mental health beds in Calderdale and Kirklees
- Barnsley – all mental health beds plus the stroke and neuro rehabilitation wards



The graph to the right shows particular challenges in December and January with regard to unfilled shifts, but an improving picture since.

Safe and effective staffing remains a priority in all our teams, and we are continuing to explore best ways to understand both the best measures of this and the impact on staff wellbeing.

The particular areas that have raised staffing as a concern include the Priestley Unit in Kirklees, the Oakwell Unit at Kendray Hospital in Barnsley and Newton Lodge in the Forensic BDU.

There have been supportive measures put in place in these areas including block booking staff to provide consistency and continuity,
placing bespoke recruitment adverts and ensuring that additional resources are placed at their disposal.

Registered on Days -Trust Total 86.0% (a decrease of 2.8%).

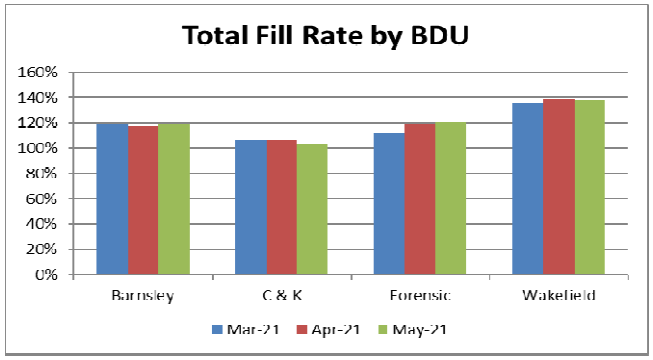
The number of wards that have failed to achieve 80% registered nurses increased by one to ten (32.0%). Four wards were within the Forensic BDU, two in Barnsley and five in Calderdale and Kirklees. Although our overall fill rates remain high, all inpatient areas remain under pressure from a registered staffing perspective. This continues to be compensated by increasing the number of HCAs per shift. Contributory factors included high levels of acuity, high sickness/absence and existing vacancies. We are running bespoke adverts for several areas as well as attending virtual University Career fairs. We continue a rolling recruitment campaign for substantive and bank staff as well as sourcing block bookings for the areas from both bank and agency.

Registered on Nights- Trust Total 103.7% (an increase of 3.4%).

One ward (3.2%), consistent with the previous month, fell below the 80% fill rate. This allowed the trust to achieve above 100% registered overall fill rate on nights for the first time since May 2020. Melton Suite within Barnsley BDU achieved 77.6% (an increase of 7.5%). This was due to several reasons reflective as above. The number of wards who are achieving 100% and above fill rate on nights increased by one to 21 (67.2%). Four wards, a decrease of one on the previous month, utilised more than 120%. These were two within the Forensic and specialist BDU and one each within C&K and Wakefield BDUs.

Overall fill rate for registered staff increased by 0.30% to 94.85%.
Overall fill rate for all staff within inpatient areas decreased by 0.1% to 118.8%.

Within the individual BDUs Forensic and LD increased by 1% to 120%, Barnsley decreased by 2% to 119%, Calderdale and Kirklees decreased by 2% to 104%. Wakefield decreased by 1.0% to 138%.



Throughout March the main wards where staffing was a raised concern remain as Ward 18, Barnsley, 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. These figures do not include OT shifts.

Without the overtime fill rate the requested sum of additional shifts, indictive of acuity including sickness absence, increased to 4,158 (892 RN and 3,266 HCA) shifts.

Unfilled Shifts				Filled Shifts
Categories	No. Of Shifts	Total Hours	Unfill Percentage	
Registered	236 (+13)	2,479.00	25.74% (0.62%)	656 (+26)
Unregistered	224 (+39)	2,814.58	7.59% (+0.58%)	3,003 (+256)
Grand Total	447 (+52)	5,293.58	11.33% (+0.54%)	

We are continuing to target areas where vacancies are within our recruitment campaigns. Block booking and prioritisation within bank booking varies on a daily/weekly basis dependent on acuity and clinical need.

After the spike that was caused by various cost pressures including end of year payments, the levels of bank spend reduced to expected levels within the month of April.

In May Agency spend reduced by £31k to £214k whilst bank spend increased by £140k to £606k. Overtime reduced by £61k to £79k.

Information Governance

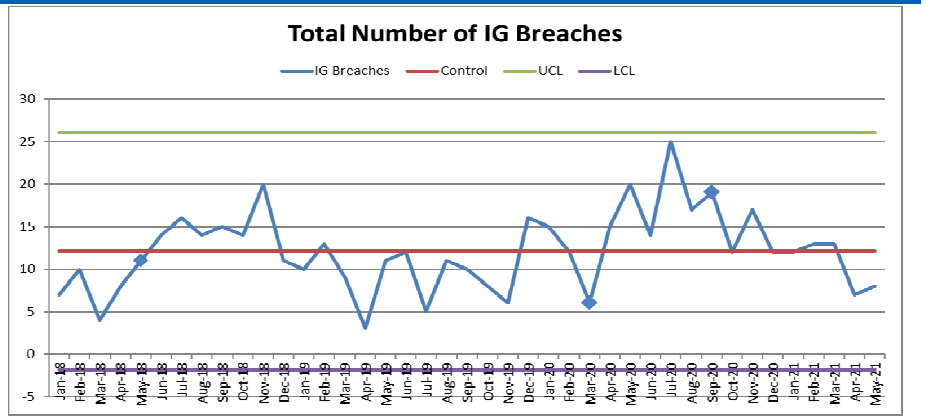
8 data breaches were reported during May, which is slightly higher than April but is lower than any month during the previous financial year.

6 incidents involving information being disclosed in error were reported, which was the most reported category throughout 2020/21.

A new IG communications plan is being finalised, which will involve continued use of The Brief to publish case studies on the impact that personal data breaches have, raising awareness of the Freedom To Speak Up Guardians for staff to contact if they suspect inappropriate use of personal data is happening and communicate the need to ensure personal data is not stored in more than once place. Work using the Quality Improvement methodology continues to work through suggestions for improvement that were made during change improvement (CI) sessions that were run between November 2020 and January 2021.

The Trust did not report any incidents to the Information Commissioner's Office (ICO) during April and no complaints were made about the Trust by members of the public.

SPC Chart
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported IG breaches are within the expected range. The data point in May 2018 has been highlighted to indicate the introduction of GDPR.
The data point in March 2020 highlights the start of the Covid-19 pandemic, which resulted in changes to some working practices.
The data point in September 2020 has been highlighted given the start of the refreshed awareness and communication plan.



Commissioning for Quality and Innovation (CQUIN)

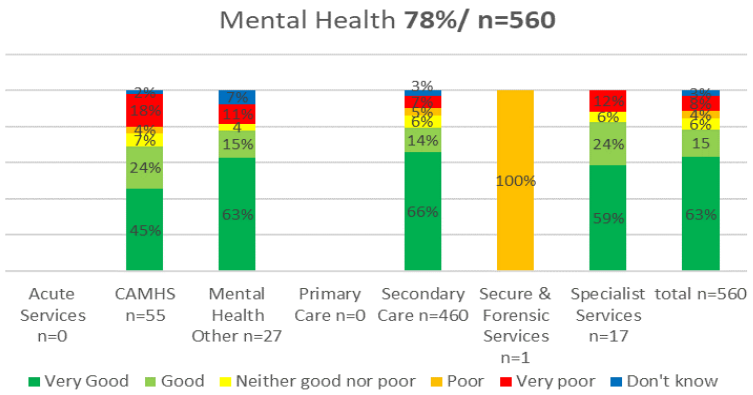
Schemes for 20/21 were suspended during the Covid-19 pandemic period. Similarly there are no CQUIN schemes for Q1 2021/22.

Patient Experience

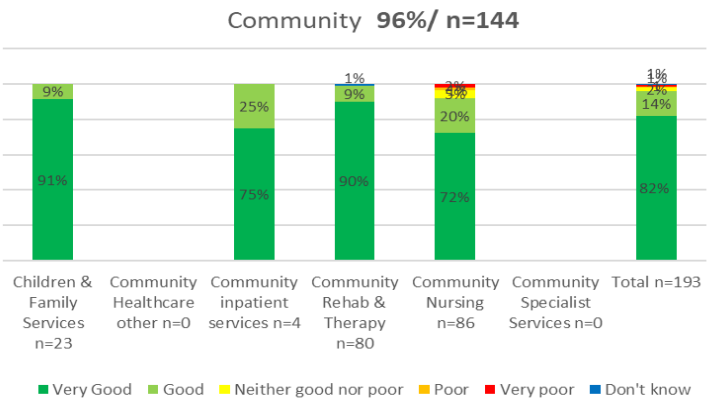
Friends and family test shows

- 96% would recommend community services.
- 78% would recommend mental health services

Mental Health Services



Community Services



- 83% (753) of respondents felt that their experience of services had been very good or good across Trust services.
- 96% (n=193) of respondents felt that their experience had been very good or good across community services.
- 78% (n=560) of respondents felt that their experience had been very good or good across mental health services.
- The text messaging service provided 67% of responses for April. The Trust has identified that the although the text messaging continues to provide over 50% of the Friends and Family Test responses, we are only receiving ratings and no comments. This is being reviewed to see why we are not receiving comments and how we can improve this.
- Electronic devices have been recalled from wards. These will be redistributed in July. Paper surveys have been provided in the interim.

Safeguarding

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. Levels 1 and 2 have been accessed via e-learning with all mandatory courses (including PREVENT) reported above the 80% mandatory training target.

All members of the team have attended virtual webinars and/or training sessions to ensure that their practice, the training material, and advice provided is up to date and relevant. The Safeguarding team have attended: Liberty Protection Safeguards training, Domestic Abuse and Social work, awareness of counter terrorism (ACT) and the UK Hoarding Awareness training.

The team continue to review Datix and clinical records as part of internal quality monitoring and in preparation for external CQC and Ofsted inspections. All external information gathering requests have been responded to in a timely manner. The team are currently supporting Barnsley CAMHS with the preparation for a South Yorkshire and Bassetlaw Provider Collaboration Review, due to commence on the 5th July 2021.

The safeguarding team have provided bespoke training sessions to a clinical team in Wakefield, community forensic team and in Barnsley, for domestic abuse and the safeguarding documentation toolkit. The 'impact of parental mental illness' training continues to be delivered across the Trust.

Following an internal review of the safeguarding team the standard operating procedure for the safeguarding team has been presented at the June Clinical Policy Ratification Review Group and following minor amendments will be presented to OMG.
The safeguarding team have supported the thematic review that is being carried out at Wetherby Young Offenders institute.

Infection Prevention Control (IPC)

Ongoing work for COVD19 pandemic, with reset, restoration and recovery

Surveillance: There has been zero cases of ecoli bacteraemia, C difficile, MRSA Bacteraemia and MSSA bacteraemia.

Mandatory training figures are healthy:

Hand Hygiene-Trust wide Total –95%
Infection Prevention and Control- Trust wide Total –94%

Policies and procedures are up to date.

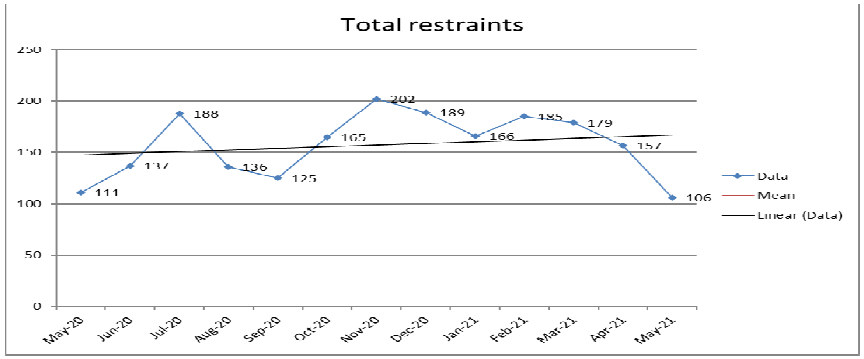
Complaints

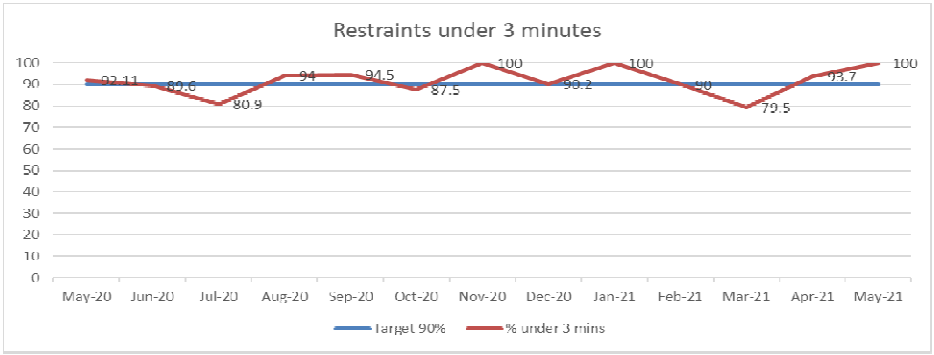
There were 35 new formal complaints in May 2021. Of these 6 have a timescales start date and 26 are awaiting consent/questions. We have closed 3 due to no contact/consent.
6% of new formal complaints (n=2) had staff attitude as a primary subject
28 compliments were received

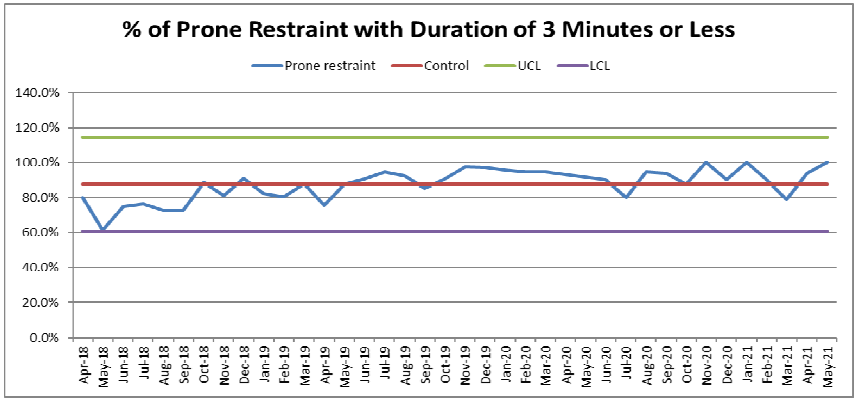
7 formal complaints were closed in May 2021. 71% (n=5) of complaints exceeded 40 working days and 29% of complaints were closed within 40 working days. If we look at the revised timeframes then only 1 complaint (14%) met the new target and 86% (n=6) exceeded the revised target based on the number of issues/complexity. There were a number that should have been responded to within 25 working days (n=5) and none met this target. The average working days to close a complaint for May 2021 was 43 days.
Count of written complaints/count of whole time equivalent - 4.73WTE

Reducing Restrictive Physical Intervention (RRPI)

There were 106 reported incidents of Reducing Restrictive Physical Interventions used in May 2021 this is a decrease of 51 (32.5%) incidents since April 2021 which stood at 157 incidents.
Of the different restraint positions used in the 106 incidents, standing position was used most often 69 (41%) followed by seated at 27 (16%).
Prone restraint was reported 18 (11% of total restraints) times in May 2021, this is an increase of 4 (28%) from last month. 17 (94%) of the prone restraints were directly linked to seclusion (15) or medication (2) events.
Incidents where prone descent immediately turned into a supine position were recorded at 7 (4%) this is a separate entity to prone restraint.
Wakefield recorded seven prone Restraints; Calderdale had four, learning disabilities three, Forensics two, Barnsley, and Kirklees all reported one.
The Trust target of 90% of prone restraints lasting under 3 minutes and the importance of striving to maintain this is strongly emphasised. In May the percentage of prone restraints lasting under 3 minutes was 100% which is an increase of 6.37%. Each incident of prone restraint has been reviewed by a member of the RRPI team and an explanation can be found further in the report.
The use of seclusion has decreased in May by 15% from 57 to 48. Zero incidents of seclusion have been attributed to Covid themes in March
The RRPI team continue to provide face to face training in line with current IPC guidance. Although Covid restrictions have impacted on our delivery we have maintained a compliance of over 80% in all courses. (figures sourced from the Mandatory training OMG report).
The refresher courses were re-introduced in May this year with update periods extended by 12 months from March 2020. Supplementary to this we commenced a period of workplace competency assessments from April 2021.
Discussions regarding the planning for the reintroduction of training has occurred within the Mandatory and Essential to Job Role Training Group, proposed dates have been distributed to the Learning and Development team for circulation.
Other courses such as personal safety and de-escalation and breakaway courses have been adapted to workbooks and e-learning packages, the practical face to face elements will be delivered as one -hour sessions over a day in each location from April 2021.



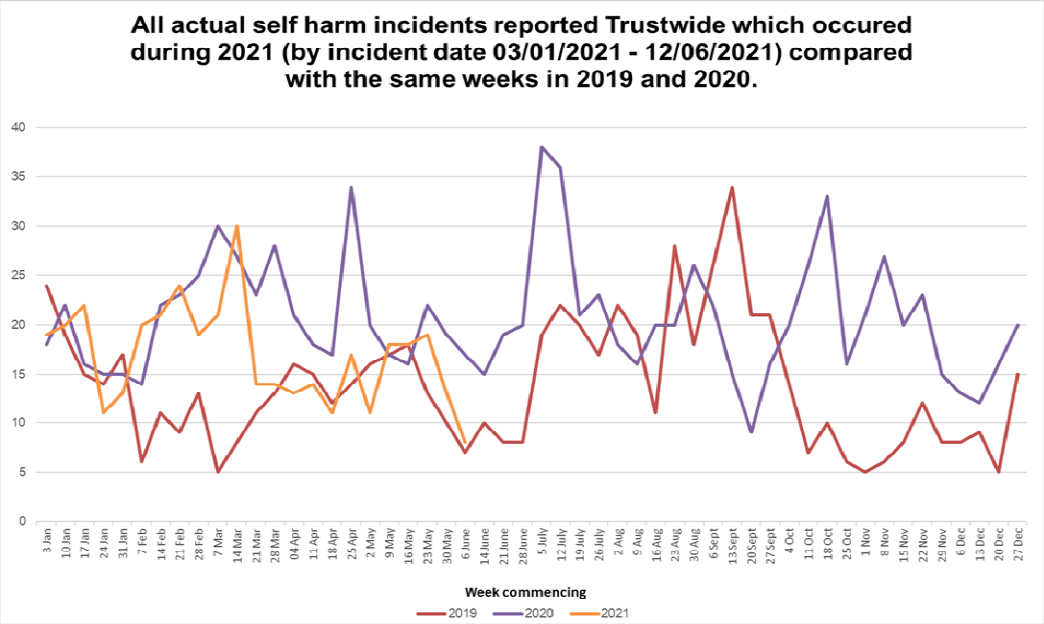




All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

Self Harm

Actual self-harm incidents reported on Datix occurring between 03/01/2021 and 12/06/2021 at 14/06/2021, compared with incidents occurring in the same period in 2019 and 2020.



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 (2 in total pending review). Figures may change as incidents are reviewed and approved.

Analysis of trends

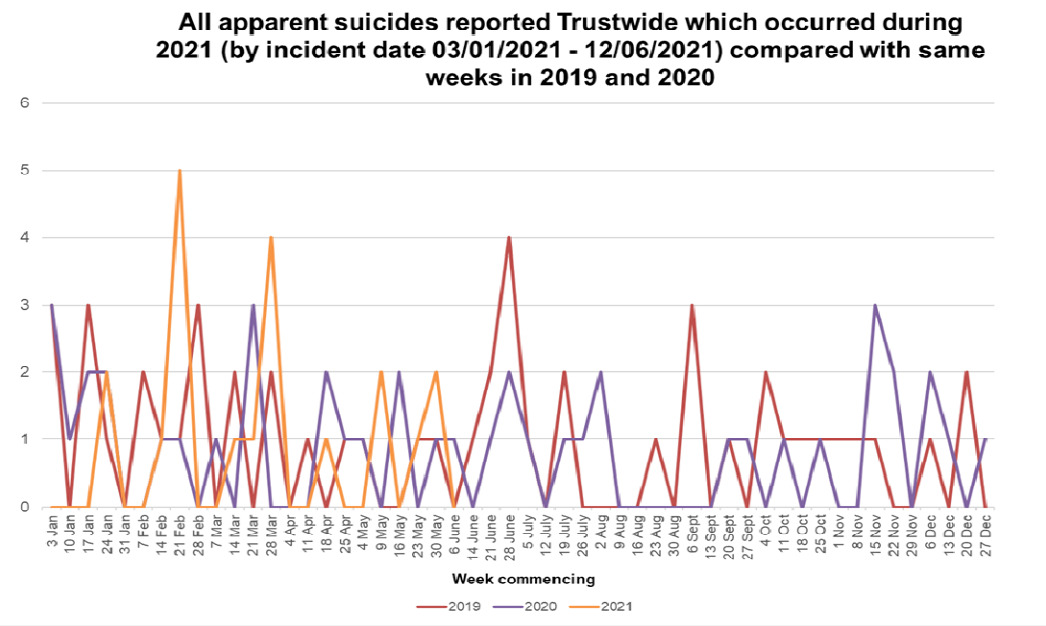
July 2020 - The peak in July 2020 was explored further and analysis showed that between 1/7/2020 - 1/8/2020 there was a total of 135 incidents of actual self-harm.
This involved 34 patients. 27 patients had 3 or less self harm incidents in the period. There were 6 patients who had more than 3 incidents. 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.

October 2020 - The peak in incidents in October 2020 was explored further. Analysis showed that this was 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.

June 2021 - Analysis of the data from 2021 shows that two subcategories of self harm remain higher than other methods. These are cutting (90) and self strangulation(89) incidents each reported.
Analysis of the cutting incidents showed that the incidents took place over 18 wards/teams with the majority of incidents occuring on Elmdale ward.
Analysis of the self strangulation incidents showed that the incidents took place over 10 wards with the majority of incidents occuring on Clark ward. Analysis of incidents shows that a small number of individual service users account for this higher number of incidents.
The next highest subcategory is headbanging (62 incidents). Again analysis of incidents shows that a small number of individual service users.

Apparent Suicide

Apparent suicides reported on Datix occurring between 03/01/2021 and 12/06/2021 at 14/06/2021, compared with incidents occurring in the same periods in 2019 and 2020



Please note:

Data refreshed and verified on 14th June 2021 from Datix for 2019, 2020 and 2021 data.

When this report was originally requested, data included any apparent suicide that was reported within the Trust. This included apparent suicides that were not within the Trust's mortality scope, such as deaths of patients discharged more than 6 months prior to death, death of someone who had touched the police liaison practitioner but had no mental health concerns, etc. (A list can be provided if required).

The report content has been revised to ensure it mirrors the same data as other apparent suicide reports in circulation in the Trust to avoid differences in data because of different criteria being used.

This report is now based on apparent suicides that are in the Trust's scope for mortality review. All data has been refreshed for past years.

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	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Data quality rating 8	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	90.0%	98.7%	99.2%	99.9%	98.2%	99.6%	99.9%	100%	100%		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	28.5%	43.8%	56.8%	97.8%	43.7%	74.3%	97.8%	98.7%	100%		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	100%	96.1%	98.7%	99.4%	100%	99.1%	99.1%	100%	100%		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	297/299 = 99.3%	300/302 =99.3%	301/302 =99.7%	277/281 =98.6%	89/90 =98.9%	90/90 =100%	98/101 =97.0%	93/96 =96.8%	82/83 =98.8%		
Data Quality Maturity Index 4	Improving Health	Responsive	CH	95%	98.5%	98.7%	98.8%	98.7%	98.9%	98.9%	*98.3%*	*99.1%*	*99.1%*		
Out of area bed days 5	Improving Care	Responsive	CH	21/22 - Q1 629, Q2 514, Q3 284, Q4 428	415	737	316	251	91	78	82	122	204		
IAPT - proportion of people completing treatment who move to recovery 1	Improving Health	Responsive	CH	50%	46.6%	52.7%	56.3%	53.4%	53.1%	53.4%	53.7%	57.0%	*55.6%*		
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	CH	75%	88.3%	92.8%	96.5%	98.8%	98.4%	99.0%	98.7%	99.1%	*98.6%*		
IAPT - Treatment within 18 weeks of referral 1	Improving Health	Responsive	CH	95%	98.9%	99.1%	99.9%	99.9%	99.6%	100%	100%	100%	*100%*		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	60%	84.6%	87.0%	94.4%	91.5%	92.0%	90.6%	91.9%	87.0%	89.7%		
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	91.3%	91.1%	91.7%	92.1%	92.0%	92.2%	92.2%	92.3%	*92.4%*	⚠	
% clients in employment 6	Improving Health	Responsive	CH	*10%*	12.5%	12.6%	12.5%	12.5%	12.4%	12.4%	12.6%	12.7%	*12.9%*	⚠	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Data quality rating 8	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	10	34	10	23	11	6	6	25	22		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	4	6	2	6	2	1	3	3	3		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	258	205	210	189	189			Due July 2021			
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	CH	*Trend Monitor*	14.7%	13.7%	18.1%	19.0%	19.0%						

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Data quality rating 8	Trend
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance 1	Improving Health	Responsive	CH	90%	99.1%	99.8%	99.5%	99.4%	99.8%	99.4%	98.9%	98.9%	*99.6%*		
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%	100.0%	100.0%	99.9%	100.0%	*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%	98.4%	98.0%	98.1%	98.0%	98.2%	98.1%	98.3%	*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 remains above the target threshold at 100%
- The percentage of service users seen for a diagnostic appointment within 6 weeks has improvedto 100% and is now above target, which represents excellent recovery from the impact if the pandemic.
- Inappropriate out of area bed placements amounted to 204 days in May. This is an increase from 122 in April.
- During May 2021, there were 3 service users aged under 18 years placed in an adult inpatient ward for a total of 22 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.
- The proportion of people detained under the Mental Health Act who are from a BAME background increased from 18.1% to 19.0% quarter on quarter. This compares to a BAME population of 11.3% across the places the Trust operates.

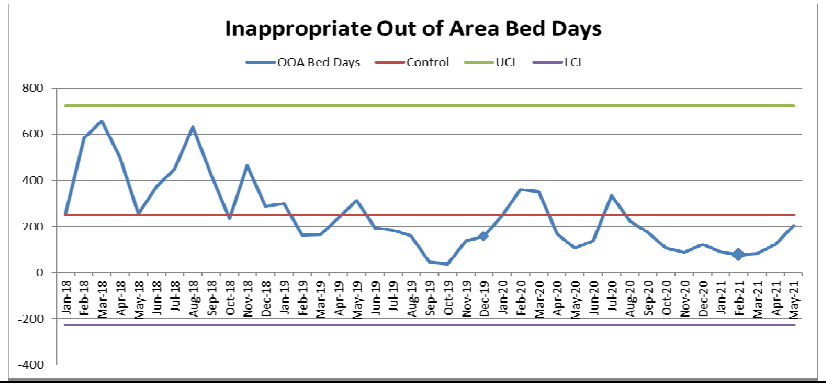
Data quality:

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.

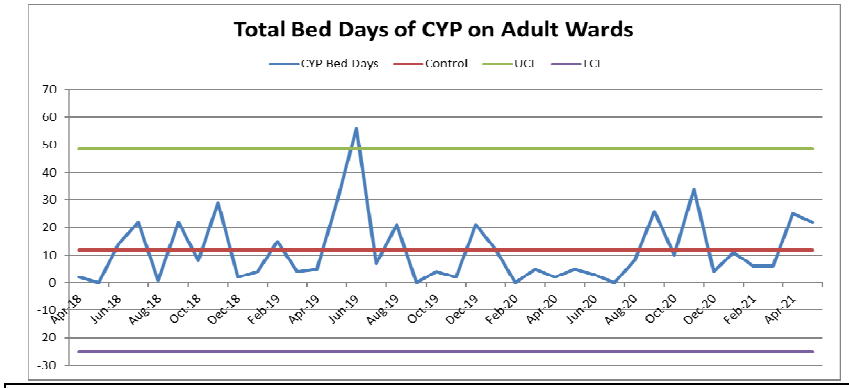
For the month of May the following data quality issues have been identified in the reporting:

- The reporting for employment and accommodation for May shows 14.0% of records have an unknown or missing employment and/or accommodation status, this is in line with April which showed 14.1% 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.

SPC Charts



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 points in December 2019 and February 2021 have been highlighted for this reason.



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 Jun-19.

This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU).

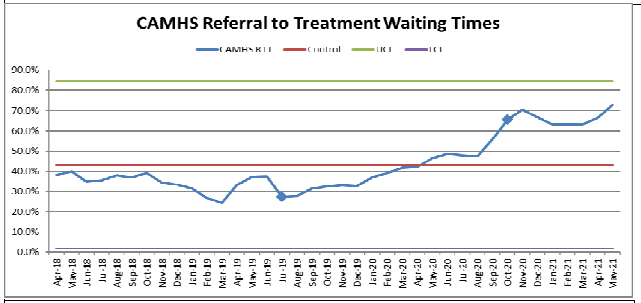
Barnsley mental health services and child and adolescent mental health services:

Mental Health:
Strengths
• In discussion with the Primary Care Network/GP Federation to develop the detail of the local transformation development plan. The proposal regarding a brief intervention service to support primary care (as part of additional roles reimbursement scheme) has been approved and scheduled for implementation in September 2021.
• Service resilience maintained. Contacts continue to be delivered by telephone/video link where practicable with face to face support offered as necessary.

Areas of focus
• Increased referrals and acuity – with associated increase in caseloads across core, enhanced and intensive home based treatment
• Urgent access (assessment within 4 hours) performance has improved with further focus through supervision on accurate/reliable inputting.
• Improving % service users on care programme approach (CPA) with a formal review within the previous 12 months with ongoing attention in supervision to recording
• Non-recurrent recovery investment made available by the CCG. Plans submitted to support caseload pressure in single point of access (SPA) and core/enhanced teams.
• IAPT waiting list initiative being developed with emphasis on group work. Implementation from July 2021.

CAMHS
Strengths
• Business continuity plans have to date been effective.
• Waiting numbers/times from referral to treatment being maintained in Barnsley

Areas of focus
• Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have significantly increased. Business case under consideration by CCG in Calderdale and Kirklees.
• Referral numbers placing pressure on waiting times in Calderdale/Kirklees and Wakefield. Medium term trajectory unclear. % treated within 18 weeks currently improving but this is unlikely to be maintained
• Crisis referrals. particularly in relation to eating disorders, are high. Tier 4 bed access remains problematic leading to inappropriate stays for children and young people in acute or Trust mental health beds.
• Staffing capacity issues across eating disorder pathway. Proactive discussion with CCGs regarding additional investment
• Small number of high risk cases in Wetherby Young Offenders' Institute. Unable to source appropriate specialist beds and placing pressure on CAMHS staffing resource.



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 October 2020 has been highlighted for this reason.

Barnsley general community services

Key Issues
• Yorkshire smoke free (YSF) Calderdale contract has been extended until 2023
• Urban House nurse prescriber role remains out for recruitment. No suitable temporary solution has been found through bank or agency. This is recognised as a risk on the BDU risk register.
• Ever increasing demands on services due to patient flow through the health care system and community services are picking up a significant proportion of that workload.
• Yorkshire smoke free Wakefield tender has been submitted

Strengths
• All health and wellbeing and children's service areas performing well with positive commissioner feedback
• Flexible and adaptable teams that are looking at new ways of working to meet the challenges of the workload with the current workforce.
• First meeting of the Barnsley Integrated Stroke Services Improvement Group took place this week. The purpose of this group is to implement, facilitate and monitor performance of the Barnsley integrated community stroke service including inpatient rehab beds and early supported discharge.

Challenges
• Commencement of the organisational change process across the integrated neighbourhood teams for the crisis response pathways
• Recruitment of the nurse prescriber for Urban House
• Podiatry has increased amount of wound care referrals.

Areas of Focus
• Developing an integrated lymphoedema pathway with the Hospice
• Mobilising the Breathe service ready for go live on 1st July
• Work is ongoing within neuro rehabilitation to review pathways in line with CCG request
• Aiming to improve job satisfaction of podiatrists while maintaining the caseload.

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:

Forensics
• OPEL Level remains at level 2.
• Work on the Adult Secure Provider Collaborative continues with an earliest revised 'go live' date of 1st August 2021
• Services are clinically very acute particularly Sandal, Hepworth, Bronte and Newhaven.
• Staff supervision levels 74% in medium secure, 89% in low secure and 79% in Newhaven, with ongoing work ongoing to ensure they reach target by the end of this quarter.
• Staffing levels remain under constant review, with skill mixing seeming to have supported easing the pressure.
• Staff wellbeing remains a focus, with the service utilising recent NHS survey results to modify plans.
• Focus on recruitment and retention continues. Forensics have piloted a survey around retention. The uptake was very encouraging, and the results will be analysed and actions to address issues developed.

Learning Disability services
• OPEL level remains at level 2
• Supervision is currently 77%
Community:
• Referral rates continue to be 20-30% higher than 20/21 and are roughly at the level seen pre-pandemic.
• There is some pressure building on certain waiting lists, particularly for psychological therapies, but generally whole team waiting times are within commissioned limits (18-weeks).
• Face to face contacts continue to represent about 50% of total activity with other contacts mostly via telephone.
• Staff are continuing to work in a 'blended' way (working from home or in base) but spending increasing time in our Learning Disability hubs.
• The continued medical staffing pressures in Calderdale (due to absence and lack of locum availability) is impacting on delivery of some services (responsiveness of medical input to requests) and starting to affect other learning disability and mental health services.
Inpatients:
• Commissioned bed occupancy is at 83% (5/6 commissioned beds), with high support needs of patients
• Delayed Transfers of Care have increased and whilst there is some movement this is slow. Some patients are still significantly delayed, without onward moves identified.
• High bank/agency use continues, though this is being supported by safer staffing team with block bookings.
• Significant turnover of substantive staff (leavers and new starters) and further vacancies
• The Trust form part of the regional (West Yorkshire and Barnsley) ATU service, with new contractual arrangements expected to be in place from 1st October 2021
• Quality monitoring visit (QMV) Action Plan is in place and being implemented

ASD/ADHD
• There has been a surge in referrals for assessment.
• Supervision is currently at 65%
• The Government in Iceland has invited the team to present the work they have been doing with local universities on ADHD.

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Inpatient:
• Maintaining patient flow and facilitating sufficient ward capacity has been challenging and whilst use of acute beds out of area has been kept to a minimum, there have been acute out of area placements particularly in response to demand for male admissions. The use of PICU (psychiatric intensive care unit) out of area beds is mainly attributable to gender specific and safeguarding clinical reasons although bed availability has become a factor. High demand for inpatient beds continues. Concerted work on optimising patient flow is continuing and the service is now fully recruited and is providing a 7 day a week service.
• Following two incidents which occurred within unsupervised garden areas on the working age adult wards, a decision was taken to restrict all garden access to supervised access only. This was until a more detailed risk assessment of the garden areas and process for risk assessing unsupervised access to outdoor areas could be undertaken through the implementation of a risk assessment tool developed in conjunction with the Health and Safety team. The tool has been presented to EMT and is currently being reviewed by the executive trio and the service will receive feedback. The blanket restriction will remain in place until this process is complete and the tool is approved and operational.
• The wards continue to deal with Covid-19 requirements for admission and episodic testing, and routine or infection related isolation and quarantining arrangements. Cohorting standard operating procedures to support the separation of people with symptoms or a positive Covid-19 diagnosis are in place for acute and older people's services together with an inpatient clinical pathway for Covid-19 positive patients. This is proving a robust framework within the parameters of demand and limitations of estate.
• Acute wards continue to see high levels of acuity and service user distress, with further challenges as above in managing isolated and cohorted patients. The difficulties have been compounded by staff absences and difficulties sourcing bank and agency staff leading to some staffing shortages across the wards. Senior leadership is available to the wards 7 days a week from matrons on site. Staffing levels have been maintained at safe levels with bank and agency staff and by utilising a trust-wide approach to staffing where possible. Continued weekly meetings are taking place with mental health partners across the integrated care systems have enabled the strengthening of collaborative approaches, shared learning and innovative practice developments. Bed occupancy levels have remained consistently high even when moderated by the need for isolation areas, extra care zones and cohorting.

Community:
• Work 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 continued developments in the trauma informed personality disorder (TIPD) pathway. Work continues in the intensive home based treatment teams (IHBT) to look at building up early discharge, alternatives to admission and to ensure robust gatekeeping. A gatekeeping review of admissions has taken place to inform learning and planning around community alternatives to inpatient care and the learning from this is currently being collated and embedded across the system. We have currently strengthened our discharge coordination offer on the wards to complement this.
• Community services are providing 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. We are optimising our use of space across Trust sites so that group work and more face to face therapies can be delivered, and currently reviewing space utilisation in each building to optimise clinical capacity.
• There has been an impact on prevalence rates for IAPT as a consequence of the Covid-19 period. IAPT access has been lower over the last year as a consequence of limitations on access to primary care, as the main referral method into the service is GP directed self-referrals. Referral figures for recent months are showing a sustained increase and demand is now growing.
• Demand into single point of access (SPA) continues to increase, leading to significant pressure in the service and necessitating the use of additional staff and sessions for assessment slots. We are seeing a notable growth in self referrals. SPA is prioritising risk screening all referrals to ensure any urgent demand is met within 24 hours but routine triage and assessment is now at risk of being delayed. The situation is being kept under close review by General Managers and teams and all mitigations are in place.

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

- Coronavirus update sent out weekly to all staff and governors
- Coronavirus sections on the intranet and website maintained and updated.
- Sharing of staff and service user good news stories, internally, externally and through social media channels
- Coronavirus vaccination comms, general focused and targeted. Supporting the decommissioning of the Trust vaccine hub and planning for staff celebration/thank you
- Communication on Trust leadership changes, both internally and to partners
- Continued promotion of 'Choose Well for Mental Health' guide; internally, on social media channels and with partners, alongside award submissions
- Staff wellbeing initiatives promoted e.g. launch of 'Menopause Mondays' and sleep seminars
- Design and print of materials continuing for services and corporate functions
- Awareness days and weeks supported on social media and in internal communication channels, including LD week, nutrition and hydration week, volunteers week, carers week.
- Information governance campaign- continued support and new comms plan developed.
- Nhs.net removal and Trust email accreditation comms planning
- Forensic improvement programme - continued support
- Supporting patient experience and feedback - Friends and family test relaunch, mental health act reforms and the community mental health survey
- Partner Bronze command meetings continue to taking place in all areas
- Supported the launch of Barnsley 2030, and the QUIT programme.
- Support provided to EyUp Charity, Creative Minds, Spirit in Mind and Mental Health Museum
- New intranet development project supported – migration of information and site development.
- Promotion of West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICS' initiatives and campaigns.

Engagement, Equality and volunteering update

- EIA process and forms reviewed and presentation at OMG to capture feedback. EIA process to be taken to EMT for approval
- Resources to support the EIAs are available for the intranet, due to delays we are awaiting an opportunity to upload the resources which includes links to BI intelligence and local authority needs assessments
- Website material is also ready for upload once the platform is in place following work to improve
- Virtual Visitor is now called 'CHATpad' and devices have been updated and leaflets and instructions reissued. The new version includes links to advocacy and access to our survey tool 'Healthcare Comms'
- Work is still progressing to launch the equality data improvement campaign – the Trust will use a previous campaign and refocus.
- Awareness raising training planned for specific groups starting with Transgender Awareness, which has been well received and more sessions arranged
- Trust wide EECM strategy short film has been signed off by the now named Equality, Inclusion and Involvement Committee (EIIC)
- The draft easy read strategy has also been reviewed and will be shared for comment with staff and service users
- Work continues to support recovery planning continues using insight and intelligence to inform decision making
- A quarterly insight report has now been developed and the format agreed. The report has been shared at EIIC and through to Governors who contribute to the report. Healthwatch provided positive feedback on the format and will use the insight feed in route to provide additions
- A programme update on the strategy action plans has been agreed by EIIC and KPIs will be developed.
- Support for Older People transformation consultation in partnership with CCGs and the development of a plan, timeline and governance
- Training bid developed to identify funding to refresh mandatory equality training and create short films to support the online EIA toolkit
- Working with Voluntary and Community Sector VCS umbrella organisations to support the mapping of local groups and allocation of small grant fund opportunities is part of our planned approach to engaging communities
- Provided an update on the Trust response to the 8 actions to address inequalities at the June EIIC
- Working on the addressing inequalities agenda in Calderdale and leading on a composite report of insight to inform the approach
- Working in Barnsley to support the development of an engagement and communication approach which includes developing a shared set of principles
- Working closely with the Mental Health Alliance to support a partnership approach to involvement which includes a development session and plan to support the programme of work for mental health
- Process to support SEQUIN submission for secure services continues with monthly updates forming part of core work
- Carers lead now in post following a successful charitable funds application
- Payment for involvement policy now being looked at and a draft will be circulated for comment by EMT in the next month
- Community reporter post which were part of a successful bid to charities commission focussed on BAME staff and BAME communities is being rolled out further in Calderdale, Kirklees and Wakefield
- Senior Peer Support worker has delivered a staff event and the action plan for the forthcoming year is in development. A co-designed training package and resources for peer workers is being delivered initially in recovery colleges
- Draft strategy for volunteering developed and a framework to support volunteers is in place, the strategy has been reviewed by Trust staff and volunteers and is near completion. The Volunteer policy has been updated in line with the strategy.
- Volunteers are starting to return with support and guidance. The return of volunteers will be supported by ESR training and DBS refresh

Overall Financial Performance 2021/22

Executive Summary / Key Performance Indicators

Performance Indicator		Year to Date	Forecast 2021/22	Narrative
1	Surplus / Deficit	£1.3m	£0m (H1 21/22)	In May a surplus of £0.7m has been reported which is favourable to plan. The forecast position for the first half of the year will be assessed by the end of the first quarter. Currently delivery of the breakeven target is forecast.
2	Agency Spend	£1.1m		Agency run rate continues to be in line with that from the previous financial year with spend of £0.6m. The largest single areas continue to be in medical staffing covering vacancies and in unregistered nursing to support both backfill of vacancies and safer staffing requirements.
3	Cash	£61.3m	£54.4m	Cash in the bank continues to be positive although this is forecast to reduce in year due to the higher level of planned capital investment.
5	Capital	£0.3m	£9.6m	The capital programme for 2021 / 22 has been agreed as £9.6m. Spend to date is £0.3m as plans for the full year programme of work are developed.
6	Better Payment Practice Code	97%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 97% of invoices have been paid within 30 days for the year to date. On average non NHS invoices have been paid in 11 days from receipt.

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

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%	4.0%	4.0%	3.9%	4.0%	4.3%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	3.9%	3.9%	4.0%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%	4.0%	4.0%	3.9%	4.0%	4.3%
Staff Turnover	Improving Resources	Well Led	AD	10%	8.5%	7.9%	9.8%	8.4%	9.1%	8.9%	9.3%	9.3%	9.9%	10.0%	10.0%	10.3%	15.6%	14.7%
Gross Vacancies	Improving Resources	Well Led	AD	-	Reporting Commenced April 2021												10.8%	5.5%
Net Vacancies	Improving Resources	Well Led	AD	-													2.9%	0.6%
Aggression Management	Improving Care	Well Led	AD	>=80%	85.5%	85.5%	85.5%	85.5%	86.5%	86.0%	86.3%	85.4%	85.1%	84.1%	84.1%	82.3%	80.7%	79.95%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80%	89.4%	89.4%	89.4%	89.4%	90.3%	89.4%	88.7%	88.2%	86.2%	85.2%	84.5%	81.7%	78.8%	77.7%
Clinical Risk	Improving Care	Well Led	AD	>=80%	93.7%	93.7%	93.7%	93.7%	93.8%	93.6%	93.3%	93.2%	94.1%	93.3%	93.1%	93.5%	94.6%	94.9%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.7%	95.7%	96.0%	95.7%	95.7%	95.5%	95.6%	95.5%	95.6%	95.5%
Fire Safety	Improving Care	Well Led	AD	>=80%	93.7%	93.7%	93.7%	93.7%	93.9%	93.4%	92.8%	91.8%	87.9%	86.9%	87.6%	86.2%	85.9%	84.3%
Food Safety	Improving Care	Well Led	AD	>=80%	76.9%	76.9%	76.9%	76.9%	78.3%	76.7%	76.8%	76.5%	75.8%	74.8%	75.9%	75.3%	76.3%	77.2%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	95.8%	95.8%	95.8%	95.8%	96.2%	96.0%	96.1%	96.0%	95.6%	95.0%	94.7%	94.3%	94.0%	94.2%
Information Governance	Improving Care	Well Led	AD	>=95%	98.2%	98.2%	98.2%	98.2%	98.8%	98.8%	98.9%	98.8%	98.5%	97.5%	97.8%	97.9%	96.6%	95.7%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	95.0%	95.0%	95.0%	95.0%	95.5%	95.6%	95.5%	95.1%	95.0%	95.0%	95.1%	94.9%	95.1%	95.7%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80%	93.3%	93.3%	93.3%	93.3%	94.6%	94.3%	94.8%	94.9%	95.0%	94.6%	93.9%	91.0%	90.8%	88.9%
Mental Health Act	Improving Care	Well Led	AD	>=80%	89.5%	89.5%	89.5%	89.5%	91.2%	90.8%	91.4%	91.9%	92.1%	91.3%	90.5%	85.0%	85.1%	82.0%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	74.9%			79.3%			80.6%			81.3%			Due July 2021	
Prevent	Improving Care	Well Led	AD	>=80%	93.2%	93.2%	93.2%	93.2%	94.6%	94.6%	94.4%	95.3%	95.7%	95.6%	95.6%	95.6%	95.6%	95.3%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	96.2%	96.2%	96.2%	96.2%	92.8%	92.8%	93.0%	92.8%	93.9%	94.0%	94.2%	94.0%	94.7%	94.7%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	92.4%	92.4%	92.4%	92.4%	93.6%	93.6%	93.3%	92.8%	93.2%	93.1%	93.6%	93.5%	93.3%	93.4%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	96.9%	96.9%	96.9%	96.9%	96.8%	96.8%	No longer used							
Bank Cost	Improving Resources	Well Led	AD	-	£727k	£866k	£721k	£687k	£778k	£907k	£915k	£889k	£944k	£946k	£682k	£1,120k	£803k	£911k
Agency Cost	Improving Resources	Effective	AD	-	£469k	£507k	£518k	£558k	£606k	£588k	£604k	£573k	£686k	£587k	£562k	£760k	£583k	£560k
Overtime Costs	Improving Resources	Effective	AD	-	£196k	£382k	£342k	£257k	£276k	£213k	Data unavailable at the time of producing this report							
Additional Hours Costs	Improving Resources	Effective	AD	-	£58k	£61k	£66k	£71k	£59k	£53k								
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£374k	£388k	£399k	£408k	£411k	£387k								
Vacancies (Non-Medical) (WTE)	Improving Resources	Well Led	AD	-	222.1	222.1	192.3	208.9	205.9	234.0								
Business Miles	Improving Resources	Effective	AD	-	193k	149k	138k	164k	166k	147k								
Health & Safety																		
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	7			3			14			7			Due July 2021	

Covid-19

KPI Additional Metrics to Highlight Response to and Impact of Covid-19	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	As at 22nd December 2020	As at 19th January 2021	As at 18th February 2021	As at 24th March 2021	As at 20th April 2021	As at 20th May 2021	As at 22nd June 2021	Trend	Notes
No of staff off sick - Covid-19 not working 7	N/A	**154**	**204**	**112**	**48**	**26**	**82**	**108**	**161**	**81**	**159**	**91**	**89**	**33**	**15**	**32**		
Shielding		54	59	52	37	0	0	0	29	0	48	42	50	1	0	0		
Symptomatic		69	118	46	5	14	31	57	51	45	64	29	19	16	2	8		
House hold symptoms		26	24	13	4	7	29	31	25	10	19	4	10	5	3	6		
OH Advised Isolation		5	1	0	0	1	1	2	2	0	0	1	1	1	0	0		
Test & Trace Isolation		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Other Covid-19 related		0	2	1	2	4	21	18	54	25	28	15	9	10	10	18		
No of staff working from home - Covid-19 related 8		**125**	**136**	**107**	**90**	**7**	**53**	**79**	**147**	**35**	**84**	**78**	**88**	**16**	**8**	**21**		
Shielding		76	78	72	71	0	0	0	77	0	49	54	74	8	0	0		
Symptomatic		13	28	13	5	1	14	29	16	8	9	4	3	2	2	3		
House hold symptoms		29	23	13	1	0	26	21	33	14	6	10	4	1	3	8		
OH Advised Isolation		7	6	7	3	0	1	5	1	1	4	2	2	1	1	0		
Test & Trace Isolation		0	0	0	7	0	0	0	0	0	0	0	0	0	0	0		
Other Covid-19 related		0	1	1	3	6	12	24	20	12	16	8	5	4	2	10		
Number of staff tested 9		89	783	1798	2038	2162	2294	2498	2917	3098	3241	3353	3386	3386	3386	3386		Cumulative
No of staff tested positive for Covid-19 10		23	103	128	130	133	149	217	398	462	545	598	610	610	610	610		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%	2339/2455 =95.3%	2381/2608 =91.3%	2588/2758 =93.8%	2605/2780 =93.7%	2775/2823 =98.3%	2813/2836 =99.2%	2828/2882 =98.1%		
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%	1492/1580 =94.4%	1533/1695 =90.4%	1723/1834 =93.9%	1726/1846 =93.5%	1858/1895 =98.0%	1885/1905 =99.0%	1890/1928 =98.0%		
No of staff still absent from work who were Covid-19 positive 12		Data Unavailable	27	11	2	1	5	29	32	28	43	22	13	13	0	0		
Additional number of staff enabled to work from home		900	900	937	1003	1024	1043	1069	1095	1168	1175	1306	1369	1281	1271	1223		Cumulative
Calls to occupational health healthline		178	576	921	1230	1450	1536	1780	1967	2109	2274	2451	2565	2655	2713	2798		Cumulative

Staffing Issues

Our current response to Covid-19 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 staff bank capacity in light of recent increase in recruitment
- Continue to follow government guidance e.g. social distancing, wearing of masks, working from home where possible

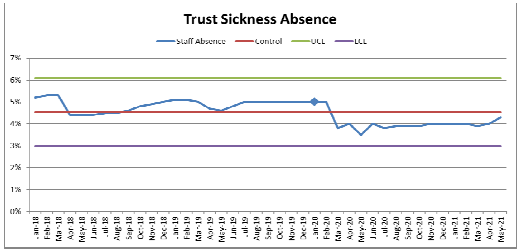
Staff Health & Well Being

- 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. 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.
- We continue to provide and use lateral flow tests for many of our staff.

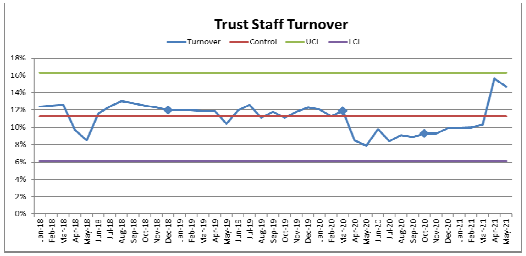
Workforce Issues

- As at 22nd June, 32 staff off work Covid-19 related, not working which compares to 15 one month earlier. A further 21 were working from home.
- 3386 staff tested for Covid-19 as at 22nd June.
- 610 staff have tested positive for Covid-19, none of which tested positive within the last month.
- Staff turnover decreased slightly to 14.7% in May.
- Non-Covid sickness absence increased slightly to 4.3% in May. This still compares favourably to previous years.

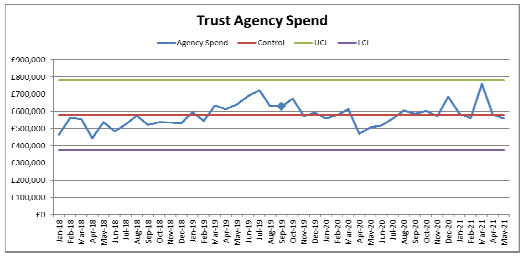
SPC Charts



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 points in January 2020 and September 2020 have been highlighted for this reason.



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 October 2020 has been higlighted for this reason. Turnover has been lower since the onset of the Covid-19 pandemic.

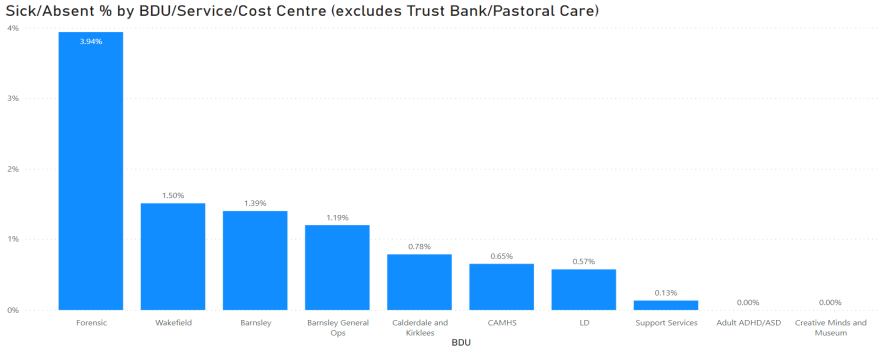


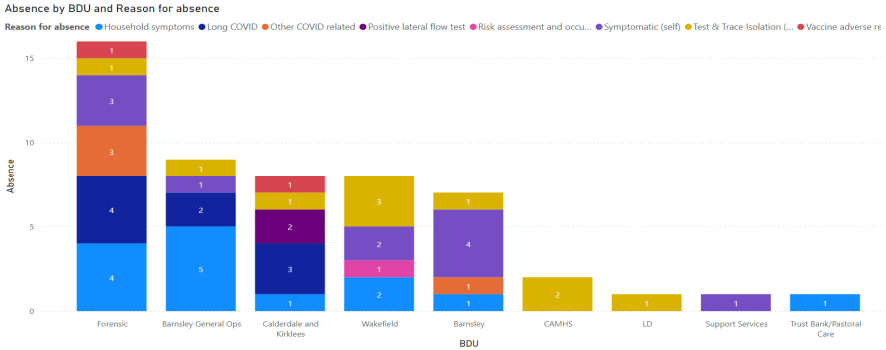
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in September 2019 has been highlighted for this reason.

Sickness reporting

As at 22nd June, the Trust has 54 staff absent or working from home due to Covid-19. This makes up 1.0% of the workforce. Of those absent, 27.8% are symptomatic and 25.9% have household symptoms. The business delivery unit (BDU) with the biggest impact is Forensic with 3.9% of staff impacted

- Bank and agency availability is continually 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-19 symptoms (based on absence start date) was 4.6 days in May.





Publication Summary

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

Department of Health and Social Care (DHSC)

Mental Health Units (Use of Force) Act 2018 statutory guidance
The DHSC is seeking views on draft statutory guidance to prevent the inappropriate use of force and ensure transparency and accountability about the use of force in mental health units. The guidance is intended for use by NHS hospitals and independent hospitals (providing NHS-funded care) in England providing care and treatment to patients with a mental disorder. This consultation closes on 17 August 2021.

Click here for link to guidance

Statistics on NHS Stop Smoking Services in England: April to December 2020

NHS Providers: children and young people's mental health survey

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 2
(2021 / 22)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

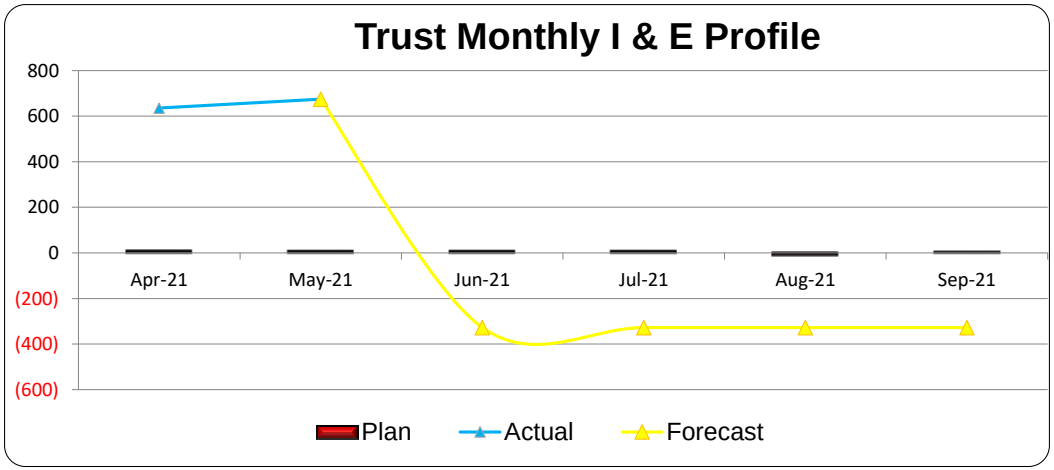
1.0	Executive Summary / Key Performance Indicators			
Performance Indicator		Year to Date	Forecast 2021 / 22	Narrative
1	Surplus / (Deficit)	£1.3m	£0m (H1 21/22)	In May a surplus of £0.7m has been reported which is favourable to plan. The forecast position for the first half of the year will be assessed by the end of the first quarter. Currently delivery of the breakeven target is forecast.
2	Agency Spend	£1.1m		Agency run rate continues to be in line with that from the previous financial year with spend of £0.6m. The largest single areas continue to be in medical staffing covering vacancies and in unregistered nursing to support both backfill of vacancies and safer staffing requirements.
3	Cash	£61.3m	£54.4m	Cash in the bank continues to be positive although this is forecast to reduce in year due to the higher level of planned capital investment.
4	Capital	£0.3m	£9.6m	The capital programme for 2021 / 22 has been agreed as £9.6m. Spend to date is £0.3m as plans for the full year programme of work are developed.
5	Better Payment Practice Code	97%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 97% of invoices have been paid within 30 days for the year to date. On average non NHS invoices have been paid in 11 days from receipt.

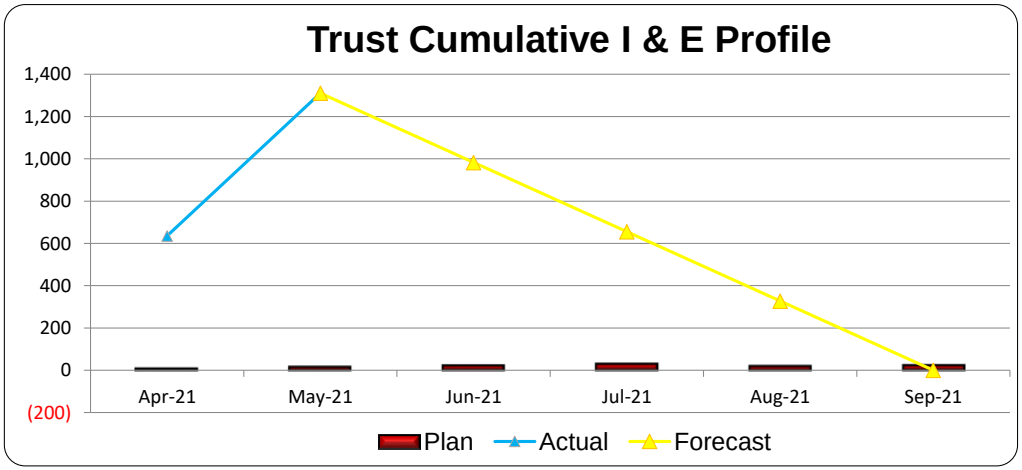
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

2.0 Income & Expenditure Position 2021 / 2022

Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Draft Budget	Year to Date Actual	Year to Date Variance	Budget M1 - M6	Forecast M1 - M6	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				20,705	20,725	20	Clinical Revenue	41,422	41,403	(19)	124,438	124,622	184
				20,705	**20,725**	**20**	**Total Clinical Revenue**	**41,422**	**41,403**	**(19)**	**124,438**	**124,622**	**184**
				1,079	1,132	53	Other Operating Revenue	2,076	2,290	214	6,359	6,863	504
				21,784	**21,857**	**73**	**Total Revenue**	**43,498**	**43,693**	**195**	**130,797**	**131,485**	**688**
4,715	4,454	(261)	5.5%	(17,392)	(16,641)	750	Pay Costs	(34,649)	(33,251)	1,398	(104,137)	(101,329)	2,808
				(3,638)	(3,783)	(145)	Non Pay Costs	(7,338)	(7,617)	(279)	(22,148)	(25,612)	(3,464)
4,715	**4,454**	**(261)**	**5.5%**	**(21,029)**	**(20,425)**	**605**	**Total Operating Expenses**	**(41,987)**	**(40,868)**	**1,119**	**(126,285)**	**(126,941)**	**(656)**
4,715	**4,454**	**(261)**	**5.5%**	**755**	**1,432**	**677**	**EBITDA**	**1,511**	**2,825**	**1,314**	**4,512**	**4,544**	**32**
				(537)	(545)	(9)	Depreciation	(1,073)	(1,090)	(17)	(3,220)	(3,272)	(52)
				(212)	(212)	(0)	PDC Paid	(424)	(424)	(0)	(1,271)	(1,272)	(1)
				0	0	0	Interest Received	0	0	0	0	0	0
4,715	**4,454**	**(261)**	**5.5%**	**6**	**675**	**669**	**Surplus / (Deficit)**	**14**	**1,311**	**1,297**	**21**	**(0)**	**(21)**
				0	0	0	Gain / (loss) on disposal	0	0	0	0	0	0
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,715	**4,454**	**(261)**	**5.5%**	**6**	**675**	**669**	**Surplus / (Deficit)**	**14**	**1,311**	**1,297**	**21**	**(0)**	**(21)**

The Trust's financial plan, in line with national guidance, covers the period H1 2021 / 22 (April to September 2021) only. The forecast shown similarly reflects this period only. Forecasts will assessed by the end of the first quarter. Development of the H2, and longer term plan, continues with a focus on recurrent and non recurrent run rates.





Income & Expenditure Position 2021 / 22

The Trust has agreed a breakeven financial plan for April to September 2021. This forms part of a consolidated Integrated Care System (ICS) financial plan.

For April to September 2021 the Trust has an operational plan to deliver a breakeven position. This is based on estimated expenditure run rates and updated funding available. This includes non recurrent funding allocated through the Integrated Care System (ICS).

Income

Income for H1 will follow the principles applied to H2 2020 / 21. Commissioner income is received as single block payments which are based on the original national funding calculation and additional Mental Health Investment Standard (MHIS) funding for 2020 / 21. New investments which have been discussed, and awaiting final formal confirmation for 2021 / 22, will be added once agreed.

Other income streams, such as local authorities, continue as normal with standard contracting arrangements in place.

In May income received from these contracts was £20.7m and in line with plan.

Pay

Pay Spend in May 2021 is £16.6m. This is the same as April 2021 and is approximately £0.3m higher than the run rate in Q4 2020 / 21. This is due to a higher number (35 wte) of staff as detailed on the pay analysis page than the average in 2020/21. Further analysis has been included to highlight the variations by staff group and service line.

Utilisation of temporary workforce options, including bank, agency and overtime payments has continued. Bank and agency accounted for 8.8% of overall pay expenditure. The headlines behind this request are covered within the pay analysis section.

Non Pay

Non pay expenditure continues to have specific areas of variability. These are subject to specific focus later in the report and include out of area bed placements and the purchase of locked rehab beds. Covid-19 response spend continues to be closely monitored; it has been confirmed that national supply of PPE will continue for 2021 / 22.

Covid-19 Financial Impact

Covid-19 continues to have an impact on our financial position and the table below highlights 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.

In line with the principles established in H2 20/21 funding for additional covid-19 costs has been provided prospectively through the West Yorkshire ICS. Reporting continues via the monthly NHS Improvement financial return with the expenditure summarised below.

Costs are reviewed and agreed through the Trust Operational Management Group to ensure that expenditure continues to provide the best possible service and value for money. This also ensures that the approach is joined up across the Trust.

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Total
Heading	**Description**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Staffing -	Additional staff costs to support Trust workforce response. Includes acting up and backfill arrangements	22	51					**73**
Staffing - vaccination	Additional staff costs to support vaccination programme (including overtime)	33	62					**95**
Staffing -	Isolation, shielding and backfill for covid absence	56	15					**71**
Total – Pay		**110**	**128**	**0**	**0**	**0**	**0**	**238**
Lateral Flow Testing	Distribution of kits to staff	7	2					**9**
Laundry & Scrubs	Purchase of scrubs for staff and associated laundry costs	2	1					**3**
IT	Purchase of equipment and agile working enabling costs (VPN)	0	35					**35**
OOA Placements	Out of area bed placements required to covid issues	0	6					**6**
Misc / other	Other general non pay not captured in the headings above	0	15					**15**
Total – Non Pay		**8**	**59**	**0**	**0**	**0**	**0**	**67**
Total cost recovery		**119**	**187**	**0**	**0**	**0**	**0**	**305**

2.1 Income Information

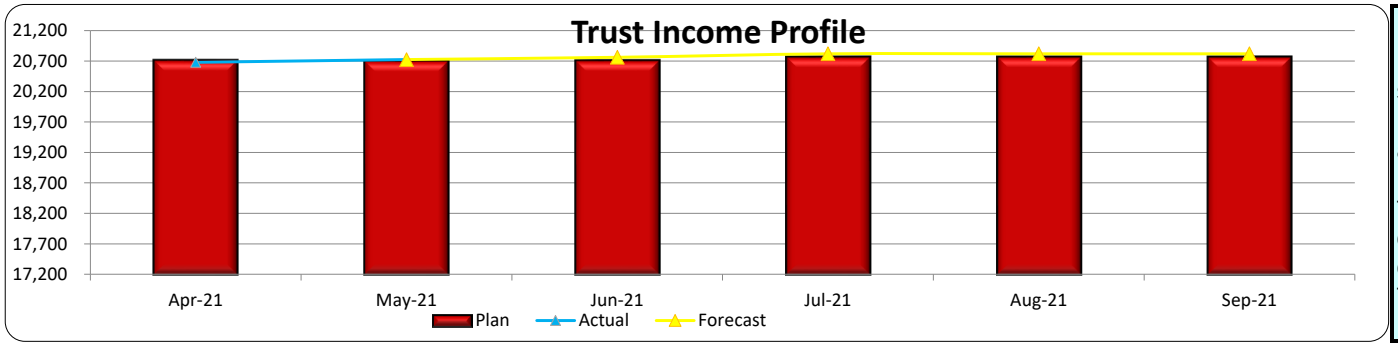
Within the Trust Income and Expenditure position clinical revenue is separately identified. This is income received through contracts to provide clinical services. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income.

The financial arrangements have been set for April to September 2021 (H1 2021 / 22). These are the same as H2 2020 / 21 with income received via block contracts from our main commissioners. The block is a combination of national calculation and agreed locally funding for the Mental Health Investment Standard (MHIS) in 2020 / 21. Additional MHIS funding for 2021 / 22 will be added as and when confirmed with commissioners.

These block payments cover all income from NHS commissioners. This includes payment for clinical services, staff recharges, recharge for projects etc.

The arrangements for October 2021 to March 2022 are yet to be confirmed.

	Apr-21 £k	May-21 £k	Jun-21 £k	Jul-21 £k	Aug-21 £k	Sep-21 £k	Oct-21 £k	Nov-21 £k	Dec-21 £k	Jan-22 £k	Feb-22 £k	Mar-22 £k	Total £k	Total 20/21 £k
CCG	15,365	15,341	15,446	15,519	15,519	15,519							**92,709**	**177,447**
ICS / System	1,737	1,737	1,737	1,737	1,737	1,737							**10,421**	**9,917**
Specialist Commissioner	2,475	2,471	2,473	2,473	2,473	2,473							**14,837**	**28,281**
Local Authority	404	490	431	416	416	416							**2,572**	**5,025**
Partnerships	657	636	629	629	629	629							**3,810**	**7,514**
Top Up													**0**	**5,458**
Other	41	50	46	46	46	46							**274**	**4,815**
Total	**20,679**	**20,725**	**20,761**	**20,819**	**20,819**	**20,819**	**0**	**0**	**0**	**0**	**0**	**0**	**124,622**	**238,457**
20/21	18,391	17,940	18,386	18,443	18,711	19,214	20,108	20,016	20,370	20,748	20,089	26,040	**238,457**	



Due to it's block nature the income received in May 2021 is the same as April 2021. This will be updated as and when 2021 / 22 Mental Health Investment (MHIS) or additional funding is agreed.

The Trust has submitted a number of proposal to each commissioner outlining how additional non recurrent income could be utilised as part of the reset and recovery programme. These will also be added when agreed.

2.2 Pay Information

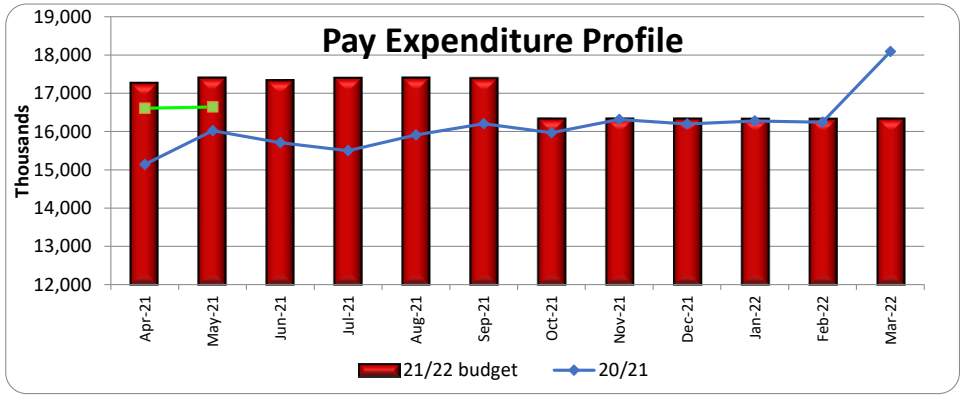
Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for 80% of our budgeted total expenditure. Trust priorities include a focus on the health and wellbeing of this workforce.

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-21 £k	May-21 £k	Jun-21 £k	Jul-21 £k	Aug-21 £k	Sep-21 £k	Oct-21 £k	Nov-21 £k	Dec-21 £k	Jan-22 £k	Feb-22 £k	Mar-22 £k	Total £k
Substantive	15,224	15,171											**30,395**
Bank & Locum	803	911											**1,713**
Agency	583	560											**1,143**
Total	**16,610**	**16,641**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33,251**
20/21	15,142	16,019	15,709	15,501	15,912	16,205	15,969	16,313	16,199	16,273	16,245	18,087	**168,476**

Bank as %	4.8%	5.5%											5.2%
Agency as %	3.5%	3.4%											3.4%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,100	4,076											**4,088**
Bank & Locum	255	263											**259**
Agency	107	115											**111**
Total	**4,461**	**4,454**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,457**
20/21	4,171	4,332	4,302	4,312	4,357	4,283	4,661	4,634	4,678	4,424	4,407	4,472	**4,419**



Spend in May 2021 is the same as April 2021 which is higher than the run rate in the previous year.

Increases for incremental pay rises are included in both the actuals and plan but no pay award assumption has been included yet for 2021 / 22 in line with guidance.

Additional estimates have been included in this position for 2021 / 22 Clinical Excellence awards and the current year impact of the Flowers legal case. These will be paid later in the year.

There has been a small reduction in substantive staff in month which has been offset by additional bank and agency so the overall workforce WTE worked has remained the same.

2.2 Pay Information

The overall Trust pay expenditure position includes different types of staffing and a wide variety of service lines and as a single value includes both under and overspends. This additional analysis provides a further level of detail and an indication of focussed action areas within the Trust.

Year to Date Budget v Actual - by staff group

Staff Group	Budget	Substantive	Bank / Locum	Agency	Total	Variance
	£k	£k	£k	£k	£k	£k
Medical	4,236	3,802	107	483	4,392	156
Nursing Registered	13,602	10,089	572	123	10,784	(2,818)
Nursing Unregistered	4,215	3,474	829	392	4,695	480
Other	9,217	8,111	85	136	8,331	(886)
Corporate Admin	2,806	2,597	53	8	2,658	(148)
BDU Admin	2,249	2,322	69	0	2,390	141
Vacancy Factor	(1,677)				0	1,677
Total	**34,649**	**30,395**	**1,713**	**1,143**	**33,251**	**(1,398)**

WTE In month Budget v Actual - by staff group

Staff Group	Budget	Substantive	Bank / Locum	Agency	Total	Variance
	WTE	WTE	WTE	WTE	WTE	WTE
Medical	225	187	2	16	204	(21)
Nursing Registered	1,468	1,224	72	14	1,310	(158)
Nursing Unregistered	867	713	159	73	944	77
Other	1,328	1,193	10	13	1,216	(112)
Corporate Admin	350	326	20	0	346	(4)
BDU Admin	477	433	0	0	433	(44)
Total	**4,715**	**4,076**	**263**	**115**	**4,454**	**(261)**

By staff group the key elements to highlight are:

In line with the trend of previous year there are vacancies within the registered nursing category although there is continued support internally through the use of bank shifts and overtime. This results in an underspend. Some of these vacancies are backfilled by temporary unregistered staffing options with high levels of both bank and agency staff.

Work continues to increase the number of registered nurses including overseas recruitment and additional substantive recruitment.

The financial plan includes a value relating to expected staff vacancies and posts not back filled. This value, shown seperately in these tables as Vacancy Factor, is a planning assumption and no posts are actively held. This is due to natural timing gaps in recruitment both for new investments and existing substantive posts.

Year to date Budget v Actual - by service

	Budget	Substantive	Bank / Locum	Agency	Total	Variance
	£k	£k	£k	£k	£k	£k
MH Community	14,704	12,815	345	574	13,734	(970)
Inpatient	7,783	6,574	1,103	498	8,175	392
BDU Support	2,115	1,241	72	15	1,328	(787)
Community	4,758	4,046	80	16	4,142	(616)
Corporate	6,966	5,719	114	39	5,872	(1,094)
Vacancy Factor	(1,677)				0	1,677
Total	**34,649**	**30,395**	**1,713**	**1,143**	**33,251**	**(1,398)**

In month Budget v Actual - by service

	Budget	Substantive	Bank / Locum	Agency	Total	Variance
	WTE	WTE	WTE	WTE	WTE	WTE
MH Community	1,797	1,599	39	25	1,664	(133)
Inpatient	1,141	969	189	83	1,241	100
BDU Support	352	213	7	0	220	(132)
Community	736	625	12	2	638	(98)
Corporate	689	669	17	5	691	2
					0	
Total	**4,715**	**4,076**	**263**	**115**	**4,454**	**(261)**

With the exception of Inpatient areas, which includes adult acute, older peoples and Forensics, all service groups are underspending and have unfilled posts. The corporate service line includes covid-19 spend which, as demonstrated earlier in the paper, is less than previously.

This information continues to inform the Trust workforce and recruitment strategy and the overall financial planning process.

2.2 Agency Expenditure Focus

Agency spend is £560k in May.

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.

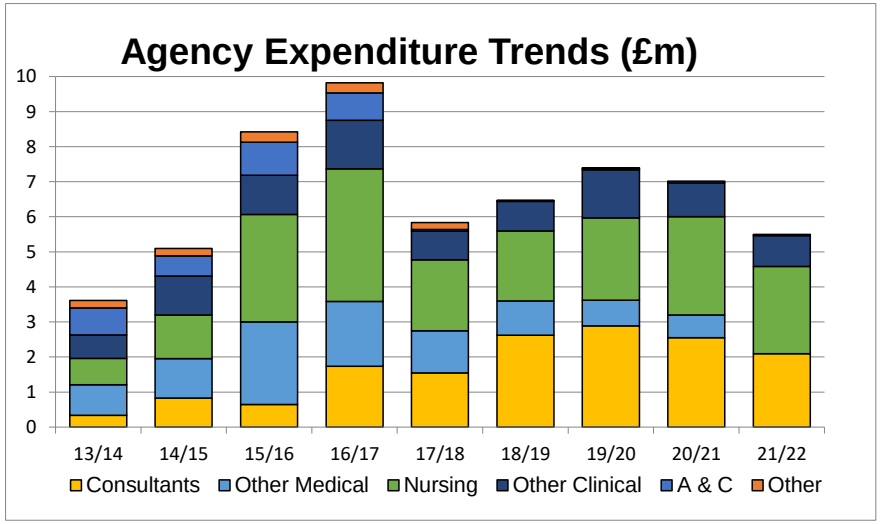
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

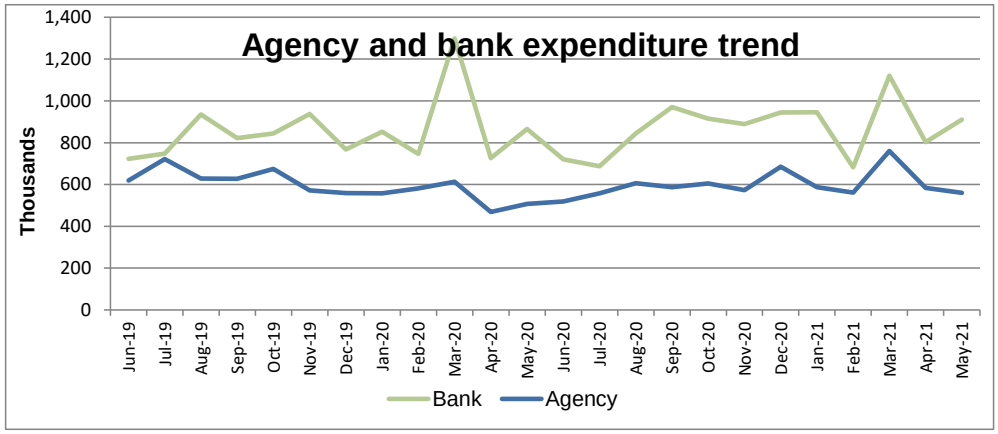
NHS E & I introduced a set of rules in April 2016 to support trusts to reduce agency spend and move towards a sustainable model of temporary staffing. Part of this support has been through the introduction of agency spend caps and suggested maximum pay rates.

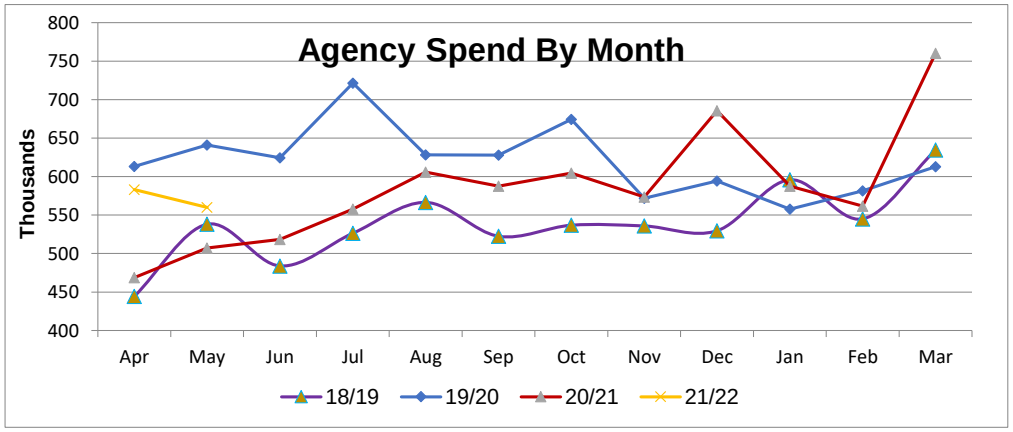
Due to covid 19 there is currently no agency cap for 2021/22, however controls remain the same. The Trust continue to submit the same detailed agency information to NHSI on a weekly basis. This information monitors both the volume of agency shifts utilised and performance against suggested maximum agency rates (caps). Shifts exceeding these caps continue to require appropriate prior approval including by the chief executive as previous.

May 2021 spend is £560k which is similar to previous run rates (2020/21 average was £585k per month). As noted on the previous page the main areas of agency usage are £233k in medics and £175k on unregistered nurses.

Triangulation continues to compare agency spend with substantive staff and bank staff payments.





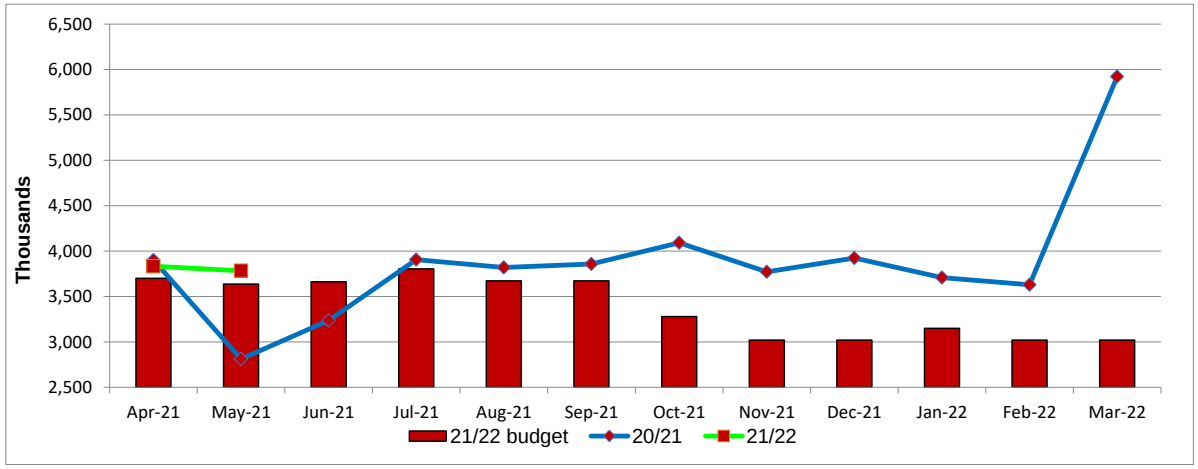


2.3 Non Pay Expenditure

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 excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position.

	Apr-21 £k	May-21 £k	Jun-21 £k	Jul-21 £k	Aug-21 £k	Sep-21 £k	Oct-21 £k	Nov-21 £k	Dec-21 £k	Jan-22 £k	Feb-22 £k	Mar-22 £k	Total £k
2021/22	3,834	3,783											**7,617**
2020/21	3,900	2,811	3,236	3,906	3,821	3,857	4,090	3,772	3,925	3,707	3,628	5,921	**46,574**

Non Pay Category	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	617	625	8
Establishment	1,267	1,311	44
Lease & Property Rental	1,248	1,324	76
Premises (inc. rates)	877	1,096	218
Purchase of Healthcare	1,115	1,169	54
Travel & vehicles	693	660	(33)
Supplies & Services	1,092	950	(142)
Training & Education	113	115	2
Clinical Negligence & Insurance	145	216	70
Other non pay	170	150	(20)
Total	**7,338**	**7,617**	**279**
Total Excl OOA and Drugs	**5,606**	**5,823**	**216**



Key Messages

The Trust non pay review group has re-commenced having been suspended in 2020/21 due to covid pressures. This group focuses specifically on non pay and ensuring that the Trust continues to secure value for money in this area. Budgets have been adjusted to take account of current working practices, and areas such as travel continue to be underspent against plan. This is because of the continued working arrangements in response to the pandemic.

Premises continues to be the largest variance to plan. The second largest is purchase of healthcare which, as per the separate analysis, includes out of area bed placements and the purchase of locked rehab beds. These continue to be pressured areas following the trend of the previous year.

2.3 Out of Area Beds Expenditure Focus

The heading of purchase of healthcare within the non pay analysis includes a number of different services; both the purchase of services from other NHS trusts or organisations for services which we do not provide (mental health locked rehab, pathology tests) or to provider additional capacity for services which we do.

Due to it's volatile, and potentially expensive nature, the focus has been on out of area bed expenditure. In this context this 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.

Breakdown of Purchase of Healthcare

	Budget	Actual	Variance
	Year to date	Year to date	
Heading	**£k**	**£k**	**£k**
Locked Rehab	380	533	(152)
Out of Area			0
Acute	209	24	185
PICU	127	24	103
Other Services	399	589	(190)
Total	**1,115**	**1,169**	**(54)**

Out of Area Expenditure Trend (£)

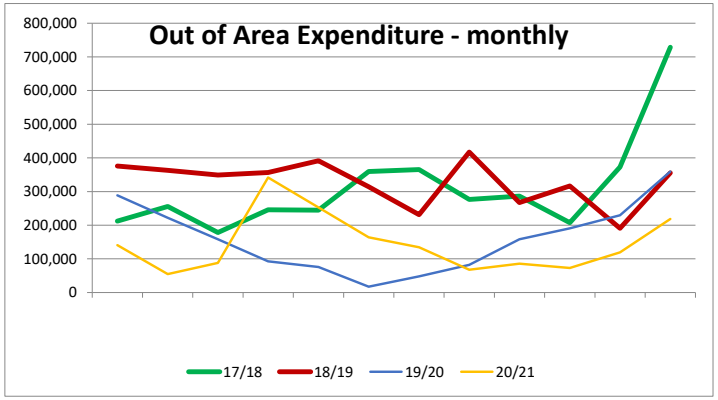
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**
19/20	289	222	158	93	76	17	48	82	158	191	230	359	**1,924**
20/21	141	55	88	342	253	164	135	68	86	73	119	218	**1,741**
21/22	195	251											**447**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
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	111	105	148	124	100	126	**1,526**
21/22	221	313											**534**

Bed Day Information 2021 / 2022 (by category)

PICU	208	241											**449**
Acute	13	72											**85**
Total	221	313	0	0	0	0	0	0	0	0	0	0	**534**



The overall delivery of activity remains a challenge for the Trust and, to date performance has exceptional in ensuring that as many people as possible are supported within the Trust bed base especially considering the impact that covid has had.

Spend of £251k in May 2021 represents the highest monthly expenditure since August 2020.

The response to Covid-19 continues to impact on demand and specific placements have been charged against the covid allocation. High levels of acuity have also been experienced adding to the pressure on inpatient wards.

The bed numbers of May 2021 also includes 48 bed days which are paid directly by the ICS. There is no cost included within the Trust financial position. This is an reduction from 55 in April 2021.

3.0 Balance Sheet 2021 / 2022

	2020 / 2021 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	104,978	102,755	Pg 14
Current Assets			
Inventories & Work in Progress	173	173	
NHS Trade Receivables (Debtors)	1,173	579	1
Non NHS Trade Receivables (Debtors)	1,828	1,252	2
Prepayments	2,867	1,827	
Accrued Income	3,090	4,922	3
Cash and Cash Equivalents	56,648	61,297	Pg 16
Total Current Assets	**65,781**	**70,051**	
Current Liabilities			
Trade Payables (Creditors)	(1,182)	(1,570)	4
Capital Payables (Creditors)	(585)	(360)	
Tax, NI, Pension Payables, PDC	(5,920)	(6,622)	
Accruals	(24,112)	(23,443)	5
Deferred Income	(3,981)	(4,602)	6
Total Current Liabilities	**(35,779)**	**(36,598)**	
Net Current Assets/Liabilities	**30,001**	**33,453**	
Total Assets less Current Liabilities	**134,980**	**136,208**	
Provisions for Liabilities	(7,348)	(7,265)	
Total Net Assets/(Liabilities)	**127,632**	**128,943**	
Taxpayers' Equity			
Public Dividend Capital	45,384	45,384	
Revaluation Reserve	11,721	11,721	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	65,307	66,618	7
Total Taxpayers' Equity	**127,632**	**128,943**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2021.

1. Due to the block nature of NHS contracts there are currently minimal NHS outstanding debtors. 100% of this value is less than 30 days old.

2. Non NHS debtors remain low and any timing issues from the move to the new system appears to have been resolved.

3. Accrued income remains high primarily due to additional income forecast from NHS England in March 2021 (£2.1m) relating to Flowers and annual leave payments. This is forecast to be received in August 2021. Outstanding purchase orders with local authorities have been chased and invoicing is expected in June 2021.

4. Creditors, invoices outstanding for the Trust to pay, continues to be closely reviewed alongside Better Payment Practice Code (page 17) performance.

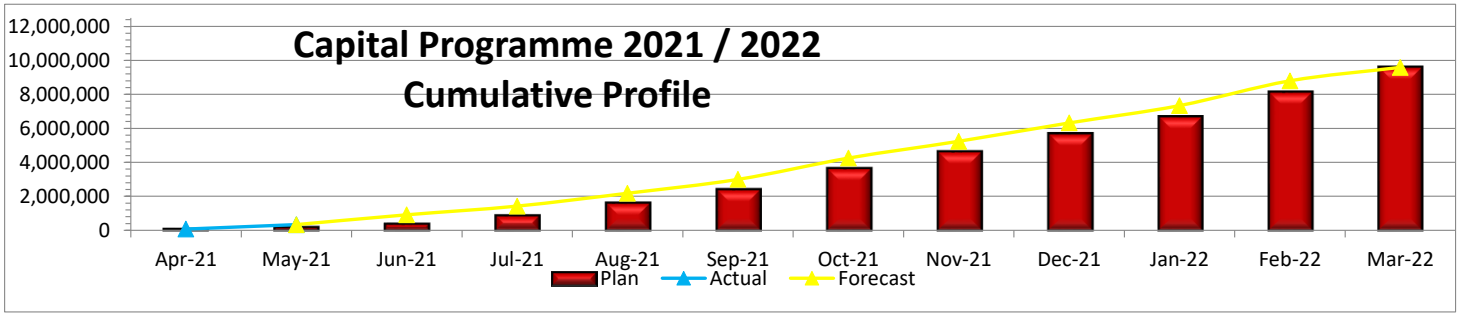
5. Accruals continue to be at a higher level than historically. Work continues to chase invoices etc to reduce this value.

6. Deferred income has increased from year end due to receipt of Q1 training and education in April 2021.

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

3.1 Capital Programme 2021 / 2022

	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
Major Capital Schemes							
En Suite	2,000	0	0	0	2,000	0	
OPS transformation	578	0	0	0	578	0	
Maintenance (Minor) Capital							
Routine Maintenance	3,194	200	72	(128)	3,246	52	
Fire Safety	160	0	0	0	160	0	
Plant & Machinery	455	0	0	0	455	0	
Equipment	100	0	0	0	100	0	
Fixtures & Fittings	45	0	0	0	45	0	
Other	643	0	256	256	464	(179)	
IM & T							
Clinical Systems	275	0	0	0	275	0	
Hardware	200	0	0	0	200	0	
Cybersecurity, Infrastructure	200	0	6	6	327	127	
Software	600	0	3	3	600	(0)	
Other	1,140	0	0	0	1,140	0	
VAT Refunds						0	
TOTALS	**9,590**	**200**	**338**	**138**	**9,590**	**0**	



Capital Expenditure 2021 / 22

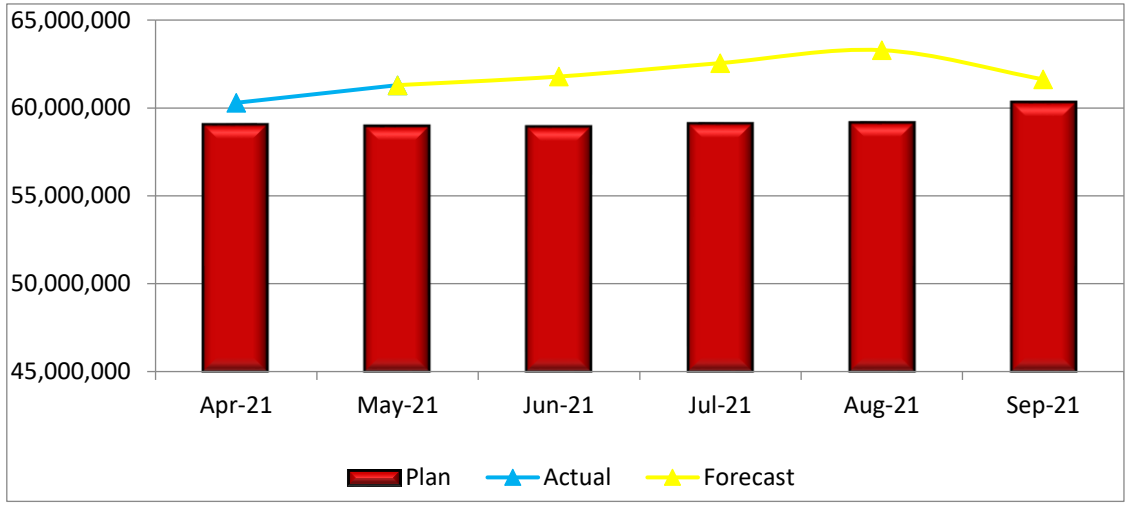
The Trust capital programme forms part of the overall ICS capital plan. For 2021 / 22 the Trust component is £9.59m

Minimal spend was planned for Q1 21//2 but preparatory work is continuing internally. This work has highlighted current increased costs and availability issue for resources. This is linked to Covid-19, Brexit, the Suez canal blockage and general demand.

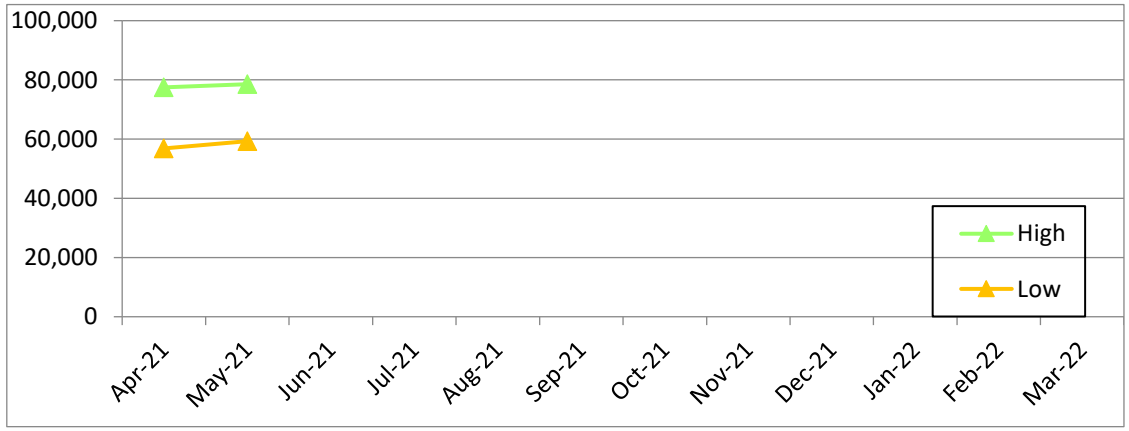
Schemes are contuinually assessed against evolving safety and service requirements and continue to be assessed to ensure they are value for money in the current climate.

Spend to date is mainly a new scheme required to enable relocation of services within Barnsley.

3.2 Cash Flow & Cash Flow Forecast 2021 / 2022



	Plan £k	Actual £k	Variance £k
Opening Balance	56,648	56,648	
Closing Balance	58,962	61,297	2,335



Cash remains positive. This helps to enable continued investment in the Trust capital programme.

An internal cash plan has been developed for 2021 / 22 showing an expected maintenance of cash levels.

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

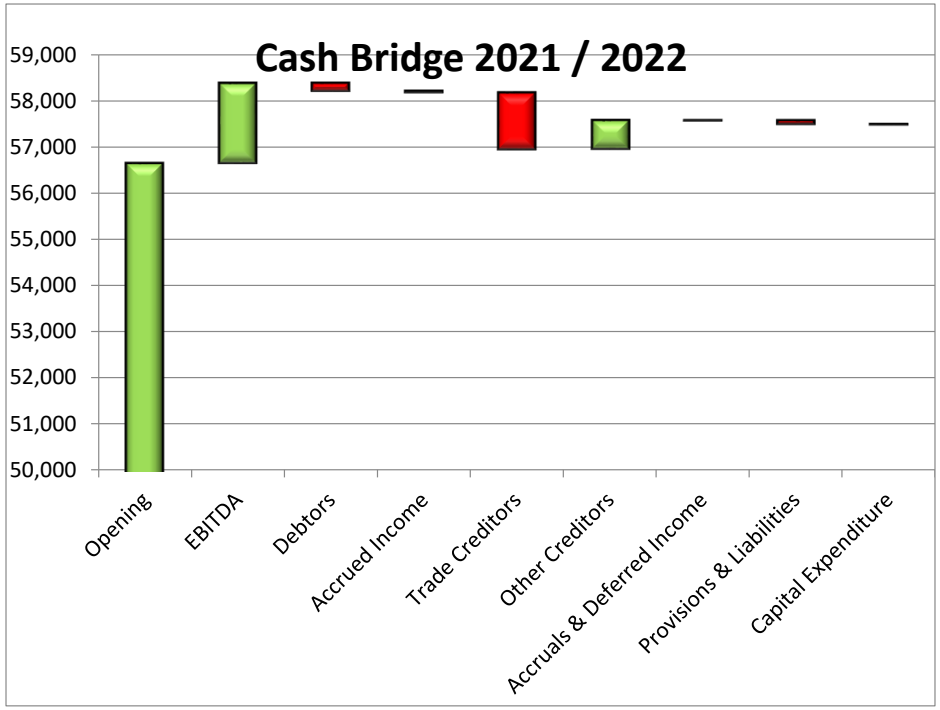
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is

The highest balance is: £78.6m
The lowest balance is: £59.3m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Note
Opening Balances	**56,648**	**56,648**	
Surplus / Deficit (Exc. non-cash items & revaluation)	1,090	2,825	
Movement in working capital:			
Inventories & Work in Progress	0	0	
Receivables (Debtors)	550	379	
Accrued Income / Prepayments	0	(30)	
Trade Payables (Creditors)	1,224	(3)	
Other Payables (Creditors)	0	622	
Accruals & Deferred income	0		
Provisions & Liabilities	0	(82)	
Movement in LT Receivables:			
Capital expenditure & capital creditors	(550)	(562)	
Cash receipts from asset sales	0	1,500	
PDC Dividends paid	0	0	
PDC Dividends received			
Interest (paid)/ received	0	(0)	
Closing Balances	**58,962**	**61,297**	



The table above summarises the reasons for the movement in the Trust cash position during 2021 / 2022. 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 current main driver is the overall Income and Expenditure position which is better than breakeven and the receipt of £1.5m from the sale of Mount Vernon.

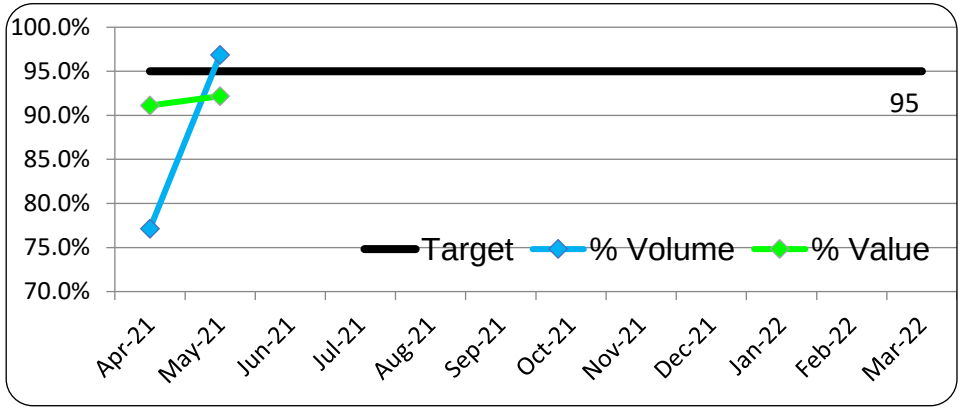
4.0 Better Payment Practice Code

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

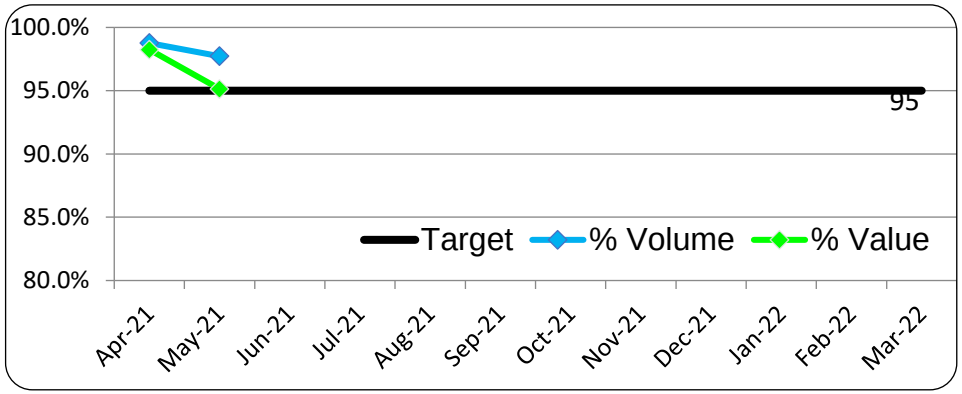
We continue to optimise the finance and procurement system which was implemented in October 2020. This includes a regular review of outstanding invoices, and working with SBS to resolve any issues.

Performance in May has seen 95% of volume and 82% by value paid within the Trust payment terms of 30 days. The team continue to work with internal stakeholders and customers to ensure that the purchase to pay service runs as smoothly as possible.

NHS	Number %	Value %
In Month	97%	92%
Cumulative Year to Date	87%	92%



Non NHS	Number %	Value %
In Month	98%	95%
Cumulative Year to Date	98%	97%



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 (£)
21-May-21	Rent	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710173570	481,824
19-May-21	Drugs	Trustwide	Bradford Hospitals NHS Trust	318958	98,577
05-May-21	IT Services	Trustwide	Daisy Corporate Services	3I470836	90,250
01-Jun-21	Rent	Wakefield	Assura HC Ltd	LINV40073	90,000
21-May-21	Rent	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710173570	81,982
21-May-21	Telecoms	Trustwide	Virgin Media Payments Ltd	7280639010010521	66,466
12-Apr-21	Drugs	Trustwide	NHS Business Services Authority	1000068934	40,945
07-Apr-21	Research	Wakefield	University Of Huddersfield Hec	5058177	40,000
13-Apr-21	Purchase of Healthcare	Trustwide	Elysium Healthcare Ltd	TOW01517	38,472
21-May-21	Staff Recharge	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710173570	36,232
14-Apr-21	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	995295	33,404
05-May-21	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	995413	33,404
28-Apr-21	Rent	Barnsley	Dr M Guntamukkala	PG10100	33,132
12-Apr-21	Telecoms	Trustwide	Vodafone Ltd	97721342	31,503
06-May-21	Utlities	Trustwide	EDF Energy Customers Ltd	000009708427	26,942

4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

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

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

* 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.

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.4%	4.3%	4.2%	4.2%	4.2%	4.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.8%	4.0%	3.8%	3.9%	4.2%	4.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.5%	83.7%	84.5%	82.0%	78.8%	79.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	89.4%	89.2%	86.8%	84.2%	82.5%	82.5%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.4%	94.8%	96.1%	96.4%	95.7%	96.1%
Equality and Diversity	Resources	Well Led	AD	>=80%	98.0%	97.9%	97.7%	97.2%	97.3%	96.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	89.8%	88.4%	89.2%	87.0%	86.4%	82.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.0%	76.1%	77.3%	75.5%	75.9%	77.7%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	97.4%	96.4%	95.9%	95.7%	95.7%	95.6%
Information Governance	Resources	Well Led	AD	>=95%	98.8%	97.2%	97.3%	97.7%	96.9%	96.0%
Moving and Handling	Resources	Well Led	AD	>=80%	89.4%	89.8%	90.1%	89.9%	90.0%	91.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.6%	94.6%	94.0%	93.1%	91.8%	90.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.5%	95.6%	93.4%	90.7%	86.8%
Prevent	Improving Care	Well Led	AD	>=80%	96.1%	96.1%	96.2%	95.5%	95.6%	96.0%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.5%	94.6%	94.8%	94.1%	94.5%	94.4%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	95.2%	95.3%	95.2%	94.8%	94.1%	93.9%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	3.2%	3.1%	3.2%	3.2%	4.2%	5.7%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.1%	2.8%	3.3%	3.0%	4.2%	5.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.0%	82.6%	83.2%	82.2%	80.7%	80.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	83.6%	83.6%	83.5%	82.7%	78.8%	78.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	93.9%	93.4%	94.0%	94.9%	95.3%	96.8%
Equality and Diversity	Resources	Well Led	AD	>=80%	96.8%	96.6%	97.3%	97.8%	98.1%	97.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.3%	87.6%	89.2%	87.6%	86.9%	87.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	77.9%	77.2%	78.3%	76.1%	76.9%	79.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	95.9%	95.6%	95.6%	95.3%	95.5%	95.3%
Information Governance	Resources	Well Led	AD	>=95%	99.0%	98.6%	99.0%	99.3%	97.5%	96.8%
Moving and Handling	Resources	Well Led	AD	>=80%	94.4%	94.1%	94.5%	94.7%	94.7%	95.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	96.0%	95.7%	94.9%	91.1%	90.3%	83.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	94.0%	93.3%	92.7%	87.9%	87.2%	79.6%
Prevent	Improving Care	Well Led	AD	>=80%	96.1%	96.0%	96.1%	95.9%	96.1%	95.8%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.2%	93.5%	93.8%	94.2%	95.0%	94.9%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.2%	94.0%	94.4%	94.5%	94.5%	94.7%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	5.6%	5.6%	5.6%	5.5%	4.4%	4.2%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	6.1%	6.0%	4.5%	4.1%	4.4%	4.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.2%	83.8%	83.7%	80.4%	79.9%	80.6%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	88.6%	86.3%	87.4%	81.8%	86.8%	73.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.2%	93.7%	93.0%	91.6%	94.4%	93.4%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.6%	94.6%	94.6%	94.3%	94.1%	94.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	89.8%	88.2%	88.3%	86.6%	86.4%	85.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	66.7%	65.9%	65.3%	64.3%	64.8%	65.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.2%	94.6%	93.9%	92.7%	92.8%	93.3%
Information Governance	Resources	Well Led	AD	>=95%	97.5%	97.2%	97.2%	96.9%	95.1%	93.3%
Moving and Handling	Resources	Well Led	AD	>=80%	97.0%	97.3%	97.3%	96.7%	97.4%	97.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.5%	91.4%	90.1%	85.7%	87.5%	87.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	89.2%	87.1%	86.1%	78.3%	80.1%	79.7%
Prevent	Improving Care	Well Led	AD	>=80%	93.0%	93.1%	92.9%	93.3%	92.3%	92.4%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.0%	92.2%	92.4%	92.5%	93.9%	94.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.2%	89.2%	89.6%	90.4%	90.2%	91.2%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

CAMHS

Month	Objective	CQC Domain	Owner	Threshold	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	2.8%	2.7%	2.6%	2.6%	2.6%	2.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	2.3%	1.9%	2.2%	2.3%	2.6%	2.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.6%	75.4%	77.0%	76.9%	74.8%	72.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	76.9%	75.2%	74.9%	72.6%	71.3%	71..37%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	96.5%	95.5%	94.0%	93.1%	94.5%	95.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.1%	92.5%	93.8%	95.5%	95.5%	96.5%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.8%	86.6%	88.2%	89.3%	81.2%	79.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	28.6%	33.3%	28.6%	28.6%	20.0%	20.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.7%	92.5%	92.5%	93.9%	93.6%	93.9%
Information Governance	Resources	Well Led	AD	>=95%	96.7%	95.7%	96.7%	97.7%	95.5%	94.9%
Moving and Handling	Resources	Well Led	AD	>=80%	97.4%	97.1%	97.7%	98.1%	98.4%	98.7%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.7%	92.8%	92.1%	83.2%	83.7%	84.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	89.4%	88.3%	88.7%	79.8%	81.2%	81.0%
Prevent	Improving Care	Well Led	AD	>=80%	93.6%	92.0%	92.3%	92.8%	93.5%	94.1%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	90.1%	90.5%	90.2%	91.3%	91.7%	92.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.4%	90.5%	90.9%	92.2%	93.0%	94.2%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Appendix 2 - Workforce - Performance Wall cont….

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	3.3%	3.3%	3.3%	3.2%	2.6%	3.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	3.3%	3.5%	3.5%	3.2%	2.6%	2.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	95.0%	92.5%	90.5%	89.3%	89.9%	86.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	87.1%	90.0%	90.0%	89.7%	93.1%	83.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	66.7%	80.0%	80.0%	80.0%	100%	100%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.8%	91.1%	90.5%	80.2%	89.3%	89.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.2%	81.1%	80.9%	80.6%	86.9%	84.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	97.8%	97.8%	97.8%	97.8%	99.3%	98.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	93.6%	92.3%	92.3%	91.5%	90.3%	91.1%
Information Governance	Resources	Well Led	AD	>=95%	99.4%	97.6%	97.6%	97.6%	96.1%	96.0%
Moving and Handling	Resources	Well Led	AD	>=80%	99.0%	98.9%	99.0%	99.0%	99.2%	99.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	98.7%	98.7%	98.6%	98.6%	98.2%	98.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	90.9%	90.5%	86.4%	77.3%	68.2%	78.3%
Prevent	Improving Care	Well Led	AD	>=80%	98.5%	98.3%	98.2%	98.7%	98.7%	97.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.8%	97.6%	97.5%	97.2%	97.4%	97.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	97.6%	97.4%	97.5%	97.6%	96.9%	97.6%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	3.1%	3.3%	3.4%	3.4%	3.4%	4.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	3.6%	4.4%	4.2%	3.8%	3.4%	3.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	87.2%	87.6%	85.5%	82.4%	80.8%	84.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	85.2%	84.3%	83.1%	79.1%	76.5%	75.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.5%	91.1%	90.4%	92.8%	94.0%	93.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	95.9%	96.1%	96.9%	97.2%	96.9%	96.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.9%	87.6%	88.2%	87.9%	86.7%	85.6%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.8%	71.3%	76.3%	82.5%	84.3%	84.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.1%	95.1%	94.3%	94.1%	93.6%	94.4%
Information Governance	Resources	Well Led	AD	>=95%	98.5%	98.2%	98.7%	98.4%	98.0%	95.9%
Moving and Handling	Resources	Well Led	AD	>=80%	96.9%	96.4%	95.9%	93.6%	93.9%	93.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.3%	92.8%	92.5%	88.1%	89.8%	89.5%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	92.1%	92.4%	91.2%	85.4%	87.0%	86.1%
Prevent	Improving Care	Well Led	AD	>=80%	95.3%	95.6%	95.8%	96.1%	95.9%	95.4%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.8%	94.3%	94.3%	93.5%	94.6%	95.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	91.5%	91.2%	93.1%	91.8%	92.4%	91.1%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Inpatient Service

Month	Objective	CQC Domain	Owner	Threshold	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.1%	5.0%	5.0%	5.1%	6.4%	7.5%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.2%	4.4%	5.9%	6.2%	6.4%	7.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	87.7%	85.7%	85.8%	84.7%	82.3%	79.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.9%	84.2%	84.0%	81.1%	78.2%	77.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.2%	90.3%	87.7%	88.4%	90.4%	89.7%
Equality and Diversity	Resources	Well Led	AD	>=80%	97.8%	97.3%	96.9%	96.7%	97.8%	97.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	89.8%	89.4%	89.4%	86.1%	81.5%	82.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	74.5%	73.5%	77.3%	76.2%	78.3%	79.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	97.0%	97.3%	97.2%	95.8%	95.0%	94.9%
Information Governance	Resources	Well Led	AD	>=95%	98.1%	97.3%	97.5%	97.2%	96.7%	95.8%
Moving and Handling	Resources	Well Led	AD	>=80%	98.1%	98.1%	98.1%	98.1%	98.3%	98.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.3%	92.6%	90.8%	88.1%	88.3%	87.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	91.5%	90.6%	88.7%	85.2%	85.4%	83.5%
Prevent	Improving Care	Well Led	AD	>=80%	95.3%	94.8%	94.2%	94.5%	95.3%	94.7%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.9%	92.0%	92.5%	92.5%	93.0%	91.8%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	86.9%	86.8%	88.6%	87.5%	87.4%	86.0%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Glossary

ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement

NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

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

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

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

South West Yorkshire Partnership
NHS Foundation Trust

Trust Board
29th June 2021
Agenda item 8.2

Title:	**Trust Operating and Financial Planning Update**
Paper prepared by:	Director of Finance & Resources
Purpose:	To provide the Trust Board with an update of the progress being made in developing the Trust's operating and financial plans
Mission/values:	All Trust objectives
Any background papers/ previously considered by:	Regular updates on plan development and Trust financial position provided to the Trust Board and Finance, Investment & Performance Committee
Executive summary:	The Trust has responded well to the necessary short-term planning requirements both in 2020/21 and again in readiness for 2021/22. The Trust has submitted a financial plan for a break-even position for the first six months of 2021/22. Work will now commence to agree longer term plans for the Trust. This will take into account such factors as the aims and intentions of the NHS long term plan, workforce planning, financial sustainability, longer-term impact of pandemic including recovery and restoration, inequalities, capital planning and the potential impact of the White Paper including the further development of integrated care systems and place based approaches The attached paper provides a summary of the planned approach to this process.
Recommendation:	It is recommended the Committee review this document and comment accordingly.
Private session:	N/A

With **all of us** in mind.

Operating and Financial Plan

Introduction

The purpose of this paper is to provide the Trust Board with an update on plans to develop a 2021- 2024 operating and financial plan for the Trust.

The Trust has responded well to the necessary short-term planning requirements both in 2020/21 and again in readiness for 2021/22. It has submitted a financial plan for a break-even position for the first six months of 2021/22. It is expected that H2 financial arrangements will be similar to H1 but with a requirement for greater efficiencies. Work is currently underway to understand our baseline position and to ensure BDUs and support services understand and agree their H2 plan.

The planning process now needs to take a longer-term view, to ensure a less reactive approach. Work will now commence to agree longer term plans for the Trust. This will take into account such factors as the aims and intentions of the NHS long term plan, the development of integrated care systems, local place plans, workforce planning, financial sustainability, longer-term impact of pandemic including recovery and restoration, inequalities, capital planning and the potential impact of the White Paper.

Approach

Over the next three months, work will progress to develop a 2021-2024 plan for the Trust for each service area namely:

- Barnsley Community and Health and Wellbeing
- Forensics
- CAMHS
- Learning Disabilities
- Inpatient mental health
- Community mental health (adults)
- Estates & facilities management
- Corporate services

Broadly, these will include:

- Overall narrative outlining our approach and setting out high-level plans and objectives
- Service development plans
- Workforce plans
- Financial plans including an updated financial sustainability plan
- Inequalities action plans
- Key assumptions

Financial Plan – Next Steps

Trust Board members confirmed agreement with the recommendation by the Director of Finance to submit a break-even plan for the first six months of the year. Further work is now

underway to understand our underlying baseline run rate for H1 21/22 and how this will move into the second half of the year and out to 2023/24.

The baseline financial position will be developed using the month 3 detailed forecast and in conjunction with BDUs and support services to understand our underlying recurrent position. This baseline position can then be adjusted with the outputs from the following activity;

- Confirmation of new investments and mental health recovery monies that have been agreed with commissioners
- Impact of the recovery programme
- Review of activity data and action required to address expected changes in demand
- Review of the financial sustainability plan with timescales and resources required to implement initiatives. The review of benchmarking and costing data will be used to inform potential opportunities
- Review of the recurrent cost impact of Covid-19 and plans to mitigate

Workforce Plans

The Head of Workforce Planning will continue engaging with each BDU and support service regarding their workforce plans. Within operations this process will be overseen by the Operational Management Group (OMG). Greater triangulation will take place with financial plans

ICS and Place engagement

The Trust has been fully engaged with the planning process in each place with senior manager representation on the planning groups in Barnsley, Wakefield, Kirklees and Calderdale.

In the development of our medium-term plan, we will ensure alignment to each ICS and place-based plan, in addition to giving consideration to key documents for example the Long Term Plan Implementation Guidance.

Timescales and Governance

We will work towards sign off of the H2 plan at the September Trust Board and the indicative plans for the following two years at the November Board.

Summary and Recommendation

In summary the Trust has submitted a draft financial plan for a break-even position for the first six months of 2021/22. Further work will now take place to develop a 2021-2024 plan.

It is recommended Trust Board note and comment on this operating and financial plan update.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 9.1

Title:	Update Integrated Care Systems and White Paper - Integration and Innovation: working together to improve health and social care for all
Paper prepared by:	Director of Strategy
Purpose:	1) To provide an update to Trust Board on national developments including the publication of the NHS England and NHS Improvement (NHSEI) Integrated Care System Design Framework that was published this month. 2) To provide an update on how the two Integrated Care Systems that the Trust is part of are responding to the White Paper and NHSEI proposals on integrated care and next steps.
Mission/values:	The Trust is a committed partner in two established Integrated Care Systems and in four place-based Integrated Care Partnerships that are at differing levels of maturity. Planning and delivering joined up care, improving health and outcomes for people in each of our places continue to be key priorities for the Trust in delivering its **vision and mission.** The development of integrated care and system working is in line with our **value to be relevant today and ready for tomorrow and has been an integral part of the Trust's strategic and operational approach over the last few years.**
Any background papers previously considered by:	Updates on integrated care developments and the national policy context are discussed regularly at Strategic Board and Trust Board meetings. The NHSEI Consultation document on the next steps for integrated care was discussed in depth at the December Strategy Board, including key considerations and implications for the Trust. The Government's response in the form of the White Paper was further discussed in detail at the February Strategy Board and updates were provided to the March and April Trust Board, with a further update to Strategy Board in May 2021.
Executive summary:	**Background/Context** The national policy context recognises the role of Integrated Care Systems as a key driver in improving health outcomes, reducing health inequalities and supporting sustainability through collaboration rather than competition. In November 2020, NHSEI set out proposals to further develop Integrated Care Systems. This was followed by the White Paper *Integration and Innovation: working together to improve health and social care for all being published in February 2021*. Trust Board has considered and discussed the details set out in both documents. The direction of travel is consistent with the Trust's strategy and ambitions and the work that we have been doing as partners in our local Integrated Care Systems.

With **all of us** in mind.

	National developments and update The proposals to legislate for ICSs are being worked through the parliamentary process. **NHSEI Integrated Care System Design Framework published** NHSEI have published the Integrated Care System (ICS) Design Framework to guide next steps in developing ICSs in line with the White Paper *Integration and innovation: working together to improve health and social care for all.* The ICS Design Framework, published Wednesday 16 June 2021, provides further clarity and sets out the core features of every ICS whilst emphasising the need for local flexibility and determination. The framework sets out the expectations/minimum standards NHSEI has in terms of membership of ICS bodies, their roles and accountabilities, governance and management arrangements, financial allocations, models for clinical and professional leadership, working with people and communities and managing data. It provides indicative outputs expected in every ICS over the course of the transition period in 2021/22. Some aspects of system development, including all content referring to new statutory arrangements and duties and/or which is dependent on the implementation of such arrangements and duties, will depend on changes to the government's legislation on integration and its parliamentary process. The attached NHS providers briefing summarises the key components set out in the framework. The framework supports the approach and ways of working that are already established and in progress through both integrated care systems that the Trust is a partner in. In due course, NHSEI will provide further guidance on the membership and governance of ICS NHS bodies; the composition and operation of the board; how to support ICS NHS bodies to manage conflicting roles and interests of board members; provider collaboratives; provider governance and supporting people transition planning and implementation. **Additional Guidance** Alongside the design framework, NHSEI has published further guidance on the *Employment Commitment* which is intended to provide people in organisations directly affected by the proposed legislative changes with employment stability throughout the transition period whilst minimising uncertainty as much as reasonably possible. **The Trust is part of two advanced ICSs and is also part of place-based partnerships and provider collaboratives.** **WYH ICS** have established a Future Design and Transition Group to oversee the transition and help make the right connections between the workstreams and a Chairs and Leaders Reference Group, which acts as a sounding board, has been established.

	As part of the preparation for the new statutory Integrated Care System (ICS) arrangements coming into force from April 2022, work has been progressed on the future design and ways of working of the NHS ICS statutory body structure and functions. High level functions have been agreed through the System Leadership Executive and work is being progressed to develop a networked model under each of these functions, clarifying what will be done at ICS level and what will be done at place level building on the approach to date. The key functions will include: • Strategy & Partnerships • Corporate • Finance • Planning & System Improvement • Clinical & Professional • People **SYB ICS** has also established an overarching Steering Group that draws on members from the 4 workstreams set out below. There is also a Change and Transition Programme Board that will provide oversight and support: • Place-based partnerships • Provider collaboratives • Commissioning changes • ICS operating model In addition, there are two enabling workstreams: • HR and people transition • ICS Financial framework Hill Dickinson have been commissioned to provide facilitation to the Steering Group and Design Groups and expert legal support in production of key documents and products. The Design Sub-Group was established from the broad membership to co-design a number of key products and these include: • A Health and Care Compact and Health and Care Partnership Terms of Reference • A Development Matrix • A Route Map for 2021/22 **Place-based Developments** We continue to work with partners in each of the places that we provide services - Calderdale, Kirklees, Wakefield and Barnsley - to review and develop Integrated Care Partnerships and arrangements to ensure that each place has a clear development plan in place to develop mature place-based partnership arrangements that can respond to the changes set out in the White Paper and ICS developments.

Recommendation:	**Trust Board is asked to:** • **Note update on National policy and guidance** • **Note update on local ICS response to the White Paper**
Private session:	Not applicable.

16 June 2021

on the day BRIEFING

NHS Providers

Integrated Care System Design Framework

NHS England and NHS Improvement (NHSE/I) published the Integrated Care System (ICS) Design Framework on 16th June 2021. This briefing sets out the operating model for ICSs from April 2022, after the enactment of the Health and Care Bill which will place ICSs on a statutory footing. It also acts as interim guidance for how ICSs need to continue developing and preparing for new statutory arrangements over the next ten months. The design framework will be supplemented by further information and guidance later this year to support detailed planning. For any questions on this briefing, please contact georgia.butterworth@nhsproviders.org.

Key points

- The ICS design framework sets out the next steps for how NHSE/I expects NHS organisations, working with system partners, to continue developing ICSs during 2021/22, in anticipation of establishing statutory ICS NHS bodies from April 2022. The framework sets out the core arrangements that NHSE/I will expect to see in each system, as well as some key elements of good practice. We expect further information and guidance to be issued later this year.
- As set out in the government's *Integration and Innovation* white paper in February, ICSs will be made up of two parts: the ICS partnership, and the statutory ICS NHS body. NHSE/I expects the ICS partnership to be a committee, rather than a corporate body. Its role will be to align the ambitions, purpose and strategies of partners across each system. It will be established by the relevant local authorities in collaboration with the ICS NHS body, and have a specific responsibility to develop an "integrated care strategy".
- The ICS NHS body will be a statutory body, whose functions will include planning to meet population health needs, allocating resources, and overseeing delivery. ICS NHS bodies will have a unitary board. The statutory minimum membership of the board will be confirmed in forthcoming legislation but is expected to be comprised of: a chair and at least two independent non-executive directors; a chief executive and three executive directors; and a minimum of three "partner" members, representing trusts, primary care and local authorities. Partner members will be expected to bring a perspective from their specific sectors, but not act as delegates of those sectors.
- The ICS NHS body will be expected to agree with local partners the membership and form of governance at place level. The design framework sets out five potential place-based governance arrangements: a consultative forum; a committee of the ICS NHS body; a joint committee of the ICS NHS body and one or more statutory provider; an ICS NHS body director with delegated authority; or a lead provider contracted to manage resources at place level.

- The design framework reiterates that all trusts providing acute and mental health services are expected to be part of one or more provider collaborative. Community and ambulance trusts and non-NHS providers should participate in these where it makes sense to do so.
- Providers will continue to be accountable for quality, safety, use of resources and compliance with standards, as well as the delivery of any services or functions delegated to them by an ICS NHS body. Executives of providers will remain accountable to their boards for the performance of functions for which their organisation is responsible.
- The final 2021/22 System Oversight Framework (SOF), which is expected to be published in the coming weeks, is expected to confirm ICSs' formal role in the oversight of organisations and partnership arrangements within their system. NHSE/I will retain its statutory regulatory responsibilities, so any formal regulatory action with providers will be taken by NHSE/I.
- NHSE/I also sets out the key features of the financial framework that will support system working, including some further detail on how resources will be managed at system level. It is envisaged that ICS NHS bodies will be given a duty to act with a view to ensuring system financial balance, and meet other financial objectives set by NHSE. This duty would also apply to trusts.
- The framework includes a roadmap to implement new arrangements for ICS NHS bodies by April 2022, including appointing leadership teams and ensuring a smooth transition of staff from CCGs.

Summary of the framework

Context

This framework builds on NHSE/I's renewed vision for ICSs in the Integrating care paper published in November 2020, which set out their four core purposes: improving outcomes; tackling inequalities; enhancing productivity; and supporting social and economic development. It also builds on the two-part statutory ICS model proposed in the government's white paper, Integration and Innovation: working together to improve health and social care for all, which stated that ICSs will be comprised of an ICS partnership – bringing together a broad alliance of organisations related to improving health and care – and an ICS NHS body – bringing together organisations that plan and deliver NHS services to improve population health and care.

The ICS partnership

Under the two-part statutory ICS model, each ICS will have a partnership, established by the NHS and local government "as equal partners". NHSE/I expects the ICS partnership to bring partners from local government, the NHS and wider organisations within the ICS together to align purpose and ambitions, and improve the health and wellbeing for their population, including influencing the wider

determinants of health. NHSE/I expects the ICS partnership to have a specific responsibility to develop an "integrated care strategy" covering health and social care for the whole population. NHSE/I indicates that the legislation for how partnerships should operate will not be prescriptive.

Membership of the ICS partnership will vary between systems, and may be drawn widely from health, care and other partners such as housing providers. They will be established by the relevant local authorities and the ICS NHS body. Partnerships will be able to use sub-groups, networks and other methods to convene parties to deliver the priorities set out in its shared strategy.

The ICS partnership chair will be jointly selected by the ICS NHS body and local authorities, who will also define the chair's role and accountabilities. NHSE/I provides some flexibility in this arrangement, by acknowledging that some systems may prefer the partnership and the ICS NHS body to have different chairs while others may choose to appoint one chair to sit across both. NHSE/I describes ten principles for ICS partnerships to consider, which include: distributed leadership; collective decision-making that seeks to find consensus; and a collective model for accountability.

The Department of Health and Social Care, NHSE/I and the Local Government Association will jointly develop guidance on the partnership, including on the role and accountabilities of the chair of the ICS partnership. This guidance will be consulted on before implementation.

The ICS NHS body

ICS NHS bodies will be statutory organisations that bring together all organisations involved in planning and providing NHS services within their footprint, to take a collaborative approach to agreeing and delivering ambitions for the health of their population.

NHSE/I outlines the specific functions that the ICS NHS body will be responsible for delivering:

- Developing a plan to meet the health needs of their population, having regard to the partnership's strategy. NHSE/I highlights a focus on recovery following COVID-19.
- Allocating resources to deliver the plan across the system, including setting principles for how resource (revenue and capital) should be allocated across services and providers. This will be a balance between enabling local decision-making and harnessing the benefits of scale.
- Establishing joint working arrangements with partners to deliver priorities, including joint commissioning (possibly at place) with local authorities under section 75 of the 2006 NHS Act.
- Establishing governance arrangements to support collective accountability. This will be underpinned by the statutory and contractual accountabilities of individual organisations.

- Arranging for the provision of health services in line with the allocated resources across the ICS. This will be delivered in several ways including: through contracts and agreements with providers; convening and supporting providers (working across the ICS and at place) to lead major service transformation programmes; and working with local authority and voluntary, community and social enterprise (VCSE) partners to put in place personalised care.
- Leading implementation of the NHS People Plan and people priorities in the planning guidance, with specific responsibilities from April 2022. NHSE/I also expects ICS NHS bodies to adopt a "one workforce" approach, developing shared principles across the NHS, local authorities, the VCSE sector and other partners.
- Leading system-wide action on data and digital.
- Working alongside councils to invest in local community organisations and infrastructure, ensuring the NHS contributes to social and economic development and sustainability.
- Driving joint work on estates, procurement, supply chain and commercial strategies.
- Planning for, responding to and leading recovery from incidents.
- Take on functions NHSE will be delegating including commissioning of primary care and appropriate specialised services. Specific public health functions may also be delegated.

Once an ICS NHS body has been established, NHSE/I expects that all CCG functions and duties will transfer over, including CCG assets and liabilities, such as commissioning responsibilities and contracts. NHSE/I is reviewing its own operating model, including how its functions and resources will be deployed in the context of the creation of statutory ICS NHS bodies.

NHSE/I expects the ICS NHS body's duties to include: supporting achievement of the triple aim, improving quality of service, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

NHSE/I will clarify in separate guidance how the statutory duties of CCGs will transition to ICS NHS bodies. NHSE/I will work with Health Education England to produce supplementary guidance and implementation support resources for ICSs on developing their strategic people capabilities.

Governance and management arrangements

This section sets out NHSE/I's expectations for ICS governance and management arrangements, with further resources to follow throughout this year. The final composition of the board and the process of appointing partner members (as described below) is subject to the parliamentary process.

The ICS NHS board

The ICS NHS body will have a unitary board, with all board members having shared corporate accountability for delivery of the functions and duties of the ICS and its performance. The board will be the senior decision-making structure for the ICS NHS body, and will be expected to facilitate finding consensus and manage areas of disagreement. The ICS NHS body should foster constructive challenge, debate and the expression of different views. If consensus cannot be agreed, the chair may make decisions on behalf of the board, and where necessary third-party intervention from NHSE/I or peer review may be needed.

The statutory minimum membership of the board will be confirmed in the legislation, but NHSE/I expects it to be comprised at least by the following roles:

- Independent non-executive directors (NEDs): This will include the chair plus a minimum of two other independent NEDs. These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body) This will include the chief executive, who will be the accountable officer for the funding allocations of the ICS NHS body, as well as a director of finance, director of nursing and medical director. These individuals will normally be full-time ICS employees.
- Partner members: a minimum of three additional board members, including at least:
    - One member from trusts and foundation trusts which provide services within the ICS;
    - One member from primary care providers within the ICS footprint; and
    - One member from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the ICS footprint.

Partner members will be expected to bring knowledge and a perspective from their specific sectors, but not act as delegates of those sectors. NHSE/I expects the partner member(s) from trusts and local authorities will often be the chief executive of their organisation. The appointment process of partner members and rules for qualification will be set out in the constitution of the ICS NHS body. The constitution, which may also include the appointment of additional members, will need to be agreed with NHSE/I.

The framework highlights the need for the board and its committees to ensure it considers the perspectives and expertise of all relevant partners, including those across the local health and care system covering physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the ICS partnership.

NHSE/I will provide further guidance on the composition and operation of the board, which will include a draft model constitution. Additional guidance on the management of conflicting roles and interests to enable effective joint working will also be published.

Committees and decision making

NHSE/I expects ICS NHS bodies to put in place arrangements for committees and groups to advise and feed into the board and to exercise functions delegated by the board. These arrangements should also enable the involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives.

Each board will be required to establish an audit committee and a remuneration committee. Other decision-making or advisory committees may be established by the board if they decide. It is expected that the legislation will give ICS NHS bodies flexibility in how committees are established, including how members are appointed and responsibilities delegated.

Place-based partnerships

The framework positions 'place' as central to the coordination and improvement of service planning and delivery, as well as addressing the wider determinants of health. The ICS NHS body will be expected to agree with local partners the membership and form of governance at this level, building on/complementing existing arrangements. The ICS NHS body will remain accountable for NHS resources deployed at place-level. At a minimum NHSE/I proposes that place-based partnerships should cover leadership from primary care, local authorities including directors of public health, providers across acute, community and mental health services, and representation from communities.

The framework sets out the following potential place-based governance arrangements:

- Consultative forum, informing decisions by the ICS NHS body, local authorities and others;
- Committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources;
- Joint committee of the ICS NHS body and one or more statutory provider;
- Individual directors of the ICS NHS body having delegated authority; and
- Lead provider managing resources and delivery at place under a contract with the ICS NHS body.

Supra-ICS arrangements

This section outlines functions where multiple ICS NHS bodies will need to work together to develop a shared plan across these systems. This includes, for example, the commissioning of specialised services and ambulance services. The governance arrangements to support this should be co-designed between the related providers and the ICS NHS bodies' clinical networks or alliances, and, where relevant, NHSE/I's regional teams.

Quality governance

NHSE/I sets the expectation for ICSs to build on existing quality oversight arrangements and work collaboratively with system partners to maintain and improve the quality of care. The ICS NHS body will have statutory duties to act with a view to securing continuous improvement in quality and will lead System Quality Groups (previously Quality Surveillance Groups). NHSE/I will provide support in line with the National Quality Board's guidance.

The role of providers

NHSE/I states that each ICS partnership and ICS NHS body must draw on the expertise and ambition of providers, given their critical role in the delivery, transformation, and improvement of services and outcomes within places and across and beyond systems. Trusts will be expected to work alongside system partners at place level to tailor their services to local needs and integrate pathways. They will have a role in agreeing how resources should be used and how they can best contribute to population health improvement as both service providers and as local "anchor institutions". There is flexibility in what this will look like locally and ICS NHS bodies will be expected to work with all providers to agree arrangements at different levels. In future, the ICS NHS body may delegate "commissioning" functions to providers for certain populations, which builds on the NHS-led provider collaboratives model for specialised mental health, learning disability and autism services. Trusts will increasingly be judged against their contribution to the objectives of the ICS alongside their existing duties, including delivering their agreed contribution to system financial balance.

NHSE/I also sets out the important role of primary care (including Primary Care Networks), independent sector providers and the VCSE sector in ICSs. NHSE/I expects primary care to be represented in all levels of ICS decision-making and by April 2022, the ICS will need to have a formal agreement for embedding the VCSE sector in system level governance arrangements.

Provider collaboratives

From April 2022, all trusts providing acute and/or mental health services are expected to be part of one or more provider collaborative. NHSE/I now states that community trusts, ambulance trusts and non-NHS providers should participate in these collaboratives where it makes sense for patients/the system. Provider collaboratives will be expected to agree specific objectives in line with the ICS's strategic priorities and help facilitate the work of alliances and clinical networks. The ICS NHS body and provider collaboratives will be expected to define their working relationships and governance arrangements, which will include their participation in committees through partner members as well as other local arrangements.

NHSE/I will publish additional guidance on provider collaboratives this summer.

Clinical and professional leadership

NHSE/I states that all ICSs should develop a model of distributed clinical and care professional leadership. This should build on clinical leadership within clinical commissioning groups, although the specific model will be determined by ICSs locally. Such leadership should be fully involved in decision-making, supported with sufficient resources and reflect the health, social care and VCSE sectors. ICSs will be expected to use forthcoming guidance to support a self-assessment of their clinical and professional leadership model, and implement mechanisms to measure progress and performance. The ICS NHS board will be expected to sign off a model and improvement plan.

NHSE/I will provide best practice guidance describing features of an effective professional leadership model for ICSs in due course.

Working with people and communities

The ICS will be expected to agree how to involve people and communities in developing plans and priorities. The framework reiterates seven principles for how ICSs should work with people and communities, including working with Healthwatch and the VCSE sector as key partners. The ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities. As part of this, ICSs should develop arrangements for:

- representation on the ICS partnership and in place-based partnerships; and
- gathering intelligence about the community's experience of, and aspirations for, health and care.

NHSE/I expects there will be a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning services.

NHSE/I will provide more information in guidance on the membership and governance of ICS NHS bodies and in the implementation support resources for how ICSs work with people and communities.

Accountability and oversight

As set out in the planning guidance for the first half of 2021/22, NHSE/I regional teams will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive. NHSE/I clarifies that providers will continue to be accountable for the quality, safety, use of resources and compliance with standards, as well as the delivery of any services or functions commissioned from or delegated to them, including by an ICS NHS body. Executives of providers will remain accountable to their boards for the performance of functions for which their organisation is responsible. If a provider executive sits on the board of the ICS NHS body, they will also be accountable for the ICS NHS body and ensuring its functions are discharged. When acting as an ICS body board member, they must act in the interests of the ICS NHS body and the wider system, not that of their employing provider.

Approach to NHS oversight within ICSs

NHSE/I confirms that the oversight arrangements for 2022/23 will build on the final SOF, which was consulted on earlier this year and is expected to be published in the coming weeks. NHSE/I expects these arrangements to confirm ICSs' formal role in oversight, including leading oversight and support of organisations and partnership arrangements within their system. The newly formed NHSE will retain NHSE/I's statutory regulatory responsibilities, so any formal regulatory action with providers will be taken by NHSE. NHSE will work with each ICS NHS body to ensure "effective and proportionate oversight of organisations" that avoid duplication. However, the framework does not set out what the role of NHSE/I regional teams will look like or whether any functions/resources will be transferred to ICSs. NHSE/I envisages that ICS NHS bodies may over time decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues through system oversight. CQC, NHSE/I and DHSC are working together to agree the process and roles for reviewing and assessing systems, which will aim to avoid duplication and overlap.

Financial allocations and funding flows

ICS allocations

In line with the current direction of travel, NHSE will allocate funding to each ICS NHS body, which will decide how such funds should be spent. This will include budgets for CCG-commissioned primary and secondary care, as well as running cost allowances. This may also include the allocations for NHSE functions, including primary care budgets, specialised services, national transformation funding, the Financial Recovery Fund, and funding for digital and data services. Full capital allocations will be made to the ICS NHS body, based on the outcome of the 2022/23 settlement.

Increasingly, funding will be linked to population need. Allocations will be based on supporting equal opportunity of access and contributing to the reduction of health inequalities. NHSE/I's approach will continue to be informed by the independent Advisory Committee on Resource Allocation. Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHSE will allocate funding to ICSs taking into account the needs of their population and how quickly they move towards their target allocations. NHSE will not set allocations to place within the ICS. The ICS NHS body will have the freedom to set a delegated budget to place-based partnerships to spend ICS NHS resources, but it must focus on equal access for equal need and reduce health inequalities. The ICS NHS body should explain any variation from previous CCG budgets and enable pooling with local authority budgets.

Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with its priorities. Money will flow from the ICS NHS body to providers largely through contracts for "services/outcomes", which may be managed by place-based partnerships or provider collaboratives.

In conjunction with ICS leaders, NHSE will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS board and chief executive will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts.

Each ICS will have an agreed framework for collectively managing and distributing financial resources within the system's financial envelope to address the greatest need and tackle inequalities in line with

the NHS system plan, having regard to the strategies of the ICS partnership and the health and wellbeing board(s). Every ICS will be required to meet the mental health investment standard and the primary and community health services funding guarantee.

Financial and regulatory mechanisms to support collaboration

These measures build on existing financial and regulatory mechanisms to support collaboration, including system financial envelopes and changes to the SOF. NHSE/I envisages that further policy and legislative enablers will support these developments, including: a duty to collaborate; a duty on the ICS NHS body to act with a view to ensuring system financial balance and meet other financial objectives set by NHSE (this would also apply to trusts); and powers to ensure organisational spending is in line with the system capital plan.

The legislation will enable NHSE direct commissioning functions to be jointly commissioned, delegated or transferred to ICS NHS bodies as soon as they are ready to do so. Commissioning of primary medical services is currently delegated to CCGs, so will transition immediately into ICS NHS bodies when they are established.

NHSE/I will review the NHS provider licence in light of the new legislation and policy developments.

Data and digital standards and requirements

NHSE/I expects digital and data experts to have a pivotal role in ICSs. The What Good Looks Like framework is due to be published in the first quarter of 2021/22. This will set out a common vision to support ICS leaders to accelerate digital and data transformation with their partner organisations. From April 2022, ICSs will need to have smart digital and data foundations in place. ICS NHS bodies are expected to: have a named SRO with the appropriate expertise; implement a shared care record; and agree a plan for embedding population health management capabilities, among other things.

Managing the transition to statutory ICSs

In this section, NHSE/I sets out how CCG staff and functions will transfer into the ICS NHS body. This change process will be guided by NHSE/I's Employment Commitment[1] and a set of core principles, and will be managed by current ICS and CCG leadership, with increasing involvement of the new leaders who may be appointed on a shadow or designate basis, pending the legislation. Plans will be agreed with NHSE/I regional teams. NHSE/I sets out indicative outputs expected in every ICS during 2021/22, subject to legislation and other factors (including pending any potential changes to ICS boundaries).

NHSE/I will issue a set of guidance and resources to support this transition, including:

- Change and transition approach (core principles)
- Employment Commitment Guidance, including national support offer

After the legislation is introduced, NHSE/I will publish the following resources and guidance:

- HR framework (technical guidance)
- Appointments guidance for the statutory roles
- FAQs for staff
- Leadership competencies, job descriptions and proposed pay structure for ICS statutory roles.

NHS Providers view

Context

Overall, the ICS design framework begins to set out a clearer vision for how the two-part statutory ICS model – with the ICS partnership and the ICS NHS body – will operate after the enactment of the legislation. Trust leaders are fully supportive of NHSE/I's ambition to set out a coherent and flexible operating model for ICSs from April 2022. They are clear that an enabling policy and legislative framework is required for systems to design what works best for their local communities and circumstances. We will continue to engage with trust leaders to determine whether the right balance between permissiveness and clarity has been struck here, considering the implications for all trust types ranging across acute, community, mental health, ambulance and specialised.

[1] The Employment Commitment does not apply to those in senior/board level roles who may be affected by the new ICS board structure.

The framework also builds on the steps outlined in the 2021/22 implementation guidance, which set out how ICS leaders and their constituent organisations, including trusts, should prepare for new statutory arrangements in this "transition period" up to March 2022. The complexity of this endeavour should not be underestimated, as systems must prepare for legislative change without pre-empting the outcome of the Bill. The collective leadership of ICSs and their constituent organisations will also need to navigate a complex new array of policy frameworks, including adjusting to a new financial regime and oversight framework. We welcome NHSE/I's commitment to supporting the system through this coming year.

It is worth remembering that these imminent changes are taking place whilst providers remain under significant operational pressure to restore routine services affected by the pandemic, tackle the backlogs of care, and meet deferred demand across urgent and emergency care, mental health and community health services. We would strongly encourage NHSE/I to keep this context top of mind, especially in light of the expectation that ICSs will maintain momentum on improving outcomes and supporting recovery at the same time as embedding significant new planning and accountability arrangements.

Principles

We fully support NHSE/I's ambition to accelerate the current direction of system working and collaboration, and welcome the recognition of providers playing a central, leadership role in ICSs. Providers are the engine for transformation and delivery. They are responsible for employing the vast majority of NHS staff and spending the vast majority of NHS funding. However, we are increasingly concerned that the language around ICSs describes them as a separate entity to providers, rather than as genuine partnerships of all the organisations that contribute to health and care services and outcomes within the system. The model risks moving away from the founding spirit of partnership and ambitions of population health, to becoming a separate body managing those within it. This leaves the proposals vulnerable to the perception that the ICS NHS body will simply act as a larger commissioner divorced from providers, when the ICS should in fact remain a sum of its parts.

Similarly, we are also concerned that collective confidence in the ICS as currently structured could be undermined in several ways, which could hinder the opportunity and ambition of system working. For example, the founding principle of local ownership that has been central to driving improvements in collaboration and outcomes thus far could be undermined if the 'partner' members are not appointed in consultation *and agreement with* the relevant constituency. There also needs to be

parity between NHS and local authority representation. For example, if all relevant local authorities, who are already represented on the ICS NHS body by a 'partner' member, are involved in setting up the ICS partnership and selecting the chair, but no additional providers are, the ICS partnership composition could be a majority local authority decision which undermines the principle of equal partnership.

Governance

Well-functioning health and care systems need good governance and clear accountabilities. We continue to have some concerns about the proposed ICS governance arrangements:

- While we agree the board of the ICS NHS body will need to be formally accountable to NHSE/I and parliament, they should also see themselves as accountable to the communities they serve and the organisations within their footprint. NHSE/I should set this out explicitly in future guidance.
- In our view, it is crucial that non-executive directors form a majority on the board of the ICS NHS body in line with best practice drawn from all types of organisations led by unitary boards, including NHS trusts and foundation trusts. This will ensure effective challenge, risk management and assurance, which in turn will ensure the board can answer for the decisions it makes. We recommend this is explicitly defined in future guidance, rather than being locally determined as currently proposed.
- We would recommend that 'partner' members be referred to as non-executive directors drawn from the system as this would provide clarity around their status in decision making.

Given the nature of the ICS task, especially in taking decisions around contract values and funding allocations, there will likely be different views within its membership and it may legitimately be difficult to reach consensus. We welcome NHSE/I's recognition of this potential for disagreement, which we have been calling for to ensure the framework is not designed on the basis that system partners will always agree. Legitimate challenge is a sign of a healthy system. One of the core ICS tasks, as the framework acknowledges, is to manage reasoned dissent well, reconcile differences and build consensus.

Involvement of all provider types

We continue to emphasise the need for NHSE/I to ensure the views of the full range of provider types have sufficient access and input to the ICS NHS body decision-making process. We welcome the framework's statement that the board of the ICS NHS body must ensure it takes into account the perspectives and expertise of all relevant partners. We would urge NHSE/I to take this further and ensure that each ICS has a mechanism which enables the views of trusts to feed into the decision-

making process, and ensures trusts agree with the way the board of the ICS NHS body is set up and comprised, with recourse to a challenge function if they are unhappy. This parity in decision-making is absolutely critical if a collaborative approach to planning and delivering more integrated care, is to be implemented as intended.

Missed opportunities

Finally, there are a few missed opportunities in this guidance. While NHSE/I references its intention to develop its own new operating model, it remains unclear how the role of NHSE/I regional teams will change and how resources and responsibilities will be transferred to ICSs over time. This leaves the framework open to the charge that it is adding to rather than reducing bureaucracy as intended, especially in the context of the renewed emphasis on place-based partnerships and provider collaboratives.

In addition, the framework states that trusts will need to meet system financial objectives set by NHSE under the new legislation; providers will need clarity on what this will look like in practice. For example, it will be vital to know what these requirements will be, who is responsible for judging whether a provider or system is compliant, and the consequences for providers and systems for not meeting these objectives. Finally, while we understand this is an NHS-only framework, it will be important to keep wider system partners involved in this process and ensure they have buy-in within the plans and priorities of their ICS(s). This is not only important in the context of improving wider determinants of health and tackling health inequalities, but also in ensuring wider public services are fully involved at system and/or place level.

We look forward to continuing to work closely with senior leaders and colleagues at NHSE/I as the framework is implemented and further guidance is produced. We will continue to engage with our members on key proposals outlined within this new framework and ensure their views are fed back to NHSE/I.

NHS Providers press release

New ICS design framework offers clarity ahead of major reforms to health service but questions remain

Responding to the publication of a new Integrated Care System (ICS) design framework by NHSE/I, the deputy chief executive of NHS Providers, Saffron Cordery said:

"Today's ICS design framework sets out a much needed, clearer vision for how ICSs will develop further this year and how these new statutory bodies will operate when the health and care bill becomes law. We welcome the dialogue with NHSE/I throughout its development.

"The framework addresses many of the concerns outlined by our members, who fully support NHSE/I's ambition to set out a coherent, yet flexible operating model for ICSs from April 2022. Providers will particularly welcome recognition within the framework of their central, leadership role in ICSs and their commitment to delivering the best possible care for their local communities.

"But there are big challenges ahead as ICS leaders and their constituent organisations adjust to the complexities of system working.

"A key concern is that these NHS reforms- the most far reaching for nearly a decade- will take place against a challenging backdrop as trusts work to clear backlogs of care, restore routine services, and tackle pent up demand across urgent and emergency care, mental health and community health services.

"It is vital NHSE/I acknowledges the pressures and expectations trusts face as ICSs take a greater role in efforts to improve outcomes and support recovery while simultaneously embedding significant new planning and accountability arrangements.

"Trust leaders are keen to ensure ICSs remain a genuine partnership of all the organisations that contribute to local health and care services and outcomes within the system. They are increasingly concerned that the ICS model risks moving away from being a sum of its parts to a separate body managing those within it. There must be appropriate governance measures to ensure ICSs are accountable not only to NHSE/I and parliament, but also to the communities they serve and the organisations within their footprint.

"In the coming weeks and months, we will continue to work closely with senior leaders and colleagues at NHSE/I as the framework is implemented and further guidance is produced. Alongside this, we will continue to regularly consult our members on key proposals to ensure their views are reflected as this framework progresses".

Contact: Georgia Butterworth, Policy Advisor (Systems), georgia.butterworth@nhsproviders.org

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 9.2

Title:	**South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) Update including Mental Health, Learning Disability and Autism Provider Alliance (MHLDA)**
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 key developments in SYB ICS and the SYB ICS MHLDA Alliance and linked programmes. • To update on partnership developments in Barnsley.
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 the development of the Alliance and the MoU was formally approved and supported by Trust Board in April 2021.
Executive summary:	**<u>SYB ICS Update</u>** **1. Coronavirus (COVID-19) Position** Hospitalisations and deaths from Covid remain low and the case rate across South Yorkshire is relatively lower than other parts of the Region, at this point in time. SYB is currently seeing lower overall numbers of the Delta variant across communities, though the situation is still being very closely monitored. During May, the millionth vaccination was administered in SYB and excellent progress continues with the SYB programme with people aged 30-and-over now being called. Nationally, over 38 million have now received their first vaccine dose and over 23 million have had their second. **2. ICS Focus Planning Meeting** A routine planning meeting with the NHS North East and Yorkshire executive team took place on 25th May. The session covered SYB's latest Covid position (including an overview of

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	prevalence, impact on services and a vaccination programme update), plans for elective services recovery, a focus on mental health and cancer services and workforce and finance. **3. SYB announced as pilot for national Accelerator programme** SYB ICS has been chosen as one of the thirteen systems to receive a share of £160m in funding and extra support to implement and evaluate innovative ways to increase the number of elective operations they deliver. The plans include: • Working with clinicians to improve capacity and streamline pathways, particularly using national care pathway blueprints that highlight best practice transformation ideas for theatres, outpatients and endoscopy services. • Offering advice and guidance from clinical specialists to support primary care colleagues. • Developing plans for even more joined up work across SYB, particularly for orthopaedics, ophthalmology and paediatric surgery. • Making best use of a wide range of providers. Learning from what works well in South Yorkshire and Bassetlaw and the other 'elective accelerator' sites will help form approaches for elective recovery to be used across the country. **4. Children and young people's (CYP) transformation workshop** The South Yorkshire and Bassetlaw Children's Network welcomed over 120 colleagues to a virtual workshop on 11th May to discuss a draft Children and Young People's (CYP) Transformation Strategy. The event brought together colleagues across the NHS, local authorities, education, the voluntary and community sector and social care teams. All health and care systems in England have been asked by NHS England and NHS Improvement (NHS E/I) to produce a system-wide Transformation Strategy for children and young people. **5. Nurses receive Silver Award from NHS England and Improvement** A team of nurses from NHS Sheffield Clinical Commissioning Group (CCG) was given a Chief Nursing Officer Silver Award by NHS England and Improvement on 5th May. The primary care development nurse (PCDN) team from Sheffield CCG was nominated for the range of skills, expertise and clinical leadership they demonstrate, in addition to their role in setting up a Covid testing service last year. The team was presented their award by Hilary Garratt CBE, Deputy Chief

	Nursing Officer at NHS England and Improvement, on behalf of Ruth May, Chief Nursing Officer, at a virtual staff event. **6. Suicide Prevention workshops** To support SYB ICS commitment to reducing suicides by at least ten per cent (as set out in our Five Year Plan), the SYB Suicide Prevention Steering Group has put together a five-day event schedule to support colleagues across the system. Between 14-18th June, a series of workshops and events will enable wider partners to share good practice, examples of success and to learn from exemplars across the system. Some of the key areas of discussion will include real-time surveillance systems, locality-based projects and the importance of voluntary sector organisations in suicide prevention. **MHLDA** The MoU, which is the culmination of work undertaken by the five providers of MH services across SYB that supports the development of a MHLDA Alliance, has been approved through partner Boards. The next steps to develop the Alliance will be explored at a future workshop. The Alliance are supporting the development of three specialist provider collaboratives, Forensics new model of care, Eating disorders and CAMHS tier 4. The Trust are a partner in the SYB ICS eating disorder collaborative as well as the WYH ICS in terms of enabling the overarching vision to support people as close to home as possible. The clinical model is in development and there is acknowledgement that the recent need for support and services has significantly increased. For the other provider collaboratives, the Trust is leading the Forensic provider collaborative as part of the West Yorkshire and Harrogate ICS and partners in CAMHS tier 4. **MHLDA Programmes** **Suicide Prevention project** – Funded until end of June 21 project is well established and discussions around sustainability continue although the current project likely to be extended until 31 March 2022. The ICS held an event to showcase best practice and progress being made across the system. **IPS** – Building on the success of this programme in Barnsley, an additional two IPS workers have been employed by SYH and are placed within the Recovery College. **Quit** – The contract between QUIT programme and Yorkshire Cancer Research has been signed, recruitment of tobacco treatment advisors underway. Quit training has also been made

	available for staff and the ICS has launched a communications campaign to support the initiative. **Community Mental Health Transformation** The Trust has secured funding as part of the SYB ICS Community Transformation funding. Partnership discussions with Primary Care Network in Barnsley are underway to discuss the new roles and the VCS to develop joined-up pathways for support and early help. Recovery Colleges are developing proposals for peer support workers and a forum for people with lived experience established with inaugural meeting taking place in May 2021. First cohort of staff have completed their structured clinical management training. **Barnsley Integrated Care Partnership and Developments** The Trust continues to work with partners to deliver the shared priorities in relation to Covid-19 response, vaccination programme, recovery and reset as well as establishing our place response to the white paper through the development of shared governance arrangements. Partners through the Integrated Care Delivery group have continued to refresh the Barnsley health and care plan and priorities that will be recommended for approval to the Integrated Care Partnership in June. The group have also developed an approach to prototype an approach to address health inequalities, prioritising people with mental health issues and CVD. The integrated community and primary care agreement was approved at the May Trust Board. The inaugural meeting of the shared leadership group was held in June and discussions to develop deeper integration and provider collaboration have continued. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register and will need to be kept in view as the SYB ICS and MHLDA Alliance develops, new risks may emerge.
Recommendation:	**Trust Board is asked to:** • **NOTE the SYB ICS update.** • **NOTE the MHLDA Alliance and programme update.** • **Note the Barnsley Partnership update**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 9.4

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 and key priorities and response to the national white paper. 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 April 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 Vaccination programme** The partnership has continued to deliver a joined-up response to Covid-19 and the delivery of the vaccination programme across the region and in each of the places that make up the partnership. **Operational Planning and financial framework 21/22** An aggregated WY&H level version of the plan was submitted to NHSE/I on 6 May 2021, following approval of the balanced financial plan by the WY&H System Oversight and Assurance Group on 5 May 2021. Following feedback to the ICS and places, a final plan was submitted in June 2021.

	WY&H Partnership response to the white paper Work is underway to develop the partnership governance arrangements in line with the establishment of the ICS as a statutory body from 1 April 2022. **Tackling health inequalities and achieving a diverse leadership and workforce** Progress continues to be made to address the recommendations set out in the review that was independently chaired by Professor Dame Donna Kinnair (DBE), including the co-production of an anti-racist campaign and social movement in collaboration with the violence reduction unit. The campaign will be launched in August. **Mental Health, Learning Disabilities and Autism Collaborative** An overview of key work streams and developments being progressed collaboratively are included in the paper, including the 'mechanics' of how the Collaborative operates in an ICS and place-based context going forward. **Place-based developments** We continue to work with partners to develop and deliver joined-up Covid-19 response and the vaccination programme in each of the places that we provide services. We also continue to contribute to place-based recovery and reset planning and place-based governance to respond to the white paper. **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 29 June 2021

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. WYH Covid-19 response and Operational Priorities

We have seen the national Covid-19 infection rates continue to rise and the case rates remain higher in Yorkshire and the Humber. The weekly system briefing meetings have continued and provide up to date information on partnership priorities and Covid-19 response plans. WYH has continued to deliver a co-ordinated Vaccination programme across the region and the focus on recovery and planning has continued.

3. Operational Planning and financial framework 21/22

On 25 March 2021, NHS England and NHS Improvement issued priorities and operational planning guidance for the NHS, covering the first half of 2021/22. This sets out a range of specific requirements that have been addressed through the partnership planning process. An aggregated WY&H level version of the plan was submitted to NHSE/I on 6 May 2021, following approval of the balanced financial plan by the WY&H System Oversight and Assurance Group on 5 May 2021. Following feedback to the ICS and places, a final plan was submitted in June 2021. As the detailed ICS level plan covers only the first half of 2021/22, it is expected that an additional planning process will be required over the summer in preparation for the autumn and winter period. **The Trust is a key partner in the ICS planning process and has been fully engaged through place-based planning discussions and updates have been provided to Trust Board on the Trust plans.**

4. WY&H Partnership response to the white paper

Work is underway to develop the partnership governance arrangements in line with the establishment of the ICS as a statutory body from 1 April 2022. The future governance arrangements are being developed and overseen through an established Design and Transition Group and Chairs and Leaders Reference Group and reported through the Partnership Group. **The Trust has been working with partners in each of its places to support the development of place-based arrangements in response to the white paper and the CEO and Chair are part of the oversight groups.**

5. Tackling health inequalities and achieving a diverse leadership and workforce

Progress continues to be made to address the recommendations set out in the review that was independently chaired by Professor Dame Donna Kinnair (DBE), including the progression of a fellowship to support the development of BAME colleagues across the system, development of equalities training and the co-production of an anti-racist campaign and social movement in collaboration with the violence reduction unit. The campaign will be launched in August. **The Trust Equality, Involvement & Inclusion Committee discussed the campaign and agreed that the Trust will formally support this, acknowledging that we are a partner in the programme and our staff contribute significantly to the outcomes of the workstream and programme.**

6. West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Update

The Trust Board was appraised at the April 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 include:

West Yorkshire Adult Secure Lead Provider Collaborative:
This is the subject of a separate update report to the Trust Board.

WY Mental Health, Learning Disabilities and Autism (MHLDA) Programme:
The May and June meetings of the WY MHLDA programme board covered a wide-ranging agenda. This included:

- Following the feedback received on the draft 'MHLDA Future Mechanics' work, for which the Trust provided a detailed response, a smaller workshop took place to 'stress test' some proposals. At the meeting on 15 June, the programme board supported a proposal as to how to take forward the 'Mechanics' in a modified arrangement, recognising that this may need to be evolved as further national guidance and legislation about ICSs is developed.
- There were presentations and papers on the progress of the work on: Workforce development strategy; PICU programme; Peer support worker role in the community mental health transformation; Complex mental health rehabilitation programme; Children and young people, a trauma informed and responsive system by 2030; Functions mapping work currently being undertaken; Mental health investment standard.

A MHLDA Programme NED/Governor event took place on 11 June 2021. The agenda covered presentations and discussion on: WY Learning Disability health inequality challenge; Workforce wellbeing; Patient and public voice in the future of the ICS.

7. 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 as well as develop our place approach and response to the white paper.

Calderdale
SWYPFT is a strong partner in delivering the Calderdale Vision 2024 and Calderdale Cares. We have continued to work with partners to develop a place-based approach and response to the national white paper - this builds on the work that we have been doing with partners over the last few years. A transition development group has been established to develop the approach and governance arrangements.

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 People's Partnership Board.

An update was provided at the April Trust Board meeting on the work of the ICP. There have been two meetings of the ICP Board, 25 May and 22 June. Items of specific relevance to the Trust that have been covered and/or are being taken forward include: The next stage of the 'system journey' in Wakefield, with proposals for next steps (this is subject of a separate Trust Board agenda item); A presentation of Wakefield's Ageing Well Programme; An update on Wakefield Families Together and the next phase of work to progress the development and

consolidation of services and identify further opportunities for partner alignment; Development of the Primary Care Networks; Learning Disabilities Mortality Review (LeDeR) programme Annual Report 2020/21; Proposed approach to Health and Wellbeing Board strategy re-fresh; Wakefield Mental Health Alliance updated partnership agreement, incorporating terms of reference.

Kirklees
The Kirklees Integrated Health and Care Leadership Board continues to meet monthly. The most recent meetings took place on 6 May and 3 June 2021. Items of specific relevance to the Trust on the agendas for these meetings included: The establishment of a Kirklees Ageing Well programme; The establishment by Kirklees Council of an Inclusion Commission, expected to run for 18 months.

The Kirklees ICP Design Team continues to meet frequently, with the establishment of several workstreams on which the Trust is represented.

As part of the Kirklees Community Services Review, a first workshop took place on 9 June 2021. This review has been driven initially by the timescales for the expiry of the current Kirklees Care Closer to Home contract. There will be work undertaken on scope, operating model, who is best placed to deliver the services and, by end of September, to determine whether this can be delivered via collaboration going forward. The Trust is represented and engaged in this review.

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

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 9.4

Title:	Wakefield Integrated Care Partnership (ICP) – "The next stage on our system journey"
Paper prepared by:	Director – Provider Development
Purpose:	The purpose of this paper is to provide the Trust Board with: • A 'system briefing' on the Wakefield ICP. • An update on the next steps for the 'system.'
Mission/values/objectives:	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.
Executive summary:	The Trust's strategy outlines the importance of the Trust's role in each place it provides services, including Wakefield. The Trust has continued to work as a member of the Wakefield partnership. At the meeting of the Wakefield ICP Board on 25 May 2021, a presentation on the next stage of the Wakefield 'system journey' was included as a main agenda item. The aim of the presentation was to: • Establish a consensus on the language and principles we will use together on the next stage of our system journey. • Consolidate the progress of work to date. • Develop and implement a programme structure. • Agree a development framework with associated timescales, lead officers and responsibilities. • Describe the interim resources and identify gaps. It was agreed at the ICP Board that the attached presentation (including briefing notes) should be used as a common briefing by

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	all organisations in order to brief their governing bodies as appropriate. The 'Proposed next steps', summarised on slide 29, were agreed by the ICP Board.
Recommendation:	**Trust Board is asked to:** • **Receive and note the content of the presentation at the Wakefield ICP Board on 25 May 2021 on the next stage of the Wakefield 'system journey.'** • **Note the 'Proposed next steps', as summarised in the presentation, and the Trust's continued contribution to the partnership.**
Private session:	Not applicable.

Wakefield

The next stage on our system journey

Introduction

The aims of this presentation are to:

- Establish a consensus on the language and principles we will use together on the next stage of our system journey.
- Consolidate the progress of work to date.
- Develop and implement a programme structure.
- Agree a development framework with associated timescales, lead officers and responsibilities.
- Describe the interim resources and identify gaps.

Components of our System Development

- Ambition and vision articulated through a co-produced, outcome-focused Health and Wellbeing Strategy, which informs all decisions and influences beyond the partnership.
- System and governance infrastructure which mirrors ICS arrangements & provides assurance on quality, safety, financial and service performance across the partnership.
- Culture, behaviours and leadership that create an environment where all partners commit to the effectiveness of the whole system and organisational objectives are achieved through the success of the whole system.

Scope of our system development

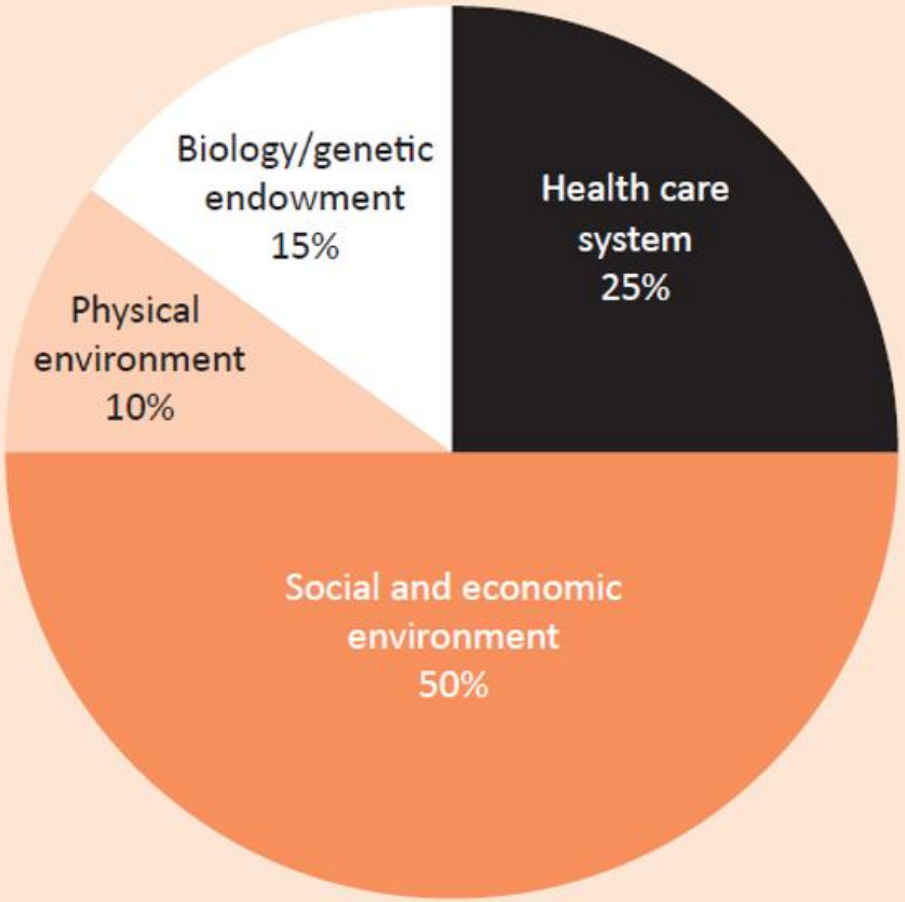
- Our system design will cover all our system/place delegated arrangements between West Yorkshire Integrated Care System and Wakefield system to provide assurance across our partnership.
- It will have shared oversight of the Wakefield NHS £.
- It will be accountable for the delivery of an oversight assurance framework.
- Its ICP remit and accountability goes beyond our four identified priorities for 2021/22.

Principles governing our system development process

- Co production – with ICS and place based partners.
- Focused on population health improvement and reducing inequalities.
- Maximising subsidiarity.
- Inclusive and participative.
- Open and transparent.
- Building on experience and evidence.
- Enabling clarity of purpose and operational efficiency.

Focus on improving health and reducing inequalities

Figure 1 Estimated impact of determinants on health status of the population



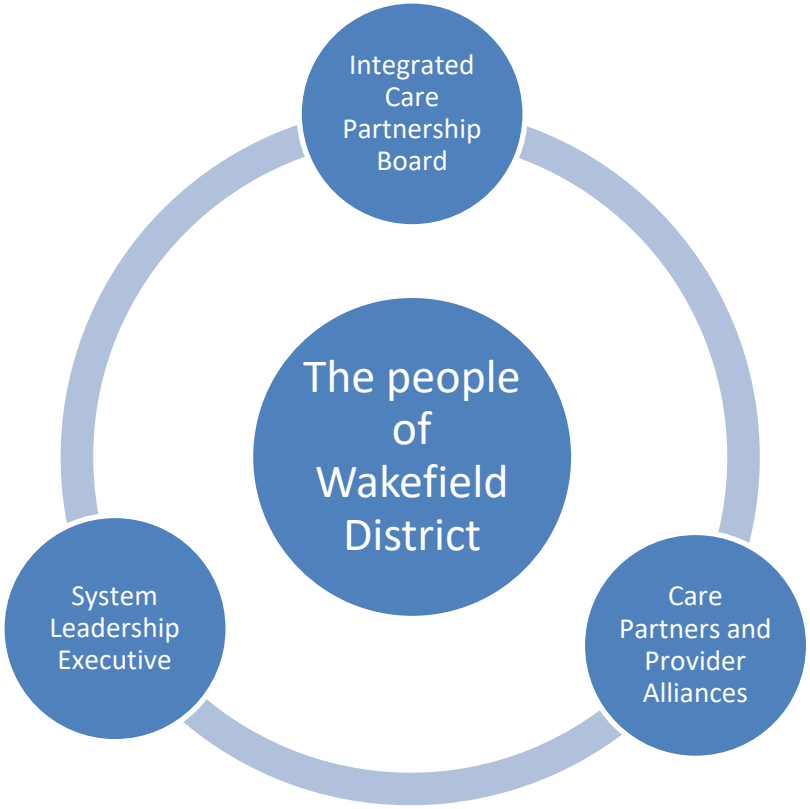
The Health and Wellbeing Strategy, Care Integration and our Health and Care System

The Health and Wellbeing Strategy is a comprehensive joint action plan for Wakefield to intervene in the most effective ways to improve the health of the population and narrow its health inequalities.

Care integration is a way of bringing together in one system the health and social care providers from the public sector, independent sector and third sector to harness all the skills and resources available to improve health in the most effective and efficient ways in partnership with the people we serve.

In order to organise ourselves as the Wakefield place system for care integration we need to develop three components which collectively support the implementation of the H&W Strategy: the partners and alliances, the Integrated Care Partnership (ICP) Board and a System Leadership Executive.

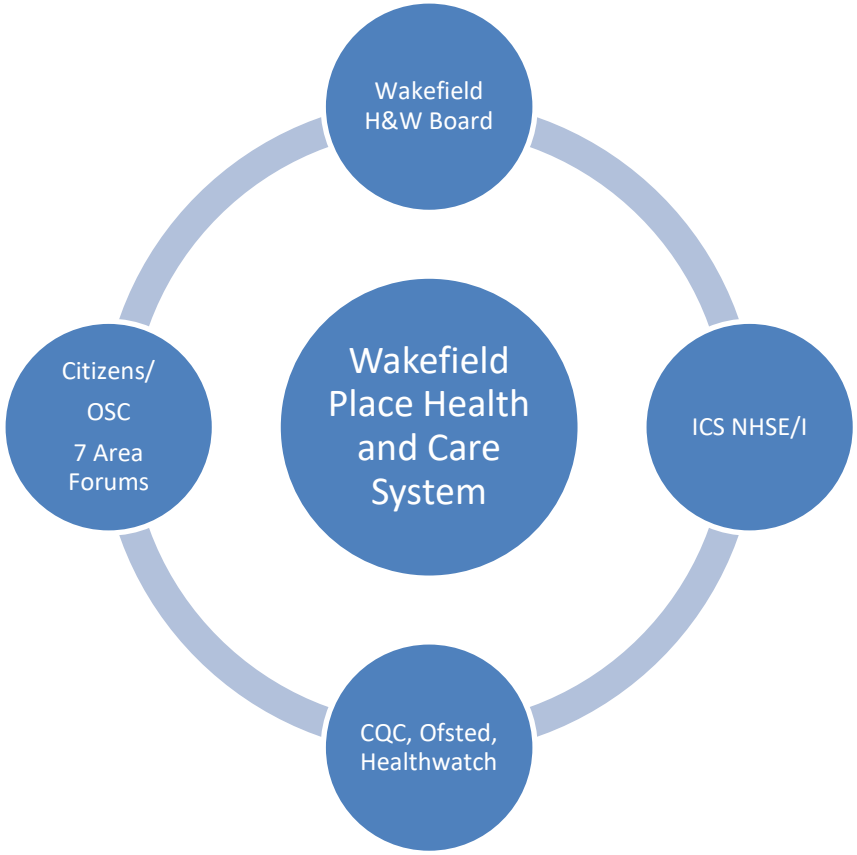
System Components



System Functions

- Wakefield Health and Wellbeing Strategy co-production and implementation
- Development of collaborative models to improve the effectiveness and efficiency of care
- Accountability to the public for care quality and the use of the Wakefield care £
- Collective delivery of national and ICS programmes and regulatory compliance

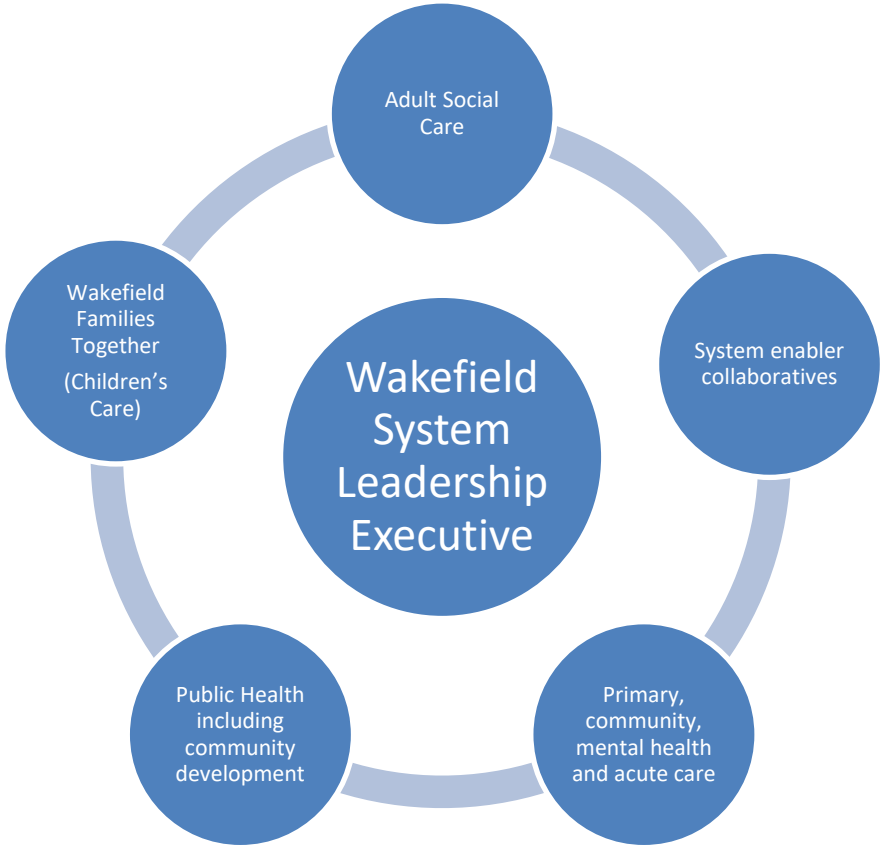
System Accountability and Regulation



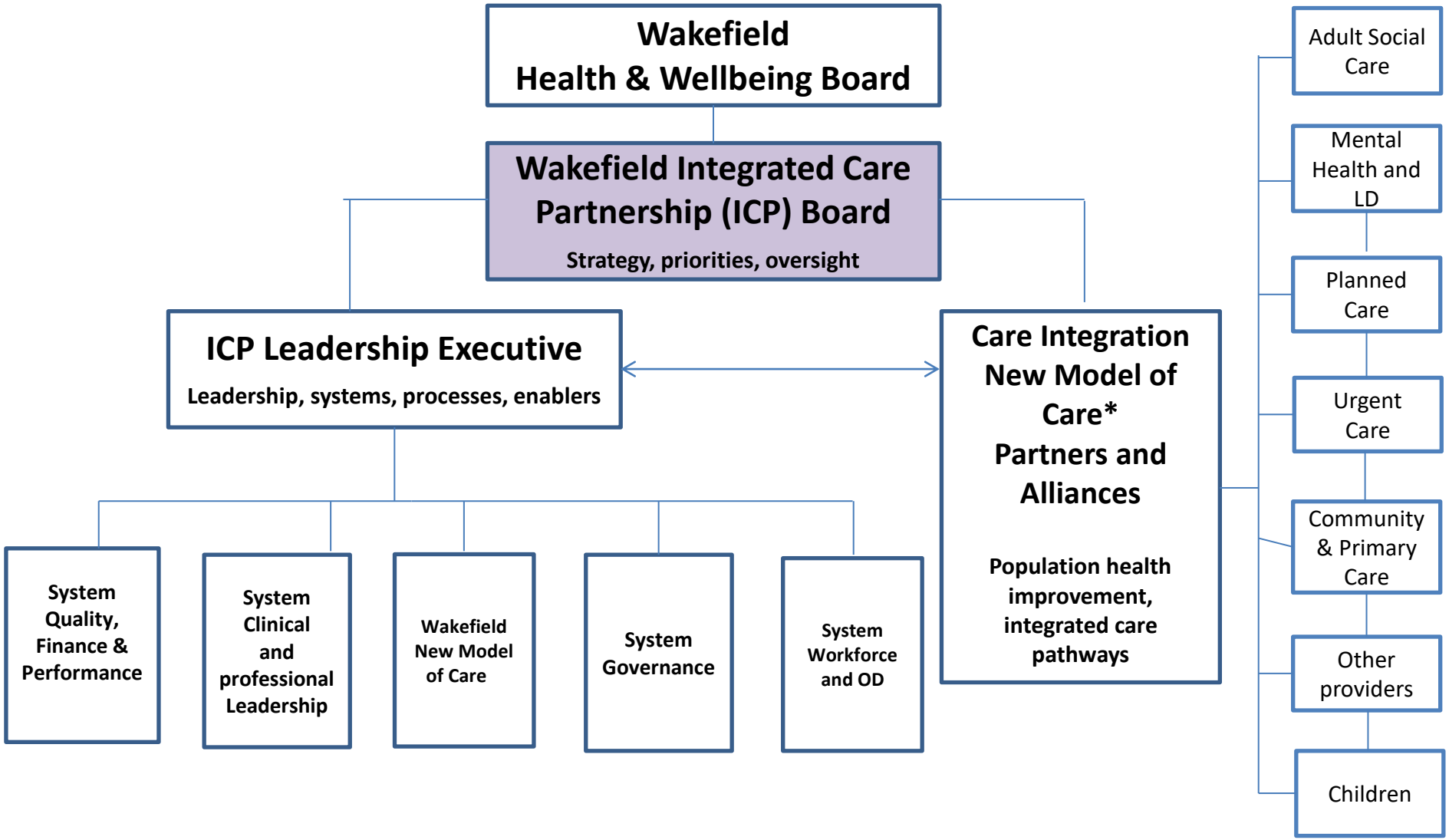
System Leadership Executive Functions

- Leading system development and assurance
- Oversight of the delivery of the Health and Wellbeing Strategy
- Oversight of system collaboratives such as quality, BI, finance, HR, workforce, communications and engagement

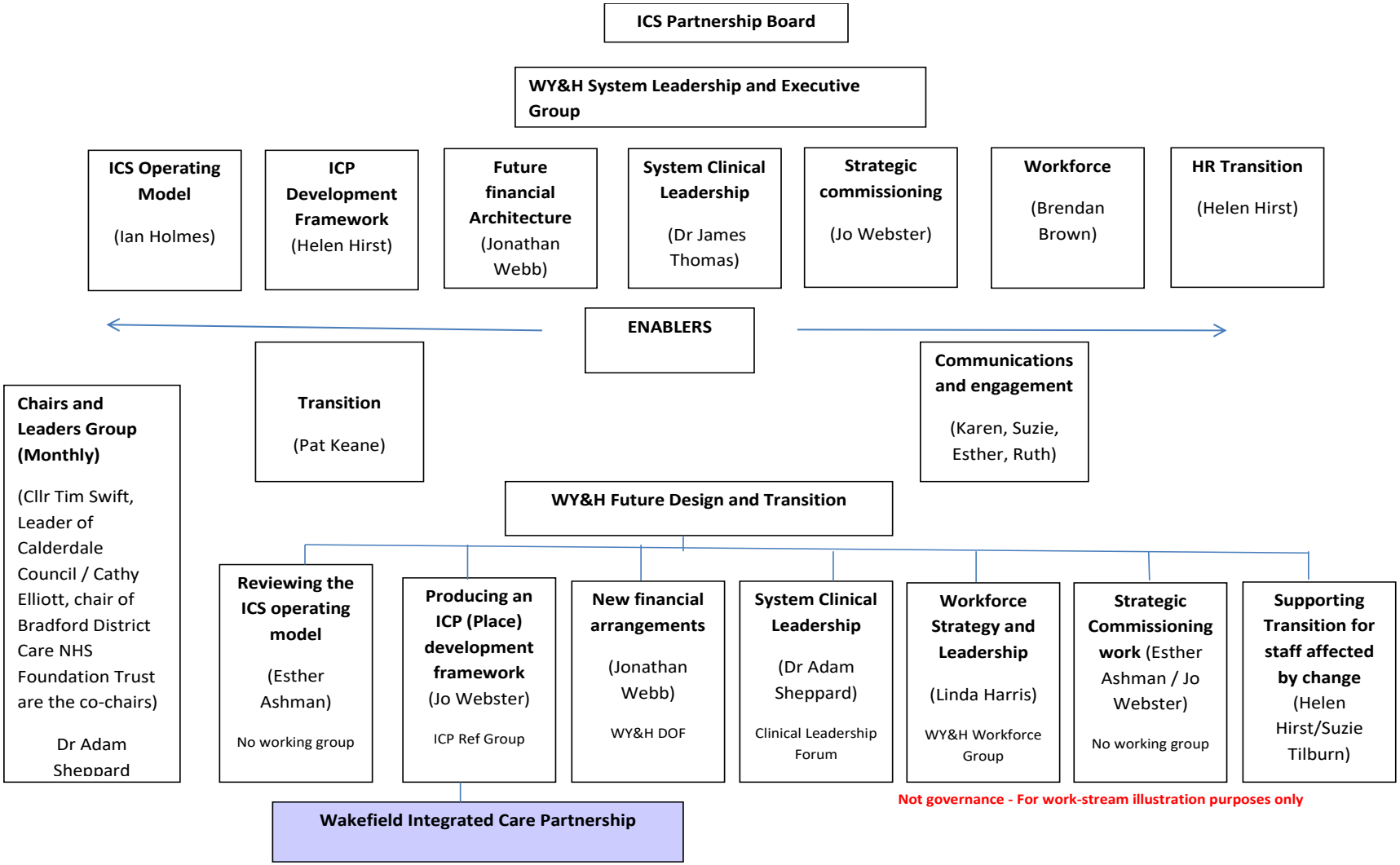
System Leadership Executive Components



Wakefield Shadow System Structure



West Yorkshire & Harrogate ICS



Wakefield System Development

Ambition & Vision
(What the partnership is there for)

- Improving All Age Population Health
- Reducing health inequalities by delivering the four health and wellbeing priorities
- Demonstrate **better experience** & **consistently good care** when accessing Health & Care services
- New relationship with people & professionals, that enables people to have a voice, to be heard and to be connected to each other and their communities.
- **Build our partnerships** across the system, to ensure we realise the full potential of all that we serve and the colleagues we work alongside

Leadership & Behaviours
(who and how it operates)

- Developing our design principles
- Our partnership is built on our relationships and behaviours
- Our leadership & behaviours help us be one team executing one vision
- Place based (system) People plan
- Resourcing & Partnership Capacity
- Distributive leadership model
- Strong Professional & Clinical leadership model
- Collaborative and Inclusive leadership, clear roles & Responsibilities

Governance & Accountability
(Structures & Systems)

- Ensure we have clear framework for decision making, that enables decisions to be taken as close to the citizen as possible
- Clear operating model, strong focus on delivery, whole population& joined up care
- Mechanisms in place through which the ICS functions that are discharged to place are robust. Finance, Quality, performance
- Mutual Accountability & Self Governing system
- Relationship and interdependences with other boards and committees
- Develop local Provider Collaborative

System Development Framework

Wakefield New Models of Care (ICP priorities)

1. Safe Transfer of Care (Discharge/MOFD)
2. Connecting Care Transformation
3. Mental Health
4. Reset and Recovery across system

Wakefield System Enablers

- Business intelligence, Performance & Quality
- Digital
- Workforce/OD – Wakefield's Local People Plan
- Co-production with citizens/residents
- Communications and Engagement

Understanding & Working with our Communities, Neighbourhood Model

Preventing Ill health, Reducing Inequalities, Addressing Social Economic factors that influence Health & Well being

Joining up & coordinating services around peoples needs

Supporting quality and sustainability of local services

Principles underpinning our system

1. Arrangements that support delivery of shared objectives.
2. Equitable distribution of contributions and benefits.
3. Fair and inclusive decision making, reflecting the citizen voice.
4. Cooperative behaviour – aligned to our shared values.
5. Fast and fair conflict resolution.
6. Low bureaucracy.
7. Subsidiarity.
8. Best practice public sector governance principles, including commitment to public accountability.
9. Authority to self govern (accordingly to principles 1-5).
10. Collaborative relations with other groups (using principles 1-6).
11. Capability and confidence to take delegated authority and be held to account for delivery.
12. Inclusive approach to developing future arrangements.

Leadership style and behaviours in our system

- Co – production.
- Distributed Leadership – **leadership is dissociated from designated organisational role and instead is about the actions of all individuals at all levels of responsibility are recognised as integral to our success.**
- Our leaders generate value wherever they work, supporting and balancing all motivations and perspectives.
- Look to inspire and promote integration.
- Transferrable skills across the system.
- Break down barriers and silo working.
- Build cross functional relationships, built on trust and strong communication.

Wakefield: Proposed Development Programmes

1. System development.
2. Developing and supporting the Wakefield Health and Wellbeing Strategy.
3. Children's and Young People Services
4. New models of care and provider collaboratives.
5. Wakefield System People Plan.
6. Infrastructure and systems.

Wakefield
System Development

Scope and Purpose:
To self-assess Wakefield System against the development framework to enable us to:

- Assess our current state;
- Determine our development needs; and
- Take action to address our needs.

To ensure that we have undertaken a review of our System (ICP) using the framework, enabling our place ICP development plans to contribute to the overall ICS development plan. In addition to provide assurance to the ICS that we are mature enough for receipt of delegated functions and associated monies from the ICS.

SRO: Jo Webster
Executive Lead: Mel Brown
Key Support: System

ICP Development Framework →

Addressing our ICP areas of development identified through ICP development framework. Aiming to be a thriving ICP through working through our actions as a ICP.

Developing Wakefield's New Care Model →

Developing a vision for a Wakefield Professional, Social Care & Clinical Care Model.

1. **See next Slide**

Capturing clear actions through our ICP Operational Plan 2021/22.

OD and Leadership →

Distributive Leadership model, Strong professional and clinical leadership models, Collaborative and Inclusive leadership, development of OD strategy.

Wakefield ICP Board OD Strategy.

Health & Well Being Strategy
Ambition & Vision
Vision, Purpose, Outcomes

Scope and Purpose:
Our ambition is to build the resilience of local people: we want people in Wakefield district to have healthier, happier and longer lives with less inequality. To deliver this we will do more to prevent ill health, to support people to make informed choices and be more in control of their lives. We know that people who have jobs, good housing, and are connected to families and communities feel better and stay healthier.

SRO: Anna Hartley
Executive Lead: Ruth Unwin
Key Support:

Ensuring a healthy standard of living for all.	**Working with our partners across the district to tackle poverty, loneliness, stress, debt, poor housing, smoking, alcohol, unhealthy eating, and physical inactivity and to minimise the impact this has on health and wellbeing.**
Giving every child the best start in life.	**Working closely with our Children and Young People's Partnership to ensure that we can provide our children with the best start in life.**
Strengthening the role and impact of ill health prevention.	**Increase a focus on self-care and support those with ill health and those who have conditions which suggest a lower life expectancy to prevent their health worsening. This includes our plans for mental health, cancer, frailty, primary care home and end of life care.**
Creating and developing sustainable places and communities.	**Adopt innovative approaches to transform health and wellbeing capturing our enabling work streams of workforce, digital, estates and communications.**
Public Engagement & Accountability	**Communications / Engagement, Partnerships Improving population health, Harnessing the Power of Communities, Citizen engagement / health watch.**

Children & Young People Transformation

Scope & Purpose:
To drive the Wakefield Families together vison and objectives and to deliver the key priorities outlined in the children and young peoples partnership plan

SRO: Beate Wagner
ICP Lead: Jenny Lingrell
Key Support: Children's & Young people partnership PMO

All children in Wakefield get the best start in life and are happy, healthy and safe

→ It is very clear that children's experiences in the earliest years of life, from pregnancy, have a profound impact on their health and wellbeing in adulthood. support children's speech and language development in the earliest years. Support initiatives to improve the health of women in pregnancy. Maximise existing initiatives on poverty, we will develop initiatives that maximise families' disposable income and improve the quality of life for families on a low income.

All children and young people enjoy good emotional and mental well-being, are resilient and feel supported and safe in their communities

→ Expanding the support offer to primary, secondary and colleges The Thrive model will be embedded within the local system approach to emotional and mental well-being and in all service developments. The development of the Future in Mind including clinical and therapeutic services.

All children and young people benefit from an all inclusive education and are well prepared for their transition to adult life

→ Improve the links between Virtual School and key partners, such as FE Colleges, to ensure effective transition of the year 11 CiC cohort. We will continue to embed and develop 'Project Search' across the District with key partners and reduce the % of our young people that are NEET across all cohorts Improve pupil outcomes at all key transition points ensure there are strong links between children and adult services to better facilitate a seamless transition to adulthood.

Wakefield – New Model of Care
Provider Collaboratives

Scope and Purpose:

- Reviewing Wakefield's provider collaboratives to determine the appropriate provider collaboratives in response to the White Paper and
- Developing a vision for a Wakefield Professional, Social Care & Clinical Care Model.

SRO: Martin Barkley
Executive Lead:
Key Support:

Urgent Care	Transforming urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay.
Planned Care	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services.
Connecting Care	Transforming, Social & community services, Community bed redesign & Care homes.
Primary Care Networks	Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
Wakefield Families Together Children's & YP	Delivery of Children's Plan.
Mental Health & Learning Disabilities Alliance	Expand and improve mental health services and services for people with a learning disability and/or autism.
Voluntary and Community Sector	Shaping and delivering services to enable the building of stronger resilient communities.

System Clinical & Professional Leadership

Wakefield People Plan

Culture, Style, Relationships & Behaviours

Scope & Purpose:
The right people confident, engaged and motivated with the right skills values and behaviours, which result in a A A workforce who collaboratively support self-management and deliver wrap-around health care and well-being services which embodies the "Triple Aim" of patient experience, health outcomes and financial effectiveness.

SRO: Linda Harris
ICP Lead: Suzie Tilburn
Key Support: PMO

Looking after our people	**Safe and healthy people - Quality health and wellbeing support available for everyone, A culture of civility and respect, Sickness absence is proactively managed, Flexible working.**
Enhancing and Growing Systems Leadership – Belonging	**Foster a culture of openness, compassion, inclusion and belonging where people are listened to and feel confident and able to speak up. Leaders at all levels take action to create an organisation culture where everyone feels they belong and diversity is celebrated, understood and encouraged.**
New roles, New ways of working and delivering care	**Create a workforce that is compassionate, flexible, adaptable, responsive and multi skilled, who are professionally competent and able to work in a person-centred manner.**
Growing our workforce and Developing our People	**Attract, recruit, retain and develop a flexible, resilient health, care and support workforce to deliver the Wakefield ICP vision. Attract the workforce from within our community along with people looking to live and work in Wakefield. Wakefield is recognised as a good place to work through valuing our people, looking after staff-wellbeing, providing excellent career and personal development opportunities.**
Strategic Workforce Planning	**A flexible approach to workforce planning which does not seek long term predicative precision but can identify and respond to potential medium-term issues enabling the workforce to evolve and adapt to inherently unpredictable health and care environment**

Wakefield
Infrastructure & Systems

Structures, Governance, Financial Frameworks, Risk, Data

Scope & Purpose:
To develop clear plans in setting out how will get to the position of being able to receive and be accountable for delegated functions.

SRO: Jane Hazelgrave
ICP Lead:
Key Support:

Provider Collaboration	**Ensure we have a clear framework for decision making, Clear Operating Model with a whole population focus to deliver connected care Mutual Accountability & Self Governing System, Develop local Provider Collaborative models using our local learning from Wakefield Mental Health Alliance, Relationships and interdependencies with other boards, committees and the ICS.**
Finance Performance & Business Intelligence	**Preparing for delegated responsibility, Deployment and management of the Wakefield NHS allocation, BCF allocation, Development of a BI/Outcomes framework, Financial strategy, Planning oversight, Capital and Estates, Contracting, Financial management.**
Quality	**Quality Improvement oversight / assurance, Safeguarding.**
System Clinical & professional Leadership	**Clinical networks, Priority programmes for specific populations, Innovation and Improvement, Digital, Meds Opt, Professional networks, Quality oversight / assurance, and Safeguarding.**
Citizen & Public Engagement	**How do we actively engage our local citizens in the design and planning of services. Capture experience and learn.**

System Development Programme SROs: Roles & Responsibilities

- Take leadership responsibility for the design of the programme and develop recommendations for Wakefield and WY&H.
- Ensure that the programme has clear outcomes based objectives supported by a clear delivery plan.
- Ensure appropriate programme governance and oversight arrangements are in place combining provider and system leadership.
- Work with the Wakefield ICP Executive to map out the important decision points – and timelines for making these decisions at ICP Board in preparation for new system responsibilities in April 2022.
- Ensure we have adequate representation, connectivity and influence at WY ICS design and delivery sub groups.

DRAFT Highlight Report

Overall progress **A** ***Risks Status*** **G**

Brief description of the project (aims, objectives, planned impactetc.)

Key Deliverables	Planned Completion Date	Suggested Revised Date	Actual Completion Date	Status / Comments

Key Accomplishments	Upcoming Major Activities

Keys Issues / Risks (Top 3)	Recommended Actions	Impact	Probability	Status
		High	Med	CLOSED
		Low	Low	OPEN
		Med	Low	OPEN

Key: **Green** = On plan; **Amber** = On/late to plan but with manageable risk; **Red** = Late to plan or requiring re-plan or scope change

Timescales

Workstream	ICS Timescales	ICP Timescales	Lead	Sponsor/SRO
System Development			ICP Lead:	ICP SRO:
• Values and behaviours toolkit to be developed.	July 21	August 21		
• NHSE Accountability and assurance work to have been developed.	July 21	August 21 (ICP BI/Assurance framework)		
• Update on detailed structure of System and ICP arrangements.	September 21	September 21		
• ICP to have clear development plans in place with a clear plan setting out how will get to the position of being able to receive and be accountable for delegated functions.	September 21	September 21 (ICP Business Plan)		
• Shadow arrangements go live.	October 21	October 21		
Governance			ICP Lead:	ICP SRO:
• ICS Governance Working Group, develop the governance arrangements for the ICS. Place arrangements to be aligned.	June 21	June 21		
• outline draft constitution and governance arrangements.	September 21	September 21		
• Put in place 'Shadow' arrangements and ways of working.	October 21	October 21		
• Complete due diligence and preparations for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies.	March 22	March 22		
• Statutory ICS organisation and supporting governance arrangements.				
• formally agreed and place functions confirmed.	April 22	April 22		
Finance			ICP Lead:	ICP SRO:
• Initial financial architecture discussion.	July 21	July 21		
• Update on Finance Structure.	September 21	September 21		
• Outline of finance allocations and arrangements for accountability and delegation.	December 21	December 21		

Timescales

Workstream	ICS Timescales	ICP Timescales	Lead	Sponsor/SRO
Workforce • Update on payroll & HR functions • Update on the WY People Plan strategy document. • Workforce strategy and planning • Update on the national HR framework, senior appointments and renumeration advice. • Update on the HR processes to support the move to the detailed structure. • Outline of process for formal notification to staff on hosting arrangements and job role. • HR update on the process for consultation with staff as part of the creation of the ICS body as a statutory body.	May 21 June 21 June 21 July 21 September 21 October 21 November 21	May 21 June 21 June 21 July 21 September 21 October 21 November 21	ICP Lead:	ICP SRO:
Clinical Leadership • Clinical leadership proposition. • Update on the National Principles Clinical and Care Professional Leadership. • Update on the ICS/ICP mapping of clinical leadership and resulting gaps and update on alignment of clinical leadership and medicines and pharmacy leadership. • Outline of Clinical Leadership peer review process.	May 21 June 21 August 21 November 21	May 21 June 21 August 21 November 21	ICP Lead:	ICP SRO:
Connecting Care Wakefield – New Model of Care	N/A	To be developed	ICP Lead:	ICP SRO:

Proposed Next Steps

- Establish ICP Executive.
- Establish development & transition plan, mapping key decisions for system and component organisation.
- Map resources and secure additional capacity where necessary.
  - Partnerships and System Reform Associate Director
  - Organisational development Expertise & facilitation
  - Strategic Communication, Engagement & Branding
- Confirm Leadership arrangements.
- Confirm arrangements & representation at WY.
- Enabler work streams to develop their plans in liaison with SROs for 5 areas of work.

For Discussion

- Does this approach make sense to colleagues?
- Agreement of SROs.
- How do we secure the collective ownership of all partner organisations to the proposed changes and secure accountability to the ICP?
- What is our Brand? Connecting Care? Wakefield Families Together, or both or something else?
- Should we shape all this in a dedicated OD session?
- How to engage with the public, OSC, others?

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Trust Board 29 June 2021
Agenda item 9.4

Title:	**Confirmation of Chief Executive's extended secondment to West Yorkshire and Harrogate Integrated Care System (ICS).**
Paper prepared by:	Director of human resources, organisational development and estates
Purpose:	The purpose of this paper is to confirm the arrangements for the secondment of Rob Webster to undertake the role of Chief Executive of West Yorkshire and Harrogate Integrated Care System on a full-time basis.
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.
Any background papers/ previously considered by:	The Workforce and Remuneration Committee and Trust Board have received regular updates on Board Succession Planning.
Executive summary:	The Trust Board agreed to second Rob Webster on a full-time basis to the role of Chief Executive for West Yorkshire and Harrogate ICS with effect from 5 July 2021 initially up to 30th September 2021. Any extension beyond this date will be subject to a further review by the Trust Board. In agreeing to this secondment, the Trust Board carefully considered the risks and potential impact of these arrangements and was assured that robust executive cover could be put in place to ensure that the Trust remains Well Led. These arrangements include: • Mark Brooks, Director of Finance and Resources will act into the role of Chief Executive with effect from 5 July 2021. • An appointment has been made following a recruitment process to an interim Director of Finance and Resources with effect from 11 August 2021. **Risk Appetite** A risk matrix was considered by the Trust Board for the potential Chief Executive secondment and these arrangements are within the organisation's risk appetite.

Recommendation:	**Trust Board is asked to NOTE the confirmation of the secondment of Rob Webster to the role of Chief Executive West Yorkshire and Harrogate ICS on a full-time basis with effect from 5 July 2021.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021

Agenda item 9.5 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	10 June 2021 Next meeting scheduled for 7 Oct 2021
Member	Chief Executive / Director of Strategy
Items discussed	• Poverty Needs Assessment. • Integrated Care System Compact. • Barnsley Sustainability. • Healthy Weight Declaration. • Collaborative Cold Weather Planning • For Information/to note: A Day in the Life of - Diane Lee
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143

Calderdale Health and Wellbeing Board

Date	15th April 2021 / 10th June 2021
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	15th April 2021 • 'Nothing About Me Without Me' – Recognising the challenge of inequality for people with Learning Disabilities • Objective - To set a system wide approach to working with people with learning disabilities so that everybody can live a larger life • To respond to the "ask" from the West Yorkshire and Harrogate Health and Care Partnership • Facilitated by Iain Baines – Director for Adult Services and Wellbeing 10th June 2021 • Calderdale Local Outbreak Prevention and Management Plan • Scrutiny Review – Economic Inequalities arising from the Covid-19 pandemic • Calderdale Cares – our next step on place-based integration. • The Wellbeing strategy re-focused • Forward plan – Informal discussion on learning disabilities
Minutes	Papers and draft minutes are available at: https://www.calderdale.gov.uk/council/councillors/councilmeetings/results.jsp?committee=190&start=15%2F10%2F2020&p_SQ_ID=5102139&phrase=N&type=agenda&offset=0&id=211221434

With all of us in mind.

Kirklees Health and Wellbeing Board

Date	24th June 2021
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	• Developing the Kirklees Joint Health and Wellbeing Strategy • Implication of the White Paper for Kirklees and West Yorkshire • Future role of functioning of the Health and Wellbeing Board • Kirklees SEND plan and Self-Evaluation Framework (SEF) • Arrangements for Health and Wellbeing Board meetings on 2021/22
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Wakefield Health and Wellbeing Board

Date	Next meeting provisionally scheduled for 15 July 2021
Member	Chief Executive / Director of Provider Development
Items discussed	Agenda not yet available
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	**Message sent on behalf of Helen Stevens-Jones** Following the co-design of the South Yorkshire and Bassetlaw Integrated Care System Health and Care Compact and Health and Care Partnership (H&CP) Terms of Reference for the transition year 2021/22, led by the ICS Development Steering Group, the Collaborative Partnership Board will be succeeded by the H&CP later this year.
Member	Director of Human Resources, Organisational Development and Estates / Director of Strategy
Items discussed	N/A
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 June 2021 Next meeting scheduled for 7 September 2021
Member	Chief Executive
Items discussed	• Update from the West Yorkshire & Harrogate Partnership CEO Lead. • Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues. • West Yorkshire and Harrogate Health and Care Partnership Health Inequalities Academy. • Support for refuges and asylum seekers. • Our response to the White Paper: Update and Next Steps. • Our response to the White Paper: Developing our governance arrangements. • Operational Planning 2021/22.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29th June 2021
Agenda item 10.1

Title:	**Update to the Customer Services Policy: management of complaints, concerns, comments and compliments**
Paper prepared by:	Director of Nursing & Quality
Purpose:	For Trust Board to note that the policy that provides the framework for responding to enquiries and learning lessons from feedback through complaints, concerns, comments and compliments has been reviewed and updated taking account of the information shown in the executive summary below.
Mission/values:	The Customer Services Policy links to all the Trust's values in supporting an improved service user experience through being open honest and transparent, respectful, putting the person first and in the centre, to improve and be outstanding, be relevant today and ready for tomorrow and demonstrating that families and carers matter.
Any background papers/ previously considered by:	The policy was reviewed and supported for approval by EMT on 20 May 2021.
Executive summary:	The Trust has an established Customer Services function, which works with Business Delivery Units (BDUs) to support a response to all enquiries. This includes a response to issues raised under the NHS Complaints procedures. The Customer Service Policy provides the framework for responding to these enquiries and takes account of relevant legislation and best practice. The policy was reviewed and updated in January 2017 and approved by Trust Board. The policy has been updated to reflect changes to the complaints procedure in general. Specific updates include: • Role titles • Definitions clarified • Complaints pathway changes • Roles & responsibilities • Learning lessons from complaints • Equality impact assessment We have also included guidance for dealing with persistent and unreasonable contact. **Risk Appetite** The Customer Services Policy supports the Trust in its endeavours to provide high quality and equitable services, which value and respond to feedback, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.

With **all of us** in mind.

Recommendation:	**Trust Board is asked to APPROVE the Customer Service policy updated as outlined above with the next review in 3 (three) years unless required earlier.**
Private session:	Not applicable.

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Document name:	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
Document type:	Policy and Procedure
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and internet
Issue date:	December 2013 (V1) December 2014 (V2) January 2016 (V3) January 2017 (V4) June 2017 (V5) May 2021 (V6)
Next review:	September 2022 (in line with National Complaint guidance update)
Approved by:	Executive Management Group on 20 May 2021 Trust Board on (tbc)
Developed by:	Reviewed by Associate Director of Nursing & Quality
Director leads:	Director of Nursing & Quality
Contact for advice:	Customer Services

With **all of us** in mind.

1. Introduction

South West Yorkshire Partnership NHS Foundation Trust endeavours to provide the best service it can to its patients. Sometimes patients' carers, families and/or their representatives may have concerns about services provided and it is important that there should be a clear and effective Customer Service Policy and Procedure for such matters. The service operates as a single gateway for raising issues and enquiries. This policy primarily covers feedback about Trust services and the management of complaints, concerns and compliments.

To enable the Trust to provide a responsive, quality public service it is essential to actively seek the views of those people who use our services and to respond appropriately when things go wrong. Complaints handling is a good proxy for an open, transparent and learning culture – which must be evident in a well-led organisation.

The Customer Services policy incorporates the obligations in the NHS Constitution and the Health and Social Care Act. It has been devised with reference to and also takes account of national reports, in particular:

- NHS England's Assurance of Good Complaints Handing for Acute and Community Care – which sets out evidence commissioners should be seeking as part of their regular quality assurance processes with providers (updated September 2018)
- The NHS Constitution (Rights and Responsibilities of NHS staff and patients)
- Patients Association, Good Practice Standards for NHS Complaints Handling (2013)
- NHS Resolution Risk Management Standards (2020)
- Lessons learnt following the inquiry into the care provided by Mid Staffordshire NHS Foundation Trust (Francis report 2013)
- Health Service Ombudsman guidance, including:- - Ombudsman Principles - Improving complaint handling across the NHS and Social care and My Expectations (2014) - 'Breaking down the barriers' (2015)
- Healthwatch (2013)
- Independent Advocacy Services
- Human Rights Act (1998)
- Duty of Candour obligations (2013)
- Care Quality Commission – Complaints Matter (2014)

Making the process of feedback easy is essential; the Trust recognises that complaints might only arise as a culmination of a number of experiences, so actively encouraging feedback and apologising for negative experience is important.

Dealing with feedback in a transparent and responsive way demonstrates a commitment to improving people's experience of services and to ensuring they get the best possible support. This is built on the duty of candour, mutual respect, effective engagement, excellent customer service and a necessary and proportionate response to issues.

Complaints matter because every concern or complaint is an opportunity to improve and well-handled complaints will improve the quality of care for other people. Failure to deal with complaints appropriately presents a risk to the organisation – a missed

opportunity to improve services as a consequence of feedback and could have an adverse effect on the Trust's public reputation.

2. Purpose and Scope

People who use Trust services have a right to have their views heard and acted upon. The Trust has given a commitment through its mission and values to put the person first and centre and to be honest, open and transparent in all its dealings.

NHS complaints legislation requires a single approach for the handling of complaints across health and social care. The Trust has adopted a person centred approach to ensure that issues are dealt with in a way that people are empowered and able to make choices about how their concerns are dealt with. This approach has been further strengthened through the adoption of the framework which sets out best practice in five steps which is reflected in this policy:

- Considering a complaint – ensuring people are given information about how to complain, that they will be supported to do so and care will not be compromised.
- Making a complaint – ensuring all staff can help, and that making a complaint is easy and convenient.
- Staying informed – keeping people up to date and making the response personal.
- Receiving outcomes – resolving complaints and achieving the appropriate outcome.
- Reflecting on the experience – ensuing complaints are handled fairly and consistently and people understand how their feedback has helped to improve services.

Every member of staff is responsible for supporting people who wish to provide feedback or raise concerns and helping to resolve issues at service level wherever possible. Staff are alerted to customer services processes through promotional activity with services and teams, supported by publicity material and intranet based information. All staff should be able to advise service users, carers, relatives and visitors to the Trust on how to access customer services, including how to make a complaint. Staff assigned to investigate complaints should be supported to take action as appropriate in accordance with Trust policy and procedures and in highlighting necessary learning.

The commitment to learning from people's experience includes:

- Staff empowered to support service users, their relatives and carers in giving feedback and to resolve issues promptly and locally wherever possible.
- The use of insight gained from complaints, concerns and compliments, and other forms of feedback to improve the care provided to service users and carers.
- Thorough and timely investigation of complaints and concerns, and an open and conciliatory response.
- Fair treatment for people who make complaints, and assurance that care will not be compromised in any way.
- Feedback used as essential element of the Trust's approach to Governance.

3. Definitions

For the purposes of this policy, feedback is defined across three categories:

3.1 Compliments

Positive feedback received regarding care received by service users, their relatives and carers.

3.2 Comments (Service Issues)

A comment is a matter that is not about an individuals care and treatment. It is something that is a cause for concern to the complainant, eg. they may be unhappy with parking arrangements at the service, or someone is leaving lights on when a building is empty which serives will respond to an provide the relevant information on a monitoring form to the customer service team.

3.3 Concerns

A concern is a matter which an individual wishes to be considered on an informal basis. It is expected that the majority of concerns raised will be dealt with by the complaints process. All staff are expected, on a routine and daily basis, to deal with patient's concerns as presented to them. Wherever possible, staff are encouraged to achieve speedy resolution of the concern by either resolving it personally or establishing a dialogue between the complainant and the relevant personnel within operational areas. The objective will be speedy, informal resolution of the concern without recourse to correspondence/formal procedure.

3.4 Complaints

The NHS complaints regulations define a complaint as an expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply:

- Action by the Trust or someone working for the Trust has detrimentally affected the experience of the service user or carer
- The complainant believes that a mistake or error occurred and that this has detrimentally affected them
- The complainant brings to the attention of the Trust an issue about a Trust service which could detrimentally affect them or someone else which they expect the Trust to put right.

4. Other forms of feedback

A range of approaches are in place across the Trust to obtain feedback from people who use our services, which, taken together, provide a framework for gathering insight into service user experience.

The framework includes real time feedback, surveys, focus groups, workshops and events, and participation in National Patient Surveys as prescribed by the Care Quality Commission

4.1 Who can give feedback?

Any individual can give feedback to any Trust employee, including Customer Services. Feedback is most commonly received from service users, those affected by service provision, those acting as a representative of a service user, carers, relatives, MPs, councillors, advocates and Healthwatch.

There is a Customer Service Information Leaflet available on the Trust Internet and Intranet (and also an easy read version) that can be provided to support people to give feedback on the services they have received.

4.2 Receiving feedback

The Trust encourages and expects staff to seek feedback and to know how to signpost to Customer Services if that is the person's preference. Customer Services leaflets and posters will be displayed in all service areas.

The Customer Services team can be contacted by telephone, email, via web link, text, in writing or by referral from a member of staff. Corporate social media accounts and external websites (NHS Choices, Patient opinion, Healthwatch) are also monitored to ensure feedback is captured and responded to if possible.

4.3 Acting on Feedback

A key objective of the Trust is to listen, learn, change and improve in response to concerns and complaints. The lessons learnt and trends identified as a result of concerns and complaints play a key role in continuously improving the quality of care received by patients and are a priority for the Trust.

4.3.1 Compliments

- Compliments can be provided to any member of staff by any member of the public, other members of staff or partner organisations. If a compliment is provided in writing to the relevant ward/department, the manager will respond to acknowledge the compliment.
- Each BDU is responsible for ensuring all compliments are logged.

4.3.2 Concerns and Complaints

4.3.2a Informal

- Services should invite and welcome feedback.
- Response to concerns and complaints should be *on the spot* wherever possible and a monitoring form completed.
- If it is not possible to resolve the concern or complaint straight away, assistance should be sought from the service line management. If the concern or complaint is raised verbally, and can be resolved within one working day, the response does not need to be in writing. The issue should be documented using the monitoring form.
- Concerns that are addressed at service level will be agreed on an individual basis as to whether the complainant prefers a response in writing or is happy with verbal feedback (verbal feedback should be recorded on the monitoring form).

4.3.2b Formal

- Concerns and complaints received in writing, by email or via telephone that cannot be resolved quickly (by the service) will be reviewed by the Customer Services manager and allocated to a case handler.

- Customer services staff will agree a handling plan with the person raising the issue.
- Formal complaints will always require a formal investigation and written response and the person raising the complaint will receive a written response from the Responsible Officer for Complaints Management

The procedure for complaints handling is detailed in **Appendix A**.

There is also guidance on dealing with persisitant and unreasonable contact in **Appendix B.**

4.4 NHS Complaint Regulations (2009)

The NHS Complaints Procedure covers the following:

- A person who is in receipt of, or who has received, services from the Trust.
- A person who is affected, or likely to be affected, by an action, omission or decision of the Trust.
- A person who is acting on behalf of a person who has died, is a child, is unable to make the complaint themselves because of physical incapacity, or lack of mental capacity (Mental Capacity Act), or has been requested to act as a service user's representative
- The Regulations require that a complaint must be made within 12 months of:
  (i) The date on which the matter which is the subject of the complaint occurred; or
  (ii) If later, the date on which the complainant become aware of the matter which is the subject of the complaint.

  Complaints made outside the established time limits can prove difficult to investigate and extremely problematic to resolve, not least because of the inevitable doubts over memories of events some time previously. This is a relevant factor to be considered in determining whether it will be possible to investigate a 'late' complaint effectively.

  Where a complaint is made outside this time limit the Customer Services Manager in discussion with the Assistant Director of Nursing & Quality may exercise discretion to admit the complaint to the Procedure if they are satisfied that:
  (i) The complainant had good reason for not making the complaint within the time limit; and
  (ii) Notwithstanding the delay it is still possible to investigate the complaint effectively and fairly.

  If it is not possible to waive the time limit and the complaint is not accepted into the Customer Services Procedure, an explanation of this will be provided to the complainant in writing.
- Complaints can also be made by a person acting on a patient's behalf for any services connected with the Trust, as long as consent is provided by the patient or the person has the legal authority to do so.
- All complainants will be informed about the right to access independent complaints advocacy.

- All complainants have the option to apply to the Parliamentary and Health Service Ombudsman, to ask for independent review of their complaint, should they remain dissatisfied following the Trust's management of their complaint.

In line with the NHS regulations, the following are **not** covered by the Trust's Customer Services policy:

- Requests for access to records or an amendment to the clinical record (refer to Access to Records procedure).
- Requests for a change to care plan or medication (refer to clinical team).
- Challenges to policy decisions by the Trust Board (refer to Trust Board chair).
- Complaints made by a member of staff about their employment or about another member of staff. (refer to HR policies).
- Complaints made about volunteer activity (refer to Equality & Engagement Team).
- Complaints about involvement activity (refer to Equality & Engagement Team).
- Commissioning decisions (refer to appropriate Clinical Commissioning Group).
- Complaints about services delivered by an independent provider, on behalf of the Trust, are not covered by the NHS Complaints regulations. However, the Trust must satisfy itself about the quality of service and that the independent provider has its own robust complaints procedure.
- Complaints about superannuation (refer to payroll/HR department).
- Staff who wish to voice concerns or grievances should be raised through appropriate line management processes in line with Human Resources policy, or through the Freedom to Speak up Guardians where appropriate.
- Complaints which have already been investigated and concluded using the NHS procedure (refer to the section of this policy covering Parliamentary and Health Service Ombudsman).

4.5 Complaints to other bodies, including the Care Quality Commission (CQC)

People who are, or who have been, detained under the Mental Health Act have the right to complain to the Care Quality Commission (CQC) about use of the Mental Health Act. The CQC will usually ask that the complaint is initially submitted to the hospital managers.

The Mental Health Act Code of Practice (2015) requires information on how to complain to the CQC to be readily available on all wards that are registered to support people detained under the Act. The Trust will ensure CQC policy material providing the relevant information is available on its wards. Due consideration will be given to the Accessible Information Standard in sharing this information.

5. Duties

The customer services process is supported by:-

5.1 The Chief Executive

The Chief Executive (or nominated deputy) has overall responsibility for ensuring the Trust Customer Service Policy meets statutory requirements as set out in the NHS Complaints Regulations (2009). Will review and sign all final responses to complainants, having received assurances from the relevant director that the response addresses all points raised in the complaint management plan.

5.2 The Trust Board

Trust Board is responsible for approving the policy for the approval, dissemination and implementation of policies and procedures as outlined in this document. The Clinical Governance And Clinical Safety Committee will receive quarterly reports from the Customer Service Team

5.3 The Executive Management Team (EMT)

The Executive Management Team will monitor key performance indicators (KPIs) in relation to complaints through monthly business intelligence dashboard reporting. The Executive Management Team will also review any action plans arising from complaints upheld or partially upheld by the Parliamentary and Health Service Ombudsman.

5.4 Directors

The Director of Nursing & Quality is the lead director for customer services, including complaints management. The Director of Nursing & Quality will ensure appropriate arrangements are in place to respond to issues raised, in ways that support people to live well in their communities, and that maintain and enhance the Trust's reputation for putting people who use services at the heart of service delivery. The Director of Nursing & Quality will ensure that Customer Services information is reported appropriately to BDUs, in integrated performance reports and in quarterly and annual reports to the Clinical Governance & Clinical Safety Committee. The Director of Nursing & Quality will review and sign all final responses to complainants, having received assurances from the relevant director that the response addresses all points raised in the complaint management plan.

Deputy Directors and Clinical Leads will ensure appropriate systems are in place to:

- Respond to feedback, investigate concerns and complaints
- Review complaint responses to ensure:
    - Ownership of the response by the service
    - Quality assurance of the response in terms of addressing the root causes
    - Actions are consistently learned and applied across services and in the system.
- Monitor delivery of complaint action plans through BDUs governance processes.
- Provide updates to Customer Services to incorporate in quarterly reports to Trust Board.

5.5 Customer Service Team

The team will ensure processes that support complaints investigation and resolution, for example the complaints toolkit, remain fit for purpose, support staff to resolve issues, and service users in an effective complaints management process.

When concerns or complaints are received, the Customer Services Team will:

- Ensure that the complainant is contacted by an allocated team member to explain the process and discuss the handling of the concern/complaint.
- Ensure the complainant is at the centre of the process, and that a complaint management plan is developed, taking account of the complainant's expectations for resolution and negotiated timescale for investigation.
- Alert directors as appropriate to concerns / complaints that suggest quality of care is compromised or other risk assessment is required.

- Ensure written acknowledgement is sent to the complainant within 3 working days.
- Ensure the assigned team member liaises with the relevant clinical lead, manager, or other organisations, to facilitate a response within the agreed timescale.
- Ensure the complaint investigator keeps Customer Services updated with the progression of the complaint at all times and at least weekly.
- Receive information from the complaint investigator to enable a response to be produced for director review prior to sign of by the Responsible Officer for Complaints Management.

Where more than one organisation (health or social care) is involved, the Customer Services Manager or Assistant Director of Nursing & Quality will ensure appropriate consent is obtained, and that a lead person is appointed to co-ordinate the investigation and response.

Where complaints received by the Trust relate to another organisation the complaint will be referred on as appropriate, without delay, following receipt of consent from the complainant.

5.6 Clinical leads / General Managers / Practice Governance Coaches/ Quality & Governance Leads/Matrons

Working with Customer Services as appropriate:

- Ensure objective and thorough investigations in accordance with the procedure, either by investigating the issues in person or by appointing a suitably skilled member of staff to conduct the investigation.
- Ensure all relevant information to respond to a complaint is collated and provided to the lead investigator, who will complete the complaints toolkit.
- Meet agreed timescales in relations to complaints investigation and management.
- Advise the deputy director about complaints, and support review of issues and learning through BDU governance processes.
- Ensure any learning for the wider Trust is shared.

5.7 Complaint Investigators

Complaint investigators will have completed relevant training. They will co-ordinate the response, collaborating with relevant colleagues as required. The complaint investigator is responsible for:

- ensuring the response for each element of the investigation is of a high quality, prior to amalgamating for inclusion in the final response;
- ensuring that the investigation is completed within the expected timeframes and escalating this if the agreed response date will not be met to the customer service team;
- ensuring an appropriate investigation has been completed;
- planning the investigation, timescale expected and keeping the customer service team informed.

5.8 All Staff

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

seek out this information. All staff will assist and cooperate in the complaints process. Wherever possible they will try to deal with issues of concern before it becomes a formal complaint.

5.9 Reporting Feedback

The Customer Services Team will provide regular reports to BDUs, advising open and closed complaints in the period and progress on complaints investigation.

The Customer Services Team will provide quarterly reports to the Clinical Governance & Clinical Safety Committee and to BDUs, covering the number of issues raised, a breakdown of complaints, concerns, comments and compliments, identification of themes and evidence to demonstrate that lessons have been learned as a result of service user feedback. Reports will also include issues referred to the Parliamentary and Health Service Ombudsman, including any financial redress. The quarterly report will be shared with the Mental Health Act Committee to alert to complaints relating to application of the Mental Health Act, and with the Members' Council Quality Group for review and information.

The Report will also be shared externally with CCGs through contracting and quality monitoring processes and with Healthwatch across Trust geography.

An annual report will be produced for consideration by the Clinical Governance & Clinical Safety Committee. The the Clinical Governance & Clinical Safety Committee is responsible for approving Trust policy in relation to complaints handling, for ensuring compliance with national and local targets in relation to complaints, and that robust systems are in place to enable feedback about services and that lessons learned lead to an improved service user experience.

6.Process for learning and improving as a result of comments, concerns and complaints

Many complaints arise from misunderstandings and may be resolved through appropriate explanation and discussion. Other complaints, however, will reveal ways in which Trust services may be improved. The Trust recognises the pledge in the NHS Constitution to learn lessons from complaints and use these lessons to improve its services.

A complaints action tracker will be held by the Customer Serivces team and progress will be required to be reported to the dedicated Customer Services Officer by the complaint investigator for each complaint. This will track whether actions are "open" or "closed".

Where the complaint raises any performance issues of particular concern, these should be reported by the relevant Deputy Director to the relevant General/Service Manager, Clinical Lead, the Medical Director or Director of Nursing & Quality, as appropriate.

Where it is clear that improvements to services can be made, these should be explained to the complainant in the response to the complaint.

Whilst responsibility for managing the Customer Service Policy rests with the Customer Service Department, it remains the responsibility of staff within individual Service to identify whether they may learn from the complaints received by the Trust and create an action plan.

Responsibility for ensuring that all appropriate actions have been implemented will rest with the Service through their established governance arrangements.

Analysis of lessons learnt from complaints will be undertaken by the Customer Service team with recommendations for wider improvements in response to identified trends considered by the Clinical Governance & Clinical Safety Committee.

7.Process for monitoring compliance with this policy

The Assistant Director of Nursing & Quality is responsible for monitoring compliance with this policy. This will be achieved through:

- The ongoing monitoring role of the Customer Services team.
- The Customer Services team make data and reports available within the Trust as described above.
- Routine contact with services and investigators regarding the ongoing process for complaints investigation.
- Feedback from Commissioners.
- Contact, as appropriate, with partner organisations, the Parliamentary and Health Service Ombudsmen, the CQC, the Information Commissioner and NHSI.

Relevant concerns will be reported to the Executive Management Team, with action by the appropriate director.

8. Associated documentation

Supporting procedural documents include:

- Investigating and analysing incidents, complaints and claims to learn from experience Policy and Procedures.
- Being Open policy – including duty of candour.
- Claims Management Policy and Procedure.
- Safeguarding Children procedures.
- Safeguarding adults procedures.
- Health and Safety policies, procedures and processes.
- Human Resources and related policies and procedural and related documents.
- Information Governance (and Caldicott Guardian) related policies and procedural documents.
- Freedom of Information Policy
- Accessible Information Policy
- Communications, Engagement and Involvement Strategy
- Preventing Violence and Agression Policy

9.Equality Impact Assessment

This policy promotes equality of access to the Trust's Customer Services function. See **Appendix C** for equality impact assessment.

The potential for people to have difficulty in accessing this procedure is mitigated by ensuring support is available through Customer Services, the availability of information in different formats on request, and promoting access to advocacy and interpreting services.

10 Dissemination and implementation

This policy will be promoted through 'The Headlines' weekly staff bulletin and accessible via the Trust intranet and internet. Leaflets and posters publicising the ways to offer feedback will be available in all Trust clinical and public areas.

Implementation of the policy will be the responsibility of staff at all levels, and supported by all managers and directors.

Managers are required to monitor compliance with this policy and to ensure a systematic approach to responding to feedback from people who use services and their families / carers.

Managers are required to ensure appropriate support is in place for staff impacted by complaints.

BDUs are required to ensure staff who undertake complaints investigation are skilled and supported to do so, to develop action plans to address areas for improvement, and to monitor delivery of same through governance processes.

11 Review and Revision arrangements

This policy and procedure will be subject to annual review by the Trust Board, with review instigated in the event of policy change. **Appendix D**

12 Document control and archiving

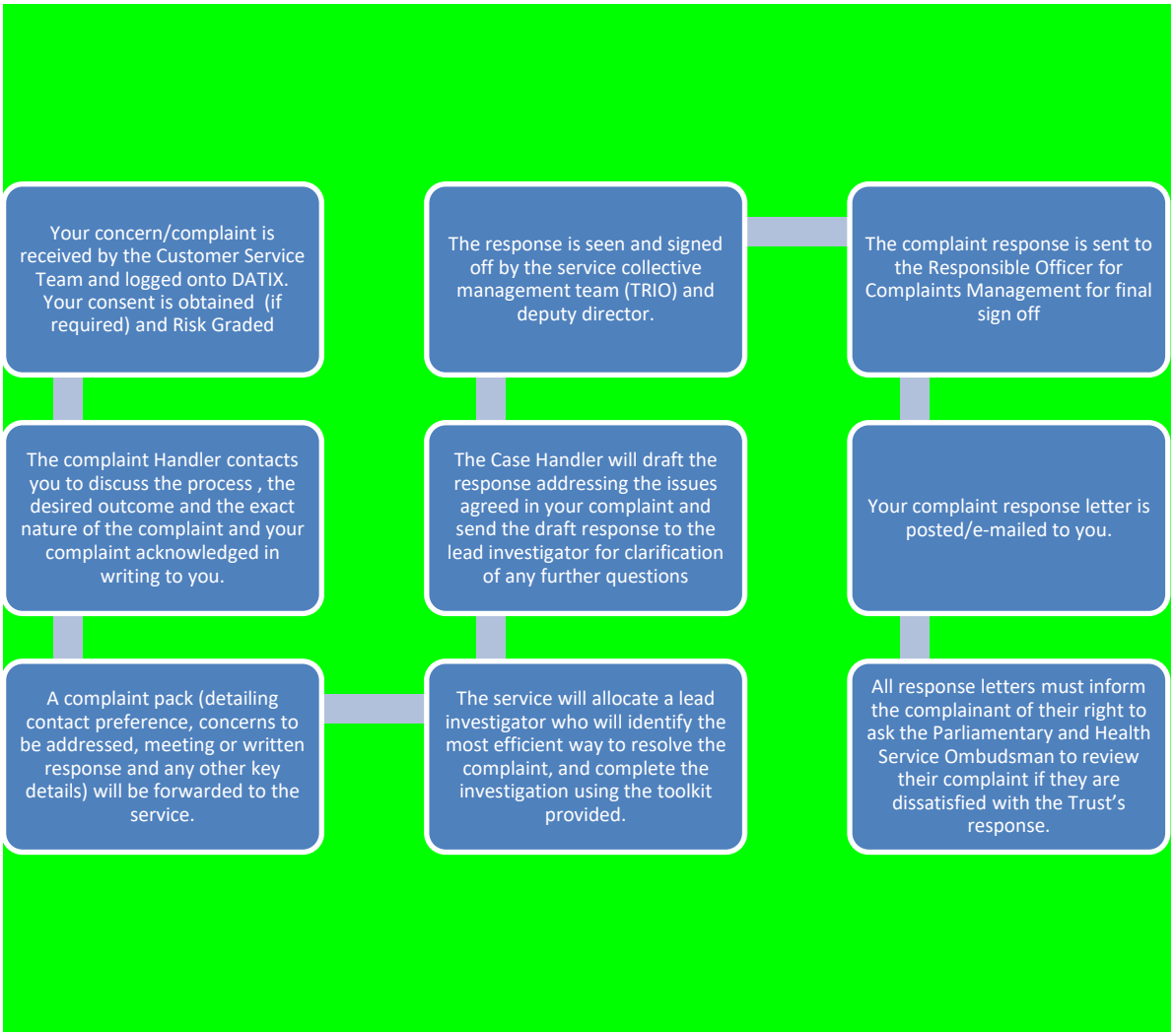
This policy will be accessible via the Trust's intranet and website in read only format and managed in accordance with the requirements for retention of non-clinical records. **Appendix E**

APPENDIX A

Complaints Procedure (Local Resolution)

All complaint investigations should follow the pathway for comapliant management as set out below.

Every effort must be made to support people who wish to make a complaint. This could include language support, support in dicumentingthe issues/concerns, signposting to advocacy services or providing mediation.



All records relating to complaints investigation are confidential and must be be kept by the Trust in a secure environment for 10 years. No other files relating to complaints should be held by the organisation and complaints correspondence should not be part of the clinical record. Clinical staff must be appraised of actions taken to resolve complaints to promote learning.

- Consideration must be given to the following:
    - All complaints are risk screened on receipt.
    - If a complaint involves clinical issues that require urgent attention or raises issues that could potentially compromise public or service user safety, the appropriate deputy director must be informed immediately.
    - Complaints that could fall into the Serious Incident category must be referred for advice to the Patient Safety Support Team. Every effort must be made to minimise distress or confusion to the complainant.
    - Where a complainant indicates they intend to take legal action, the matter must also be referred to the Assistant Director of Legal Services. The Trust will take legal advice and in some, but not all, circumstances it may be appropriate to cease action under the complaints procedure. This is consistent with national guidance.
    - Complaints / concerns highlighting professional practice issues must be referred to the medical or nursing directorate as appropriate.
    - Complaints about members of staff that involve accusation of misconduct must be referred to Human Resources. Staff have the right to be dealt with fairly in such cases, and complainants do not have the right to information about specific action taken against staff members.
    - Issues that could potentially attract media attention must be referred to the Communications Team.
    - Issues relating to child protection must be referred to the Trust's Named Nurse for Child Protection, and dealt with under joint agency protocols for child protection.
    - Issues relating to Vulnerable Adults must be referred to the Trust's Vulnerable Adults Specialist Advisor, and dealt with under joint agency protocols for vulnerable adults.
    - Where a complaint alleges a criminal offence, the complainant will be advised of their right to report the matter to the police, and will be supported to do so. If the complainant chooses not to report a serious matter which may be criminal, the Trust may choose to notify the police. Advice should be sought from the Caldicott Guardian where such action might be in breach of a person's confidentiality.
    - Investigators should always alert the Customer Service team at an early stage if a complaint is proving particularly complex or difficult to resolve. Revising the approach may prevent a complaint escalating to Ombudsman Review.

APPENDIX B

Guidance for dealing with persistant and unreasonable contact

Most complaints are entirely reasonable; however a few are not. Some may, for example, abuse or threaten members of staff or continue to raise the same concerns when these have already been addressed. The following are examples of behaviour which might be regarded as unreasonable:

- Refusing to specify the grounds of a complaint, despite offers of assistance with this from the authority's staff.
- Refusing to co-operate with the complaints investigation process while still wishing their complaint to be resolved.
- Refusing to accept that issues are not within the remit of a complaints procedure despite having been provided with information about the procedure's scope.
- Insisting on the complaint being dealt with in ways which are incompatible with the adopted complaints procedure or with good practice.
- Making what appear to be groundless complaints about the staff dealing with the complaints, and seeking to have them replaced.
- Changing the basis of the complaint as the investigation proceeds and/or denying statements he or she made at an earlier stage.
- Introducing trivial or irrelevant new information which the complainant expects to be taken into account and commented on, or raising large numbers of detailed but unimportant questions and insisting they are fully answered.
- Electronically recording meetings and conversations without the prior knowledge and consent of the other persons involved.
- Adopting a 'scattergun' approach: pursuing a complaint or complaints with the authority and, at the same time, with a Member of Parliament/a Councillor/the authority's independent auditor/the Standard Board/local Police/Solicitors/the Ombudsman.
- Making unnecessarily excessive demands on the time and recourses of staff whilst a complaint is being looked into, by for example excessive telephoning or sending emails to numerous hospital staff, writing lengthy complex letters every few days and expecting immediate responses.
- Submitting repeat complaints, after complaints processes have been completed, essentially about the same issues, with additions/variations which the complainant insists make these 'new' complaints which should be put through the full complaints procedure.
- Refusing to accept the decision – repeatedly arguing the point and complaining about the decision.
- Combination or some or all of these.

Trust staff should acknowledge that, at times, people might find it difficult to express their frustration and might behave in a way that makes resolution difficult. Staff should support people to raise their issues in a constructive manner, manage expectations, and work towards a satisfactory outcome. However, the Trust has a responsibility to protect its staff from people who behave in an abusive or malicious manner, and to

avoid inappropriate use of resources through dealing with persistent or unreasonable complaints.

If an investigation lead or customer services co-ordinator becomes concerned that a complainant is becoming unreasonable, they must seek assistance from the Customer Services Manager. It is vital that any restrictions placed on a complainant should be as a result of a fair and consistent process. Any request to cease or limit an investigation about a complaint that is considered unreasonable or persistent, needs to be considered in consultation with the Director of Operations and the Chief Executive (or nominated deputy).

It may be necessary to request that the complainant only makes contact with a named individual, by one contact method only, for example either by telephone, email or in writing. Where a named individual is assigned they should ensure a comprehensive record of all contact is maintained.

The complainant must be advised that issues already responded to will not be re-opened or re-investigated. If appropriate, the complainant should be informed that abusive correspondence, or threatening behaviour, will not be responded to. The complainant should be offered information regarding independent advocacy support.

Letters or telephone calls received during the formal investigation stage will be acknowledged and any new issues included in the overall investigation. A meeting may be offered to clarify the issues to be investigated and confirm the process. The complainant should be advised if new issues are likely to affect the timescale for providing a final response to the complaint.

The precise nature of the action the Trust decides to take in relation to an unreasonable persistent complainant should be appropriate and proportionate to the nature and frequency of the complainant's contacts with the Trust at that time.

The following list is a 'menu' of possible options for managing a complainant's involvement with the Trust from which one or more might be chosen and applied, if warranted. It is not exhaustive and often local factors will be relevant in deciding what might be appropriate action.

- Placing time limits on telephone conversations and personal contacts.
- Restricting the number of telephone calls that will be taken (for example, one call on one specified morning/afternoon in any week.
- Limiting the complainant to one medium of contact (telephone, letter, email etc) and/or requiring the complainant to communicate only with one named member of staff.
- Requiring any personal contacts take place in the presence of a witness.
- Refusing to register and process further complaints about the same matter. Where a decision on the complaint has been made, providing the complainant with acknowledgements only of letters, faxes, or emails or ultimately, informing the complainant that future correspondence will be read and placed on the file but not actioned. A designated officer should be identified who will read future correspondence.

- When a caller has been officially declared a habitual or repetitive caller, the Chief Executive, or in her/his absence by another of the Trust's Executive Directors, may decide that no further telephone communication will be accepted.
- Where there is on-going correspondence or investigation the Complaints Manager will write to the caller setting the parameters for a code of behaviour and the lines of communication. These will be communicated to all relevant staff to ensure consistency of approach within the Trust.
- When an investigation or correspondence is completed, the Complaints Manager will, at an appropriate stage, write to the caller informing him/her that the Trust has responded fully to the points raised and that there is nothing further that can be added, therefore correspondence is at an end. The Trust will state that further correspondence will be acknowledged, but not answered.

The final decision regarding ceasing all contact with a complainant lies with the Chief Executive.

Notification of the Decision.

Once a decision has been made to take action in relation to a service user/complainant under this policy, the relevant Deputy Director, in conjunction with the Customer Service Manager will write to them to explain the following:

- The decision that has been taken.
- The reasons why that decision has been taken.
- That any restrictions will remain in force until notified otherwise in writing.
- How a request can be made to have the decision reviewed and the time limit within which to make a request. The Customer Services will be responsible for ensuring that key staff are aware of the decision and any restrictions in place, including any changes to those decisions/restrictions (see paragraph below).

A central record of decisions/restrictions will be held in the Customer ServiceTeam. Where a valid request has been made to review a decision within the appropriate time limit, the review will be carried out by a Deputy Director. The review will be conducted as the Deputy Director sees fit, including considering any relevant documents that informed the original decision, the decision letter and the information provided in the request for a review. The Deputy Director has the discretion to uphold the original decision/restriction(s), uphold the original decision and amend the restriction(s), or quash the original decision in its entirety. The service user/complainant will be notified of the decision by letter or their preferred method of communication e.g. email.

Review of Restrictions

Where a decision was taken to impose restrictions on a service user/complainant, that restriction will be reviewed by the relevant service area at appropriate intervals not exceeding 12 months and the decision will either be re-imposed, amended or removed. In the event that they are amended or removed, the service user/complainant must be notified by letter or their preferred method of communication.

New Complaints from Persons who are designated as unreasonable/unreasonably Persistent

The Trust will not operate a blanket policy of refusing to deal with any genuinely new complaints. If a new complaint is received, from a person who has previously been identified as unreasonable/an unreasonably persistent complainant under this policy, the new complaint will be dealt with on its merits.

Failure to Adhere to Restrictions

Should a service user/complainant continue to behave unreasonably and/or fail to comply with restrictions previously imposed under this policy, then the Trust may take further action as it deems reasonable and proportionate, including legal action and reporting the matter to the police where their behaviour may amount to a criminal offence.

APPENDIX C

Equality Impact Assessment Template to be completed for all Policies, Procedures and Strategies

Date of Assessment: 12.05.2021

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		To provide a framework for ensuring feedback is valued and responded to appropriately. To support effective complaints management processes, consistently applied across all services. People who use services, carers, staff
3	**Who is the overall lead for this assessment?**		Assistant Director of Nursing & Quality
4	**Who else was involved in conducting this assessment?**		Customer Services Team
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?**		Customer services processes and procedures are subject to constant evaluation with service users and carers (following their contact with the team) and with staff following involvement in complaints handling or report review. Information used to inform policy
6	**What equality data have you used to inform this equality impact assessment?**		Protected characteristics data collected via the function.
7	**What does this data say?**		From the figures shown in the data there is more work to do to ensure that our services reach and obtain feedback from our diverse population to reflect and represent the population we serve. This work with be completed as part of an engagement plan.
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**No**	It is not anticipated that this Policy will have any negative impact on any of the equality groups. The potential for people having difficulty giving feedback or raising complaints and concerns is mitigated by promoting an allocated caseworker to provide individual support, access to advocacy and / or interpreting services and taking account of information requirements (which will be further

			enhanced through compliance with the Accessible Information Standard. The policy will have a positive impact on all groups 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 regarding customer feedback.
8.1	**Race**	**No**	The Trust needs to consider why there is so little feedback from certain groups (or people are not identifying their ethnicity) in our diverse population and identify strategies to obtain feedback going forward. <u>Race equality</u>

	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

Ethnicity	Total	%
White British	28320	82.93%
Pakistani	1175	3.44%
Not Stated	1156	3.39%
Any Other White background	997	2.92%
Not Recorded	691	2.02%
Any other Ethnic group	293	0.86%
Indian	265	0.78%
White and Black Caribbean	201	0.59%
Any other Asian background	176	0.52%
Black Caribbean	170	0.50%
Any Other mixed background	165	0.48%
White Irish	128	0.37%
Black African	124	0.36%
White and Asian	102	0.30%
Any other black background	96	0.28%

White and Black African	50	0.15%
Chinese	21	0.06%

Trustwide Information May 2021 data

ethnicity		%
White British	146	56
Prefers not to say	6	2
Pakistani	3	1
bangladeshi	1	1
black caribbean	3	1
black african	1	1
Unknown	97	37
Any other white background	3	1
Customer Service data 2019/2021	**260**	**100**

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 services EIA's to ensure we fully understand the nature of the disability so we can adjust and adapt our services according to need and feedback, 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

Disability	Total	%
Not Recorded	24980	73.15%
Not disabled	5937	17.39%
Disability NOS	1275	3.73%
Registered disabled	1121	3.28%
Disability status not given - patient refused	836	2.45%

			Total Patients **34149** *Trustwide Information May 2021 data* **Disability** % Mental Health Condition 40 15 Does not have a Disability 28 11 Autism 3 1 Physical Impairment 5 2 Prefers not to say 15 6 Alzheimers 1 1 Learning difficulties 12 5 Long standing illnes 12 5 Cognitive impairment 3 1 Unknown 141 53 *Customer Service data 2019/2021* **260** **100**
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. England % av. Male 49.2 Female 50.8 **Kirklees** % average Male 49.4 Female 50.6 **Barnsley** % average Male 49.1 Female 50.9 **Calderdale** % average Male 48.9 Female 51.1 **Wakefield** % average Male 49 Female 51 *Taken from Census 2011 data* **Gender** **Total** **%** F 18158 53.17 % M 15987 46.82 % I 2 0.01% U 2 0.01% Total Patients **34149** *Trustwide Information May 2021 data* **Gender** **%** female 113 43 male 72 28

Prefers not to say	1	1
Transgender	1	1
Unknown	73	27
	260	**100**

Customer Service data 2019/2021

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 feedback is encouraged across all the age ranges and support to give feedback is provided for those who need it.

	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

Age Band	**Total**	**%**
18-29	5447	15.95 %
Under 16	5405	15.83 %
30-39	4680	13.70 %
50-59	3981	11.66 %
40-49	3849	11.27 %
70-79	3104	9.09%
80-89	2823	8.27%
60-69	2590	7.58%
16-17	1625	4.76%
90-99	635	1.86%
100 and over	10	0.03%
Total Patients	**34149**	

Trustwide Information May 2021 data

Age		%
18-25	14	5
26-55	159	61
56-64	35	13
65-74	14	5
75 and over	9	4
Under 18	8	4
Unknown	21	8
Customer Service data 2019/2021	**260**	**100**

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 as this is an area that remains mainly unknown.

Sexual orientation	Total	%
Not Recorded	18182	53.24%
Heterosexual	14345	42.01%
Sexual orientation unknown	961	2.81%
Sexual orientation not given - patient refused	281	0.82%
Bisexual	208	0.61%
Female homosexual	97	0.28%
Male homosexual	75	0.22%
Total Patients	**34149**	

Trustwide Information May 2021 data

Sexual Orientation		%
heterosexual	119	46
Prefers not to say	15	6
Bisexual	4	2
Gay	1	1
Unknown	118	44
Lesbian	3	1
Customer Service data 2019/2021	**260**	**100**

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 service delivery however there is a lack of information when it comes to providing feedback and there is little or no inomfration to draw upon therefore customer services will ensure information is gathered to understand further if the Trust can make improvements around relgion or belief.

	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

Religion	Total	%
Not Recorded	12117	35.48%
Not religious	4147	12.14%
Church of England, follower of religion	3979	11.65%
Religion NOS	3258	9.54%
Patient religion unknown	2390	7.00%
Christian	1683	4.93%
Religion not given - patient refused	1661	4.86%
Church of England	1121	3.28%
Muslim	964	2.82%
Roman Catholic	901	2.64%
Christian religion	296	0.87%
Atheist	288	0.84%
Methodist	274	0.80%
Agnostic	184	0.54%
Religion (Other)	136	0.40%
	125	0.37%

			Declines to disclose religious beliefs		
			Religious affiliation	69	0.20%
			Mormon	64	0.19%
			Spiritualist	58	0.17%
			Protestant	50	0.15%
			Pagan	43	0.13%
			Baptist	36	0.11%
			Sikh	34	0.10%
			Buddhist	30	0.09%
			Hindu	30	0.09%
			Anglican	27	0.08%
			Pentecostalist	19	0.06%
			Catholic: non Roman Catholic	18	0.05%
			Nonconformist	17	0.05%
			Church of Scotland, follower of religion	14	0.04%
			Church Of God	8	0.02%
			Orthodox Christian	8	0.02%
			Rastafarian	8	0.02%
			Quaker	7	0.02%
			Patient religion could not be communicated	6	0.02%
			Wesleyan Methodist	5	0.01%
			Sunni muslim	5	0.01%
			Church of Ireland, follower of religion	5	0.01%
			Apostolic Pentecostalist	5	0.01%
			Eastern Catholic	5	0.01%
			Seventh Day Adventist	4	0.01%
			Ismaili Muslim	4	0.01%
			Evangelical Christian	3	0.01%
			Coptic Orthodox	3	0.01%
			Presbyterian	3	0.01%
			Russian Orthodox	3	0.01%
			Follower of United Reformed Church	3	0.01%
			Christadelphian	2	0.01%
			Unitarian	2	0.01%
			Orthodox Jew	2	0.01%

			Independent Methodist 2 0.01% Greek Orthodox 2 0.01% Salvation Army member 2 0.01% Greek Catholic 2 0.01% Serbian Orthodox 2 0.01% Shiite muslim 2 0.01% Old Catholic 1 0.00% Heathen 1 0.00% Congregationalist 1 0.00% Jain 1 0.00% British Israelite 1 0.00% Celtic Christian 1 0.00% Uniate Catholic 1 0.00% Christian Spiritualist 1 0.00% Jewish 1 0.00% Wiccan 1 0.00% Church in Wales, follower of religion 1 0.00% Romanian Orthodox 1 0.00% Reformed Christian 1 0.00% Total Patients **34149** *Trustwide Information May 2021 data* No information available as this is not collected by Customer Services
8.7	**Transgender**	**No**	The customer service policy and agenda for transgender people will remain a focus and data collection will need to be improved to support improvements to disclosure and recording. The 2020/21 Census report may provide further baseline data. **Gender reassignment** **Total** **%** No 34119 99.91% Gender reassignment patient 30 0.09% Total Patients **34149** *Trustwide Information May 2021 data* For Customer Service information please see figures included in sexual orientation section.
8.8	**Maternity & Pregnancy**	**No**	**Pregnancy (last 9 months)** **Total** **%**

No	33627	98.47%
Patient currently pregnant	522	1.53%
Total Patients	**34149**	

Trustwide Information May 2021 data

No information available as this is not collected by Customer Services

8.9 **Marriage & Civil partnerships** **No**

	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

Marital Status	Total	%
Single person	16072	47.06%
Marital state unknown	5047	14.78%
Married	3207	9.39%
Married/civil partner	2848	8.34%
Widowed	1326	3.88%
Not Recorded	921	2.70%
Divorced/person whose civil partnership has been dissolved	702	2.06%
Single - living with family	698	2.04%
Marital/civil state not disclosed	635	1.86%
Divorced	518	1.52%
Separated	494	1.45%
Widowed/surviving civil partner	492	1.44%
Cohabiting	381	1.12%
Single - living alone	323	0.95%

			Common law partnership 259 0.76% Widower 103 0.30% Engaged to be married 43 0.13% Broken with partner 17 0.05% Separated from cohabitee 14 0.04% Husband left home 14 0.04% Wife left home 13 0.04% Monogamous 8 0.02% Remarried 6 0.02% Number of previous marriages 3 0.01% Cohabitee left home 2 0.01% Eloped 1 0.00% Spouse left home 1 0.00% Polygamous 1 0.00% Total Patients **34149** *Trustwide Information May 2021 data* No information available as this is not collected by Customer Services
8.10	**Carers*** **Our Trust requirement***	**No**	It is not anticipated there will be any negative impact on service users or their carers, feedback is captured through service evaluation. **Relationship to service user** **%** Parent 51 20 Service user 158 61 Sibling 4 1 Son/Daughter 11 4 Spouse/Partner 18 7 Other 15 6 Unknown 3 1 *Customer Service data 2019/2021* **260** **100**
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		The Policy is subject to annual review.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		The policy promotes equality of opportunity as it provides for a supportive, fair and non-discriminatory approach to customer services and complaints management

9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**	The Trust is committed to eliminating discrimination in all its forms, including those with protected characteristics
9c	**Promotes good relations between different equality groups;**	The Trust's approach to equality promotes good relations including with those from different equality groups.
9d	**Public Sector Equality Duty – "Due Regard"**	EIAs are completed at service level as part of the introduction of new/revised policies. These documents are used in the planning, implementation, and development of services. A short form EIA and process supports decisions a that are required urgently. The voice of people who use our services is captured using feedback, involvement and learning lessons from experiences across the Trust. Regular monthly audit provides the opportunity to identify if there are any issues/trends related to protected characteristics, relationships between different groups and 'due regard'.
10	**Have you developed an Action Plan arising from this assessment?**	No but an engagement plan will be developed for the next update of the policy when further changes from the PHSO come in 2022
11	**Assessment/Action Plan approved by (Director Lead)**	**Sign:** **Title:**
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.**

APPENDIX D

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	YES	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

APPENDIX E

Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	Dec 2013	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with Francis Report, Patient's Association Report on Complaints and the Rt Hon Ann Clwyd review of NHS Complaints Management.
2	Dec 2014	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with the Francis Report, The Government's response, 'Hard Truths' and the Duty of Candour.
3	January 2016	Deputy Director of Corporate Development	Final	Approved by Trust Board Included updates in line with CQC Essential Standards and PHSO report 'My Expectations'
4	January 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes update in line with: • CQC inspection 2016 • CSE Accreditation 2016 • PHSO report 'My Expectations' • NHSE Assurance of Good Complaints Handling • CQC report 'Complaints Matter'
5	June 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes updates in line with CQC action plan to include reference to people's right to complain to the CQC about detention under the Mental Health Act – in line with the Mental Health code of practice.
6	May 2021	Accociate Director of Nursing & Quality		

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 11.1

Title:	**Trust Board self-certification (FT4) – corporate governance statement 2020/21**
Paper prepared by:	Director of Finance & Resources Assistant Director Corporate Governance, Performance & Risk
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider licence.
Mission/values:	Good governance supports the Trust to deliver its mission and adhere to its values.
Any background papers/ previously considered by:	The first part of the required self-certification (G6/CoS7) was approved by the Trust Board on 27 April 2021. The attached document has been reviewed by the Executive Management Team.
Executive summary:	**Background** NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations. The Trust Board approved the first self-certifications (G6/CoS7) on 27 April 2021 in relation to: • The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence) • If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence). • Further self-certifications (FT4) are required by 30 June 2021: • The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence) (appendix 1 – Corporate Governance Statement)

With all of us in mind.

	• The training of Governors (as required by s151(5) of the Health and Social Care Act 2012) (see below). **Self-certification - part two (FT4)** <u>Corporate Governance Statement 2020/21</u> The attached paper (appendix 1) sets out the statements (numbered 1-6) Trust Board is required to make and the assurance to support self-certification against the statements. From the assurance provided, Trust Board is asked to certify that it is satisfied with the risks and mitigating actions against each area of the required six areas within the Trust's Draft Corporate Governance Statement. The rationale for this assurance is set out in the accompanying detailed statement. The Covid-19 outbreak meant changes to the operations of the Trust. These were conducted in line with the Trust Constitution, its Standing Orders and Standing Financial Instructions. The system of governance was adhered to, with decision making always in line with powers of delegation and authority. Weekly assessments of the decisions made through the Gold Command structure were appraised by non-executive members of the Board each week at the peak of the pandemic. During the pandemic the Executive Directors have all been members of Gold Command, leading the Trust's response to the pandemic. The Director of Human Resources, Organisational Development and Estates has led the EPRR approach with very effective Silver and Bronze Command arrangements in place. <u>Training of Governors</u> Starting in 2011, the Trust has developed, through the Members' Council Co-ordination Group, a programme of training and development to ensure governors have the skills and experience required to fulfil their duties. The Trust has supported the training and development of governors in a number of ways: • Each new governor had an induction meeting with the Chair and all other governors had an annual review meeting to discuss individual performance and training and development needs. Governors are also provided with a comprehensive induction pack to support them in their role. • The Trust offered 1:1 support and 'buddying' as part of the induction programme for new Governors. • Most formal Members' Council meetings include a discussion item or development session, which allows governors, with the support of Trust Board, to look at a particular area of Trust services or activity in more detail. • Each governor has an annual performance review which includes attendance at meetings and training requirements.

	In 2014, the Members' Council signed up to the principle that there should be a level of minimum commitment and contribution from Governors at two levels: *Required* • Attendance at a minimum of three out of four formal Members' Council meetings. • Attendance at the annual evaluation session. • 1:1 introductory meeting with the Chair. • Annual review meeting with the Chair. • Attendance at the Annual Members' Meeting. • *Desirable* • Attendance at Trust Board meetings. • Attendance at training and development sessions organised by the Trust. • Attendance at the Foundation Trust Network's GovernWell modules. • Membership of formal groups (currently Members' Council Co-ordination Group, Quality Group and Nominations Committee). From the assurance provided, Trust Board is asked to certify this it "***is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.***"
Recommendation:	**Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to:** • **the Corporate Governance Statement 2020/21** • **the training for Governors 2020/21**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021

Corporate Governance Statement 2020/21

1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.
The Trust continues to implement, develop and improve its arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board undertook a well-led governance review during 2015, which has been followed up by CQC well led reviews in each of 2017, 2018 and 2019. The most recent CQC well led review (2019) provided a rating of **good**. Review and scrutiny of the Trust's governance arrangements took place as part of the well-led review, which included interviews with the Trust Board and staff. The review concluded that the Trust Board and leadership team had the appropriate range of skills, knowledge and experience, and showed integrity on an ongoing basis. The report also highlighted that there was a robust and realistic strategy for achieving Trust priorities and effective internal governance structures, systems and processes in place to support delivery of the strategy. The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements on a regular basis through our quality improvement and assurance team. To support our assessment, we have developed a quality assurance and improvement 'self-governing' assessment model. This philosophy builds on our emphasis on self-governance and evaluation. As a series of methods and tools, this approach helps map the relationships between quality improvement and quality assurance and will provide a continual source of evidence for teams to inform how well they are performing against appropriate and helpful metrics for quality. There has not been a CQC inspection completed during 2020/21, the previous inspection in 2019 recognised the improvements we have made since their last inspection in 2018 and the strength and quality of the services we provide. We delivered on the actions from the last report, which has led to four of the five overall domains now being rated as Good. We are also pleased that our mental health community services have improved and are now rated Good.

Overall, we are now rated Good for being responsive, caring, well led and effective, and Requires Improvement for being safe. This means that overall we have been rated Good as a Trust.

Risks

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

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

- The Trust's Constitution, based on Monitor's model constitution, underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution. A review of the Trust's Constitution began in December 2019, including consultation with governors and Board members. Amendments and areas of further review / investigation were approved at Trust Board in December 2019 and Members' Council in January 2020, with further work to be completed in 2020. A review of our Constution was delayed in 2020/21 due to the Covid-19 pandemic. This will now be submitted to our Trust Board during quarter three 2021/22.
- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. The annual self-assessment will be presented to Trust Board in July 2021.
- Each committee of the Trust Board is required to prepare an annual report, which is presented to the Audit Committee. The Audit Committee reviews overall effectiveness of committee structure. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.
- Each group and committee of the Members' Council is required to prepare an annual report and review of the terms of reference, which is reported to the Member's Council annually in April / May and provides assurance that each group / committee is meeting its terms of reference and work programme.
- The Trust undertakes an annual assessment of compliance against NHS Improvement / Monitor's Code of Governance which is reported to Trust Board.
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors are proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest

presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration. All members of Trust Board and the Executive Management Team have disclosure and barring (DBS) checks in place.

- All elections made to the Members' Council are held in accordance with the Model Election Rules in the Trust's Constitution. Elections are overseen by an external organisation (currently Civica Election Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2011. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence.
- The most recent Care Quality Commission (CQC) rating overall is **good** (which includes a rating of **good** for the well-led domain). The Board undertook a structured development programme, using the NHSI framework, which ran throughout 2019/20. During 2020/21, Board development was limited due to the pandemic, however the Board did undertake a training programme 'Inclusive Leadership via Board Development (ILDBO).

An assessment by internal audit found the Trust's arrangements around the overarching governance and risk management arrangements provided significant assurance and the Head of Internal Audit Opinion is one of significant assurance on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Board Assurance Framework and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement.

The Covid-19 outbreak meant changes to the operations of the Trust. These were conducted in line with the Trust constitution, its Standing Orders and Standing Financial Instructions. The system of governance was adhered to, with decision making always in line with powers of delegation and authority. Weekly assessments of the decision made through the Gold Command structure were appraised by non-executive members of the Board each week at the peak of the pandemic. During the pandemic the Executive Directors have all been members of Gold Command, leading the Trust's response to the pandemic. The Director of Human Resources, Organisational Development and Estates has led the EPRR approach with very effective Silver and Bronze Command arrangements in place.

Silver command had senior manager representation across the Trust and in the first peak of the pandemic met daily. During the weekend an update call by exception also took place each day at the same time.

During the summer of 2020 this was stepped down to twice weekly then once per week.

In September 2020 with Covid-19 cases rising nationally and local lockdowns being put in place this was stepped back up to twice per week, Mondays and Thursdays at 4pm.

On 26 October 2020 the decision was made to increase Silver meetings to three times a week and this continued into February 2021. In March 2021 Silver meetings reduced to once a week.

In January 2021 a Bronze Command for the vaccination programme was established, this group met three times per week and supporting task and finish Groups once per week.

Two other Bronze groups have continued throughout, testing and PPE, meeting weekly than fortnightly.

Rapid Decision-Making

In the first wave of the pandemic a paper was shared with executive directors, non-executive directors and the Audit Committee which outlined a process to enable decisions to support the response to Covid-19 to be made rapidly.

The process involved the use of a senior internal group reviewing required decisions on a weekly basis and either agreeing or making a recommendation. All such decisions were logged and forwarded on to the Chief Executive and non-executive directors within twenty-four hours.

Weekly meetings in which the director of finance provided an update on governance decisions to non-executive directors, and if required sought approval or ratification have now been stood down, with the option to reintroduce if required.

Risk

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

The Care Quality Commission improvement plan was initially due to be complete in June 2020, however due to the ongoing pandemic some elements of the plan, i.e. **actions related to risk assessment and care planning, and suitable psychology provision on our older peoples' wards, have been delayed**. All other elements of the plan have been completed.

The CQC improvement plan was formally closed by Clinical Governance & Clinical Safety Committee (CGCSC) in April 2021. An oversight of the outstanding actions will be maintained by CGCSC.

Risk

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

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

Examples of corporate governance audits undertaken 2021/21 and their ratings are:

Cyber security, significant assurance
data quality framework, Limited assurance
Data Security Toolkit (The Data Security and Protection Toolkit was submitted on time and is “substantially” compliant with the standards)

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the EMT. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the EMT focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented.

- The Head of Internal Audit Opinion for 2020/21provides **significant assurance** on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.
- As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in NHS Improvement’s Foundation Trust Annual Reporting Manual. The Statement for 2020/21 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust’s annual report and accounts.
- The Trust’s Board assurance framework and risk register have been assessed as appropriate as part of an internal audit of the risk and governance in 2020/21 which received **significant assurance**.
- The Trust Board reviews compliance with the NHS Constitution annually, last reviewed in January 2020. A review of our Constitution was delayed in 2020/21 due to the Covid-19 pandemic. This will now be submitted to our Trust Board during quarter three 2021/22.
- The Trust Board receives annual self-certifications of compliance with the NHS Provider Licence (April) and corporate governance statement (June).

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

The cycle of Trust Board meetings continues to ensure that the Trust Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Within each quarterly cycle, there is one monthly meeting with a forward-looking focus centred on business risk and future performance, one meeting focusing on performance and monitoring, and one strategic development session. The Trust Board meetings relating to business risk and future performance, and performance and monitoring are held in public and the Chair encourages governors to attend each meeting.

In addition to measuring performance against our quality priorities we monitor our performance against a range of other key performance indicators (KPIs). A number of these are reported to our Trust Board and others are reported and acted upon internally. A range of performance data is also shared with our commissioners.

For 2020/21, the Trust identified those metrics that would best demonstrate performance against achievement of its agreed objectives. These are reported to the Trust Board as part of the Integrated Performance Report (IPR) every month. The KPIs represent a mix of nationally and locally set targets.

During 20/21 the impact of the Covid-19 pandemic meant that contractual arrangements and national priorities around reporting shifted. Despite this, the Trust continued to report and monitor its performance against both strategic objectives and other targets using metrics that were largely already in existence. Additional operational data was reported during 20/21 to assist with monitoring impact and effect of Covid-19.

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

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

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

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

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

In addition during the Covid-10 pandemic this was further strengthened through:

- Process to receive, review and implement national guidance.
- Decision logs and formal notes in place for the command structure.
- Specific proactive task and finish group put in place to consider and monitor future Covid-19 related future to compliance

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

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

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

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

- Audit Committee
- Clinical Governance and Clinical Safety Committee
- Equality,Inclusion and Involvement Committee
- Finance, Investment and Performance Committee

- Mental Health Act Committee
- Workforce and Remuneration Committee
- West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Committees-in-Common
- Charitable Funds Committee (Committee of the Corporate Trustees)

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

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

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

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

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

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within BDUs, deputy directors

provide operational leadership and management allowing BDU Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. BDUs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

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

4. The Board is satisfied that the Trust effectively implements systems and / or processes:

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

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

As part of its annual audit, the Trust's external auditor, Deloitte, was satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in 2020/21. There were no issues identified to report in this regard in the audit opinion.

The Trust's internal audit plan is risk-based to enable the Trust to identify areas where improvement is sought and to learn from best practice. The Audit Committee approved the internal audit plan for 2020/21. The plan included core reviews to inform the Head of Internal Audit Opinion relating to core financial controls, governance and risk management, which included a focus on Board committee arrangements, policy monitoring and data security and protection toolkit. This was supported by a number of cyclical and risk reviews covering cost improvement process and reporting. The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the EMT. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the EMT focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

In respect of the internal audit plan for 2020/21, 10 internal audit reviews have been conducted and presented to the Audit Committee. Of these, there were 5 significant assurance opinions, 3 were advisory audits with no rating provided and the other 2 provided limited assurance opinions.

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each 'limited' or 'no assurance' report to attend to provide assurance on actions taken to implement recommendations. For all 'limited' and 'no assurance' reports, a follow up audit is undertaken within twelve months. Completion of recommended actions is tracked by the Audit Committee and over the course of the year 79% of actions were completed within the original time frame specified and 98% of all recommendations have been completed

The Head of Internal Audit's overall opinion for 2020/21 provided **significant assurance**' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Examples of corporate governance audits undertaken in 2021/21 are:

Cyber security, significant assurance
data quality framework, Limited assurance
Data Security Toolkit (The Data Security and Protection Toolkit was submitted on time and is "sunstantially" compliant with the standards)

The conclusions and recommendations from all internal audit reports are reported into EMT and the Audit Committee and if deemed appropriate the Audit Committee will seek further assurance and updates on actions being taken.

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

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

The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust has a robust process in place to ensure that it meets the requirements of its registration. Action plans were developed in response to recommendations included in the most recent inspection reports published in 2019.

Trust continues to assess its compliance with CQC registration requirements on a regular basis through our quality improvement and assurance team. To support our assessment, we have developed a quality assurance and improvement 'self-governing' assessment model. This philosophy builds on our emphasis on self-governance and evaluation. As a series of methods and tools, this approach helps map the relationships between quality improvement and quality assurance and will provide a continual source of evidence for teams to inform how well they are performing against appropriate and helpful metrics for quality.

As part of this initiative, we have developed an accreditation scheme underpinned by quality measures and a quality monitoring system to recognise teams that are delivering high quality care and reward them for their efforts. Although this was not launched as we had hoped due to the Covid-19 pandemic, two wards did take part in the programme during 2020/21.

The following steps have been put in place to assure the Trust Board that appropriate controls are in place to ensure the accuracy of data, these are described below and demonstrate that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

We have a strong system of quality reporting:

- Quality metrics are reviewed monthly by Trust Board and the EMT, alongside the performance reviews undertaken by BDUs as part of their governance structures.
- The Integrated Performance Report covers substantial quality and performance information and is reported to the Board and EMT. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints and patient experience.

- The Clinical Governance and Clinical Safety Committee oversee the development of the Quality Report and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance and Resources, supported by the Director of Nursing and Quality.
- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy and evidenced through the Trust's Information Assurance Framework.
- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- The SystmOne optimisation programme has been managed with input from the Improving Clinical Information and Information Governance Group (ICIG) and with significant governance via the programme board, and Executive Management Team.
- The Director of Nursing and Quality (Caldicott Guardian) and Director of Finance and Resources (SIRO) co-chair the Trustwide Improving Clinical Information and Information Governance (ICIG) meeting. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.
- The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

Mental Health Act (MHA) visits from the CQC continued but via video due to the pandemic. Mental Health Act tribunals also continued via video link and have been compliant with tribunal requirements throughout. We continued with hospital managers' hearings, conducted via Microsoft Teams. MHA administrators worked on site to ensure support available to services in situ. We supported the introduction of electronic management of MH Act administration regulations and additional support to staff.

A quarterly briefing is also provided to the Trust MH Act Committee.

The Trust accounts are prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual which defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. This was confirmed by the Trust Board in April 2021.

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

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

The Board Assurance Framework and Organisational Risk Register with mitigating actions are reported to Trust Board on a quarterly basis set in the context of the Board's risk appetite statement. Other key issues are identified through the biennial Board investment appraisal reports

along with PESTLE (Political, Economic, Sociological, Technological, Legal, Environmental) and SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis and are set out below. In addition to the key risks identified above we identified and acted upon a number of other issues as set out below.

We identified: Opportunities for partnership in local places building on the work of Creative Minds and our Recovery Colleges to improve health and wellbeing
We acted: We are supporting our partners to enhance health and wellbeing, for example in Calderdale supporting the arts and health programme, and development of an emotional and wellbeing hub. We have worked with partners across West Yorkshire and Harrogate Integrated Care System to implement suicide prevention plans, for example expanding postvention services through partnership with Leeds Mind

We identified: The need to be well placed in each of our localities to meet changing population and workforce requirements
We acted: In Barnsley we have been actively involved in the integrated care delivery group which has governed local service integration. This has included the integrated offer in relation to stroke services as well as significant work on integrated neighbourhood teams. We continue to pursue collaborative partnership working in all places with third sector organisations such as within the Live Well Wakefield service, and in primary and secondary health and care through the active development and leadership of the Wakefield Mental Health Alliance, the establishment of a Kirklees Health and Wellbeing Alliance, and active involvement in Calderdale Cares and Barnsley integration including stroke services as well as significant work on integrated neighbourhood teams

We identified: The need to really understand the key challenges faced by the services regarding workforce and the changes in workforce required
We acted: A series of Great Place to Work engage and listen events were held and a staff engagement plan agreed. A Great Place to Work leadership forum has been established. The Trust has continued our focus on development of staff networks and has three established equality networks for BAME staff, staff with a disability and LGBTQ+ staff. A fourth network is being supported for staff who are carers.

We identified: Clinical record system resilience and suitability for current clinical practice was a risk.
We acted: Following the implementation of a new clinical record system in 2018 the Trust has continued with its optimisation plan during 2020/21 with the implementation on the new FIRM risk assessment and improvements to mental health care plans.

We identified: The need to embed a Trustwide quality improvement culture
We acted: We have successfully implemented a quality improvement training programme at all levels of the organisation and have trained 193 improvement facilitators with a #allofusimprove network being established. Some good practice examples have emerged e.g. safety huddles, reducing restricted practice and flu vaccination programme.

5. The Board is satisfied that:

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

Risk

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

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

- policies developed, reviewed and in place
- governance systems
- the assurance framework
- k and risk register presented to Trust Board quarterly
- Integrated performance report submitted monthly to Trust Board
- audits undertaken both internally and externally
- a programme of unannounced visits
- reports submitted to Trust Board and its Committees, as well as the Members' Council, detailing our performance against mandatory, contractual, quality & safety metrics and action plans as required.

The Trust's Quality Account publication for 2020/21 will provide a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The report will not be externally audited as this is not currently a requirement and will be submitted to NHS Improvement during August 2021.

The process introduced by the Director of Nursing and Quality to assess risk to and impact on quality and safety of the cost improvement and efficiency savings proposed by BDUs was again applied in 2020/21. The Quality Impact Assessment process, led by the Director of Nursing and Quality undertaken in conjunction with clinical and general management within BDUs, provides assurance throughout the process to the

Executive Management Team (EMT) and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements do not have an adverse effect on Trust services.

Quality impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing and Quality approval required before a scheme can proceed. Quality Impact Assessments (QIAs) can also be invoked in year where concerns trigger the requirement to do so. Given the temporary financial arrangements in place, with the suspension of cost improvement programmes during 2020/21 this process was not required during the year

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

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

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

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators (KPIs) relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board. This was continued for priority indicators during 2020/21.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality. .

The Trust approved an Equality, Involvement, Communication and Membership Strategy in September 2020 which has supporting annual action plans to ensure an integrated approach. This is insight driven and will 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

The Committee oversees the implementation of the Equality, Involvement, Communication and Membership Strategy to improve access, experience and outcomes for people from all backgrounds and communities. This includes people who use, work and volunteer for our Trust services and those who work in partnership with the Trust with the strategic aim of improving health, care, resources and making our Trust a great place to work.

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

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

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

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

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

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

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

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors, Governors and stakeholders. Trust Board undertakes ongoing Board development, using external expertise where required. During 2020/21 a structured development programme was followed using the NHS Improvement framework.

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

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

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

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

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

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

For non-medical professional qualifications, all nursing, Allied Health Professionals and psychology registered professional staff are subject to revalidation arrangements through their professional bodies. The Trust provide a monitoring and reminder system to all registered professional staff to ensure that registration is maintained. The revalidation process is also monitored by nominated professional leads with routine reporting into Clinical Governance and Clinical Safety Committee around compliance.

The NMC have remained clear that if a nurse is able to revalidate within the allocated timeframe, then they should so, however, during the Covid-19 pandemic, the NMC helped to support the process of revalidation by providing extensions where required. For those due to revalidate between July and December 2020 who required more time to send their application, a request for a 12-week extension was available through the NMC Online account.

For nurses due to revalidate from January 2021, if more time is required to complete an application, an 8-week extension can be sought through the NMC Online account. The NMC require a reason for the extension and each request is considered on a case by case basis.

The process of verifying applications, through the selection of a sample of applications, which is completed every year, was suspended throughout the Covid-19 emergency, with plans to resume this for applications from January 2021 onwards.

For the recruitment of medical staff, doctors are assessed during the application and interview process to ensure they have the relevant qualifications and experience to fulfil the post. Medical HR will meet with the doctors to verify their ID and complete the Disclosure and Barring Service (DBS) check. The Medical Directorate request information relating to the doctor's last appraisal date, whether there are any concerns

about the doctor's practice, conduct or health and if there are any outstanding investigations. The information received is checked by the Trust's Responsible Officer (RO), prior to final offer being made. Where this information is not received prior to the final offer being made, the offer remains subject to satisfactory RO information or satisfactory Annual Review of Competence Progression (ARCP) outcome for those doctors joining the Trust straight from a training programme.

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

From the 2019/2018/19 appraisal and revalidation report, 89% successfully completed the appraisal process during 2019/20, a slight drop on 2018/19 which was 92%. 11% had an agreed postponement in line with the Medical Appraisal Policy or the Covid-19 changes to appraisal and revalidation. These were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate. This is an increase of 3% 2019/20.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board
29.06.2021
Agenda Item 11.2

Title:	**Incident management annual report 2020/21**
Paper prepared by:	Director of Nursing and Quality
Purpose:	The purpose of the paper is to provide assurance to Trust Board that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust.
Mission/values:	The report demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	Trust Board has received quarterly Incident Management reports, which have also been considered by the Clinical Governance and Clinical Safety Committee. This report has also been considered by the Clinical Governance and Clinical Safety Committee.
Executive summary:	The annual report key headlines follow; • The number of incidents reported across the Trust (12,717) has decreased by 3.7% on the previous year, however reporting patterns remain within the expected range. • 92% of all incidents reported resulted in no harm or low harm. A high level of incident reports, particularly of less severe incidents is an indication of a strong safety culture (NPSA Seven Steps to Safety). • The number of serious incidents reported has reduced (34) compared to last year. The overall proportion of serious incidents has reduced to 0.26% of all incidents. • Accreditation has been achieved for our Serious Incident Investigation processes from the Royal College of Psychiatrists (RCP). • During 2020/21 there were no 'never events'. • There has been one homicide. • We have reviewed 335 deaths that were in our learning from healthcare deaths scope. This compares with 286 in 2019/20. The reviews ranged from accepting the death certification, case record reviews through to investigations, in line with the National Quality Board levels. The Patient Safety Support Team will prepare two further reports. The first, 'Our Learning Journey' report which will present the ongoing work across the trust in terms of sharing and implementing the learning from serious incident investigations. The second report to be prepared is the 'Apparent Suicide Report'. These will be available in September 2021. The Clinical Governance and Clinical Safety Committee considered the report at the June meeting and commented as follows; • Gaining RCP accreditation during the pandemic is a significant achievement and should be noted. • The report provides important information to support the actions being taken within the Patient Safety Strategy

	• The report is an important component in developing our understanding of the impact of the pandemic on the people we support • The report is of good quality and should be shared through the usual routes. **Risk appetite** • Risk identified – the Trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting and investigating healthcare deaths. • This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite – low and the risk target 1-6. • The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6. • Financial or commercial risks - Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious/Moderate 4-6 The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. For learning from healthcare deaths, we continue to meet the national guidance, and make revisions as needed. We publish our quarterly data on deaths on the internet page.
Recommendation:	**The Trust Board is asked to RECEIVE and comment on the annual report on incident management and to NOTE the next steps identified.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Incident Management Annual Report

April 2020 to March 2021

Patient Safety Support Team

May 2021

With **all of us** in mind.

Executive Summary

This report provides an overview of **all** the incidents reported in the Trust during 2020/21. It also includes further analysis of Serious Incidents, and analysis of action themes arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2020 to 31 March 2021 (data as at 22/04/2021).

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

- **12717** incidents reported
- **3.7%** decrease in reporting on 2019/20 (but similar to 2018/19)
- **92%** of incidents resulted in no/low harm
- **34** Serious incidents reported
- No Never Events
- One homicide reported
- Serious Incidents account for **0.26%** of reported incidents
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture[1]

The Trust reported **12717** incidents during the year; a 3.7% decrease on the 2019/20. A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture. 92% of reported incidents resulted in low or no harm to patients, service users and staff, recognising that the Trust has a risk based and good reporting culture (compared with 93% 2019/20).

There were **34** serious incidents reported during the year accounting for 0.26% of all incidents. The highest overall category of serious incident is apparent suicide of service users (16) compared with 2019/20 (24). It should be noted that not all suicides are investigated as serious incidents.

No 'Never Event' incidents were reported by SWYPFT in 2020/21. The last Never Event reported by the Trust was in 2010/11. Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Further detailed analysis of all apparent suicides occurring in 2020/21 will be available in September 2021 in the apparent suicide report.

Contents

Introduction

This incident management annual report focusses on incidents and serious incidents reported within the Trust during 2020/21.

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

The patient safety support team will be preparing two further reports. Firstly, we will prepare 'Our Learning Journey' report which will present the work of the BDUs in implementing learning from incidents. This will be available in September 2021. The second report to be prepared is the 'Apparent Suicide Report'. This will be available in Autumn 2021.

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

The report is structured into the following sections:

Section 1 includes a summary of all reported incidents occurring from 1 April 2020 to 31 March 2021. It should be noted that this report provides only an overview; detailed reports are produced on a quarterly basis for Business Delivery Units and many specialist advisors run/analyse incident reports.

Section 2 focusses on incidents reported as Serious Incidents during 2020/21. The first part looks at what these incidents were, and secondly provides more details on the different types of serious incidents that were reported.

Section 3 sets out an analysis of the serious incident investigations that have been completed and sent to commissioners during 2020/21. It includes an analysis of the themes arising from serious incident recommendations.

Section 4 focusses on reported deaths in line with the Learning from health care deaths policy

Section 5 Overview of incident management plans for 2021/22.

Section 1 - Incident Reporting Analysis

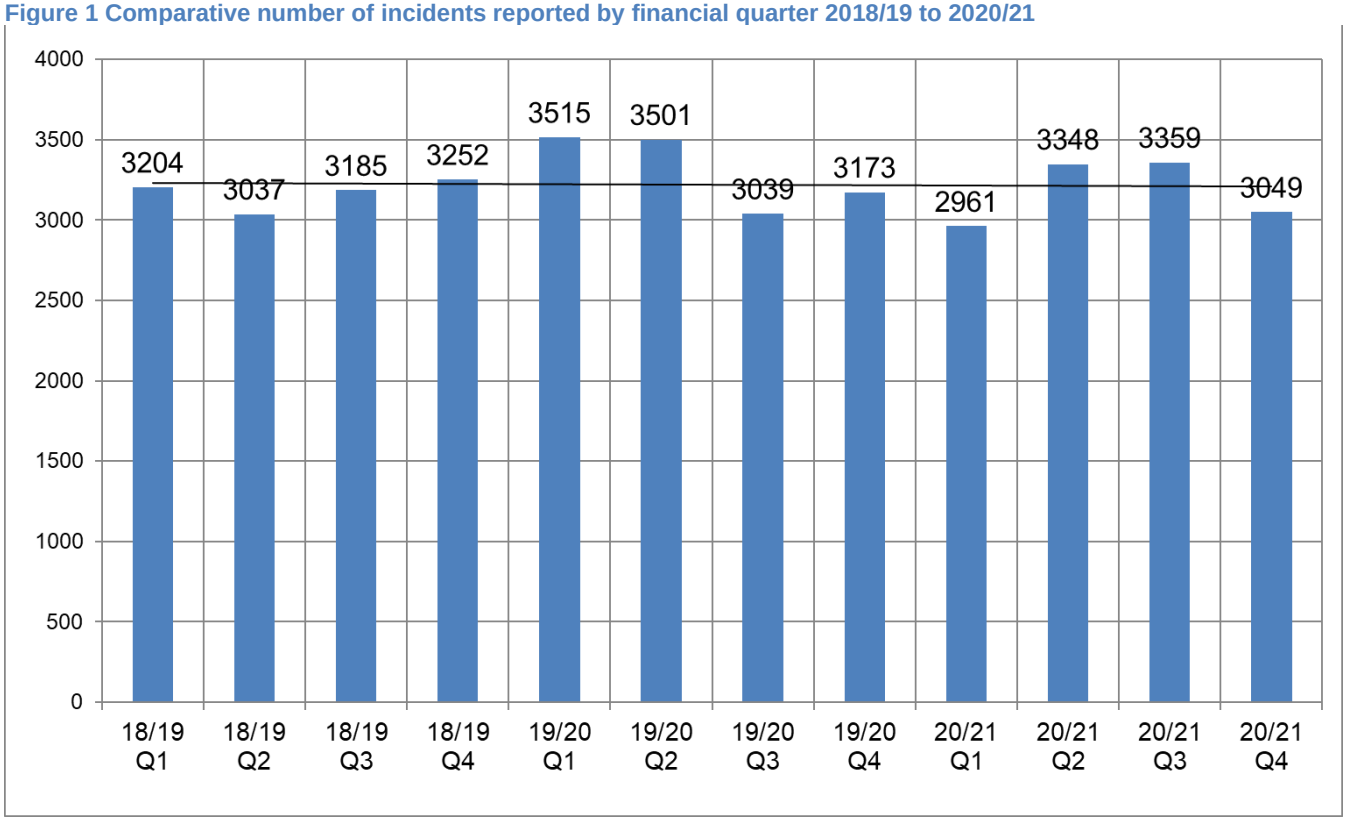
Headlines

The Trust reported **12717** incidents of all severity during the year, a 3.7% decrease on 2019/20 (**13206**). However, the reporting rate for 2020/21 is consistent with the average number of incidents reported over a 3-year period (12737 incidents/year).

- **12717** incidents reported
- **3.7%** decrease in reported incidents compared with 2019/20, but similar to 2018/19
- **92%** of incidents resulted in **no/low harm**
- **34** Serious incidents reported (0.26% of all incidents)
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

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

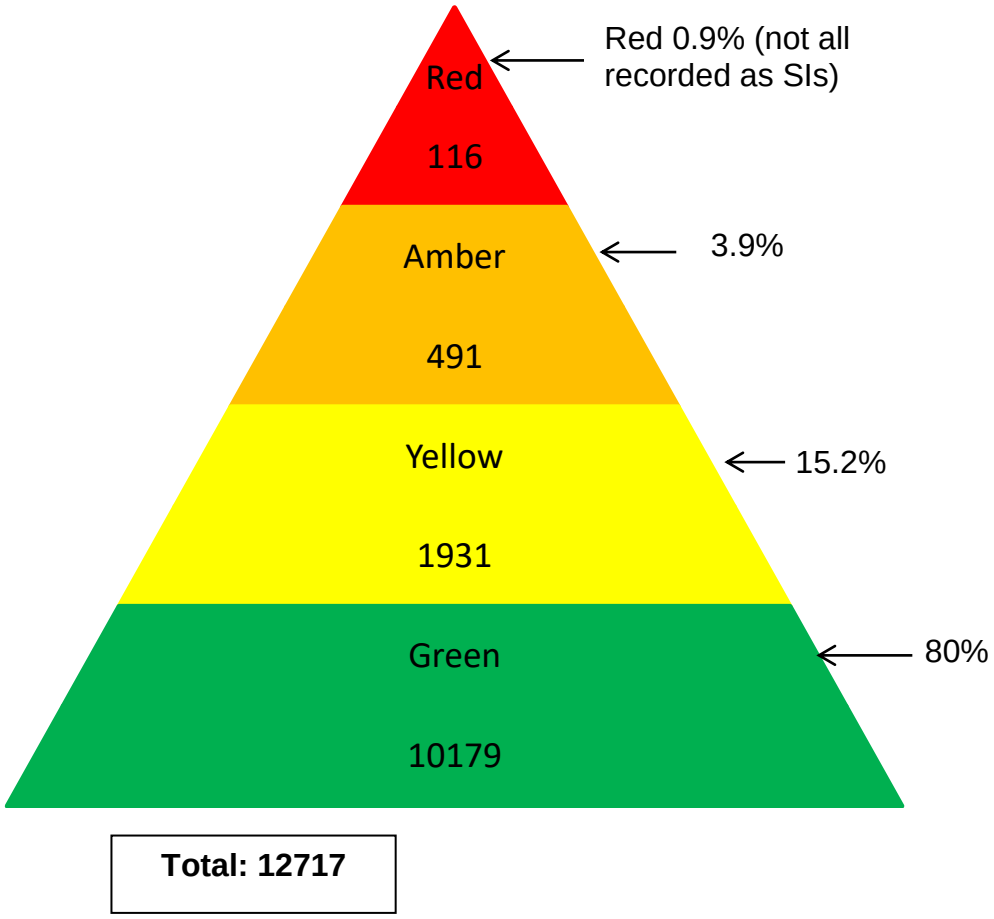
Figure 1 Comparative number of incidents reported by financial quarter 2018/19 to 2020/21



Severity

The distribution of these incidents in terms of severity is pyramid-shaped (figure 2) with red incidents being fewest in number; and 80% being graded green.

Figure 2 Incidents reported by severity 2020/21



Note: The red incidents in this chart are based on the date when the incident occurred, which is often different to the date it was reported on the Strategic Executive Information System (StEIS) as a Serious Incident (SI), which use the date reported on StEIS. Not all Red incidents are reported as SIs. Red incidents include unexpected deaths where the cause of death is not yet known. Incidents are re-graded as further information is received.

Actual harm

In addition to the severity of incidents, we also record the level of harm that was caused by an incident, irrespective of the severity. This is called the Degree of harm. In 2020/21, 92% of incidents in 2020/21 resulted in no harm or low harm to patients and staff. The proportion of no/low harm incidents has remained consistent with previous years. An organisation with a high reporting rate, particularly with a high proportion of no/low harm is indicative of a positive safety culture where staff are encouraged to report incidents and near misses.

Type and Category of incidents

All incidents are coded using a three-tier method to enable detailed analysis. 'Type' is the broadest grouping, with Type breaking into 'categories', and then onwards into 'sub-categories'.

Figure 3 below shows all reported incidents in 2020/21 by the type of incident. Violence and aggression incidents are the highest type of incident.

Figure 3 Trust-wide incidents reported by type of incident during 2020/21

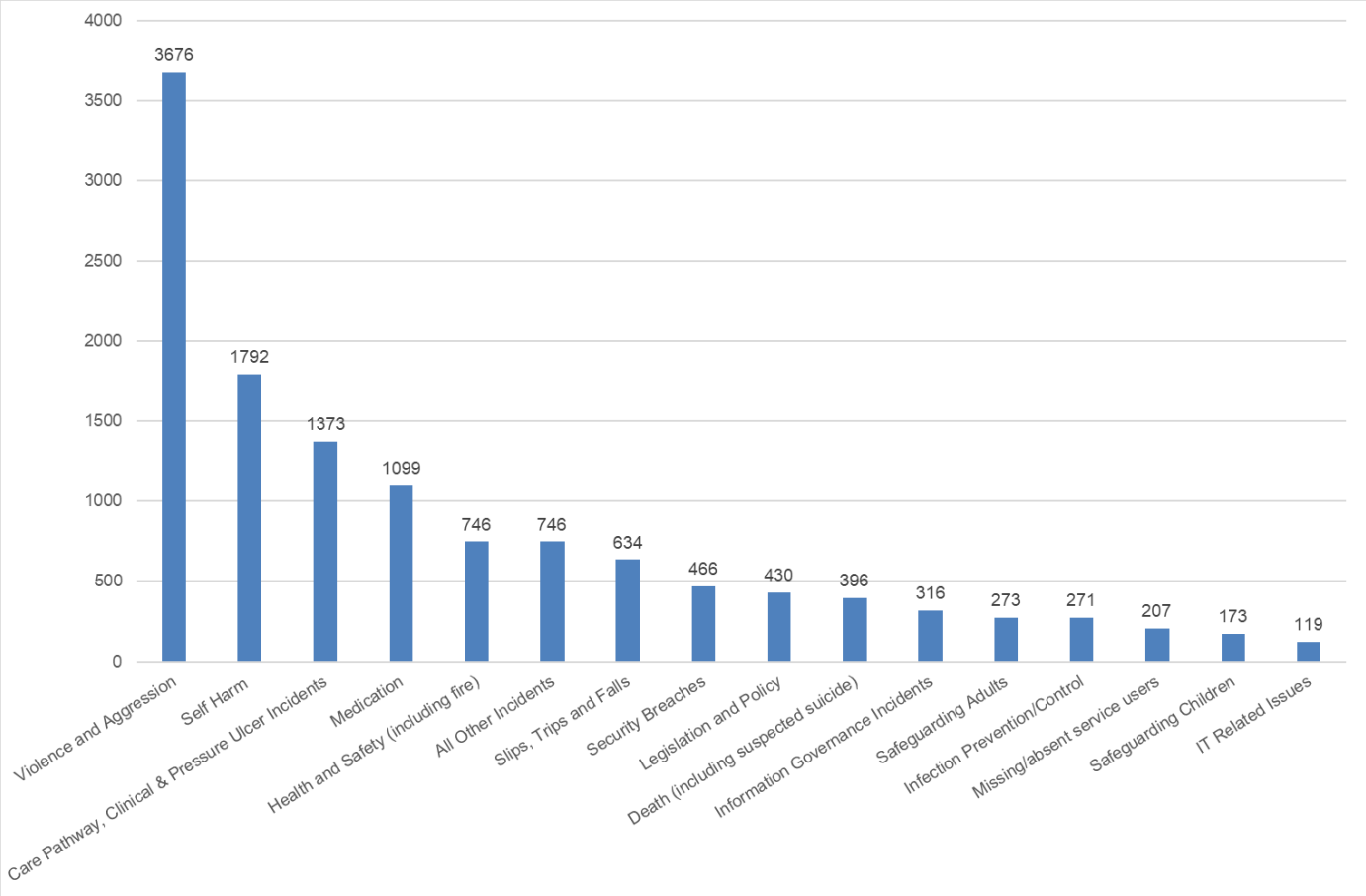
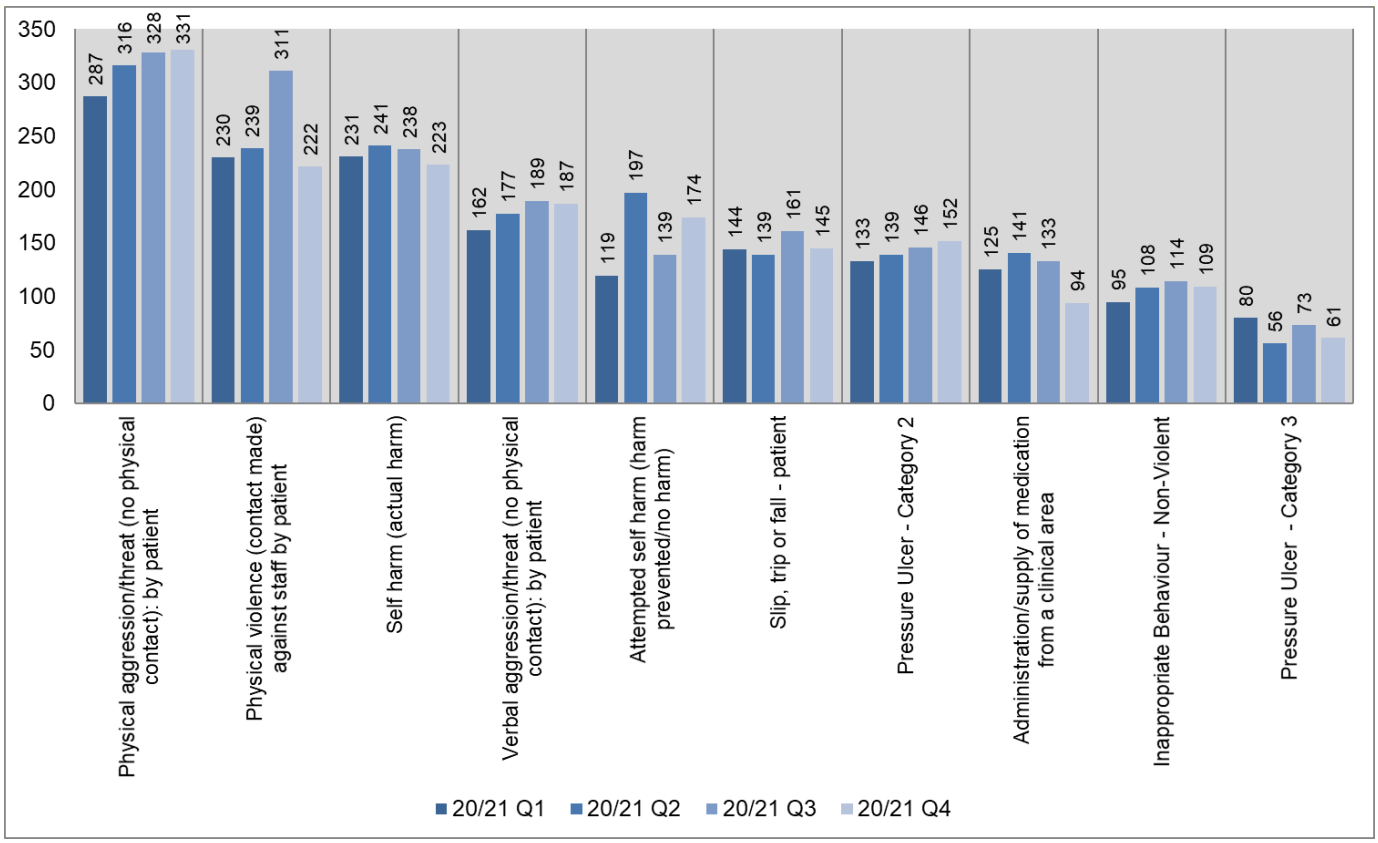


Figure 4 shows the top 10 highest reported categories of incidents across the Trust during 2020/21. During 2020/21 incidents were reported against 152 different categories of incident. The top 10 categories account for 54% of all incidents reported, which is consistent the proportion in previous years.

Figure 4 Trust-wide Top 10 most frequently reported incident categories in year 2020/21



'Physical aggression/threat (no physical contact): by patient' was the highest reported incident category in 2020/21 with a total of 1262 incidents, accounting for 10% of all incidents reported. This is a reduction on 2019/20 (1364) but this has remained the top reported category in the last three years. This includes incidents such as threatening behaviour against others or where physical violence was prevented.

There are two other categories of violence and aggression related incidents appearing in the top 10; 'Physical violence against staff by patient (where contact was made)' and 'Verbal aggression/threat (no physical contact): by patient'.

Note spike in Q3 for physical violence contact made by pat against staff -? reason

All three categories have appeared in the top 10 in the last 4 years. In previous years, we have seen 'Inappropriate violent/aggressive behaviour (not against person) by patient' in the top 10, but this no longer appears.

Requested commentary from RRPI team on V&A incidents

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

The third highest category of incident is 'Self harm (Actual)' with 'attempted self harm' also appearing in the top 10, which is consistent with the previous year. In 2020/21 there were 933 actual self harm incidents (an increase on 2019/20 [719]). The figures for self-harm fluctuate through the year and numbers are closely affected by individual service user presentation.

The categories for Pressure ulcer – category 2 and 3 both appears in the top 10. It should be noted that these are incidents that are generally identified by staff in the general community services and many are attributable to other agencies. The Datix system is used to capture the identification and actions taken by our staff.

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

Affected party demographics

Appendix 1 provides a breakdown of some protected characteristics of those affected in the incidents.

External Review

Reporting to National Reporting and Learning System

The Trust captures the severity of all incidents locally on Datix using the risk matrix which scores incidents ranging from green through to red (see Figure 2). This includes actual and potential harm of all incidents and near misses (i.e. psychological harm, potential risks).

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

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

The NHS Patient Safety Strategy [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.

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

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

In 2020/21 the Trust uploaded a total of 6252 patient safety incidents to the NRLS (at 17/5/21), compared with 6278 reported in 2019/20 Quality Accounts. 94% of the 6252 incidents resulted in no harm or low harm (note this figure is not all incidents). This is similar to 2019/20 (95%).

The Trust reported a total of 57 severe harm and patient safety related death incidents in 2020/21, compared to 53 incidents in 2019/20 (as at 17/5/21).

In relation to the total number of incidents uploaded, the percentage of severe harm incidents has slightly increased to 0.45% when compared with 0.38% in 2019/20. The percentage number of patient safety related deaths (uploaded to NRLS) is the same percentage as last year which was 0.46%.

National Reporting and Learning System reports

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

NHS Improvement publishes data from the NRLS system on a six-monthly basis. These reports are designed to assist NHS trust boards to understand and improve their organisation's patient safety culture and reporting of patient safety incidents to the NRLS. The reports have changed over time, but now encourage organisations to compare against themselves over periods of time, rather than with other organisations which may not be comparable for a number of reasons.

The published reports are added to the NRLS intranet page when released.

The latest NRLS Summary Report published in September 2020, covers the period 1 October 2019 to 31 March 2020 compares the Trust's data for the same period in 2019. 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 reduced slightly between 1 October 2019 and 31 March 2020 when compared to the same period in 2018/19.
- The team continue to protect time to approve incidents internally prior to uploading. Overall, this improves the speed with which incidents are uploaded to NRLS however there are some minor fluctuations related to capacity in the team.

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 directly correlate with those collected locally. Work takes place to confirm our mapped data with NHS Improvement, this is expected to be part of the transition to the new national reporting system.

Have the care settings of your incidents changed?

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

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 were identified, and an action plan developed and completed during 2020/21.

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

During 2020/21, the Patient Safety Support Team took part in the Royal College of Psychiatrists Serious Incident review accreditation process. This involved several months of self and external peer review and culminated in the achievement of accreditation for a three-year period. This achievement demonstrates the assurance in our serious incident investigation process from a national body and enabled the team to showcase our commitment to continuous improvement in line with our values. We will continue to improve further in line with national developments and ensure consolidation of the work to achieve accreditation.

Duty of Candour

Duty of Candour applies to all patient safety incidents that result in moderate harm or above. The Trust has been following the principles of Being Open since 2008 and had a policy in place since that time. The NHS contract includes Duty of Candour for patient safety incidents with moderate harm and above and the Trust has been reporting on this since April 2014. In November 2014 this was strengthened when this became a statutory CQC regulation[3] to fulfil the Duty of Candour requirement.

Failure to comply with the contractual requirements could result in recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown (NHS Contract) and/or it is a criminal offence to fail to provide notification of a notifiable safety incident and/or to comply with the specific requirements of notification. On conviction a health service body would be liable to a potential fine of £2,500.
The data contained in this section of the report was correct at the time of reporting (21/4/21). The data is extracted from a live system and is subject to change.

Duty of Candour applies only to those incidents with a degree of harm of moderate or severe harm or death caused by a patient safety incident. The Degree of Harm is used by all Trusts (other Trusts may call it something else) to grade the level of harm caused by an incident to ensure consistency of recording nationally. During February 2021, Datix was changed so that staff reporting incidents would complete the Degree of Harm themselves (as close to the incident as possible; prior to this, it was completed centrally by the Patient Safety Support Team). The Degree of harm is reviewed by the responsible manager and will be updated as further information comes to light. This differs from the incident severity (green, yellow, amber, red), which is how we grade incidents locally in the Trust. Other Trusts may do this differently (eg numeric rating). Incident severity considers actual and potential harm caused and the likelihood of reoccurrence (based on the Trust's risk grading matrix), whereas the Degree of Harm is only the actual harm caused.

During 2020/21, there were 356 potentially applicable patient safety incidents (2.8% of all incidents reported; a slight rise on 2.2% in 2019/20). The number of patient safety incidents meeting the NRLS definition of moderate or severe harm or death is higher in some quarters in 2020/21 compared to 2019/20 as shown in Figure 5. The percentage of Duty of Candour applicable incidents against the total number of incidents reported each quarter is usually fairly consistent, however Quarters 1 and 3 (see figure 5) show a higher proportion of applicable incidents, particularly due to an increase in category 3 pressure ulcers (moderate harm), and self harm incidents in quarter 1. Quarters 3 and 4 saw a slightly higher number of patient safety related deaths recorded (this may be related where we are awaiting confirmation of cause of death, which may result in changes in degree of harm).

It should be noted that the figures included in this section of the report regarding Duty of Candour will not match the number of incidents reported to the National Reporting and Learning System (NRLS)

[3] Care Quality Commission. Duty of Candour guidance

as some incidents where Duty of Candour applies, are not reportable to NRLS, e.g. apparent suicide of a discharged community patient.

Figure 5 Total number of patient safety incidents with moderate or severe harm or death between 1/4/2019 and 31/3/2021

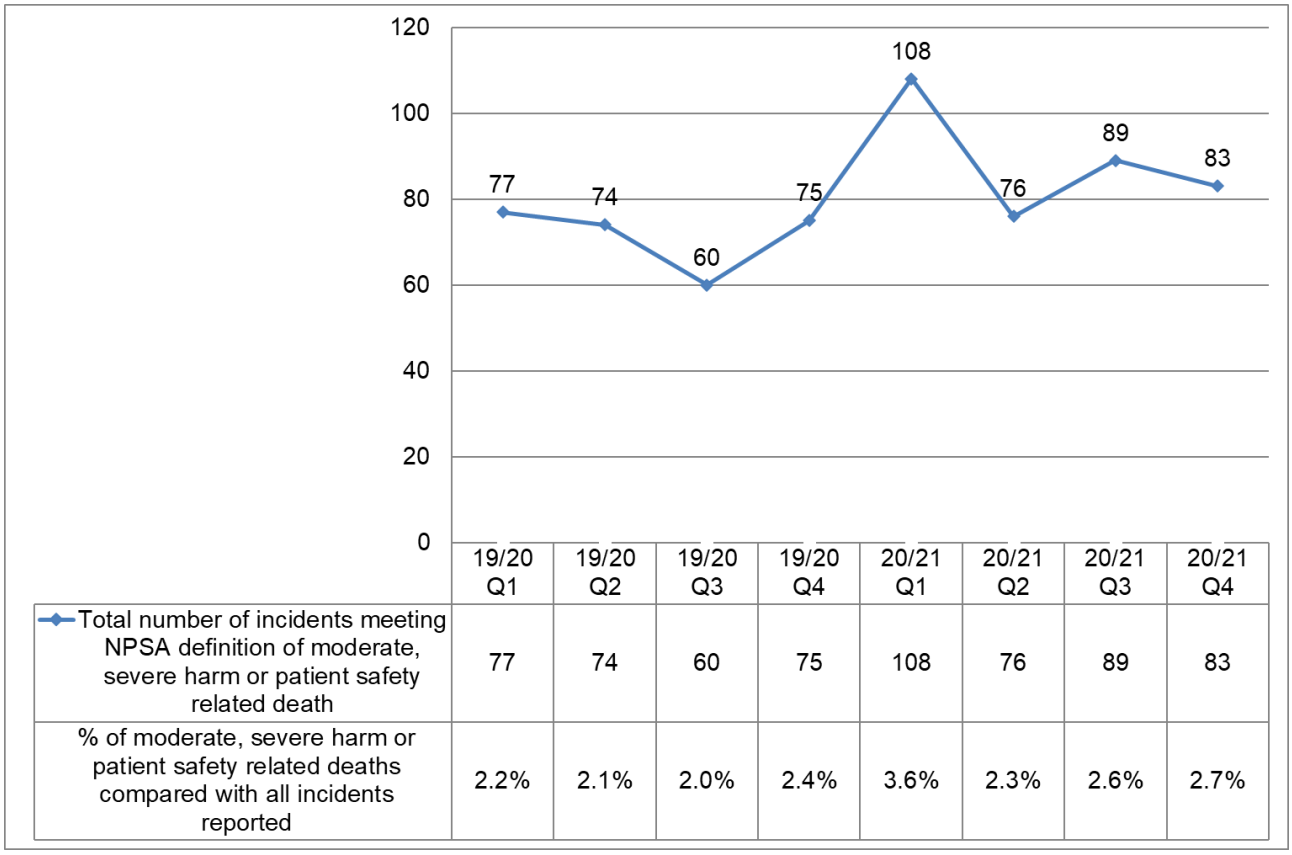


Figure 6 shows the degree of harm (moderate, severe or death) from patient safety incidents over a two-year period.

Figure 6 Duty of Candour applicable incidents by degree of harm and month 1/4/2019 and 31/3/2021

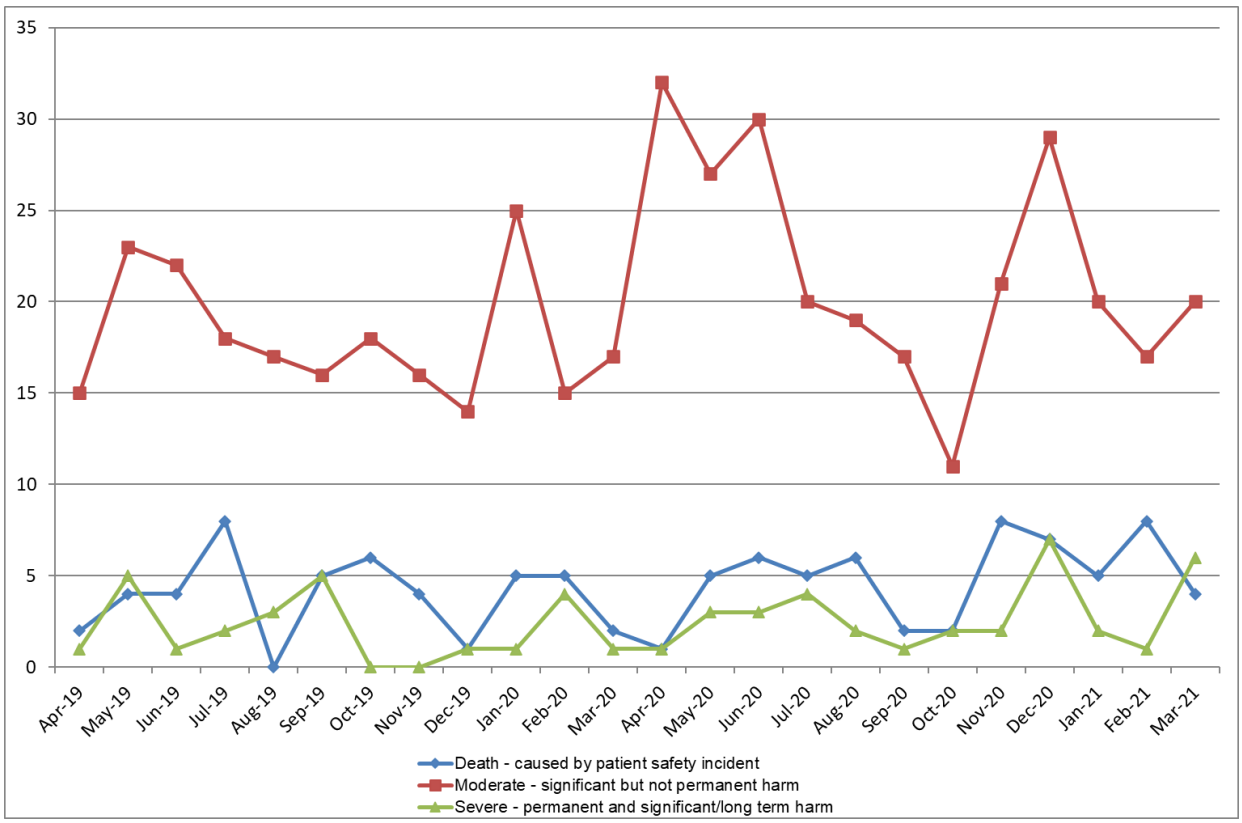


Figure 7 shows the highest number of applicable incidents is in Barnsley General Community Services with 192 incidents [an increase on 2019/20 152]. A high proportion of these were pressure ulcers, category 3 (moderate harm).

Figure 7 Duty of Candour applicable incidents in 2020/21 by BDU and financial quarter

BDU	Quarter 1 2020/21	Quarter 2 2020/21	Quarter 3 2020/21	Quarter 4 2020/21	Total
Barnsley General Community Services	67	34	52	39	192
Mental Health Inpatient Services	18	12	8	16	54
Kirklees Community Mental Health Services	11	8	5	11	35
Wakefield Community Mental Health Services	3	6	9	3	21
Barnsley Community Mental Health Services	3	8	5	2	18
Calderdale Community Mental Health Services	5	3	3	6	17
Forensic Service	1	3	4	3	11
Learning Disability services	0	1	2	2	5
CAMHS Specialist Services	0	1	1	1	3
Total	108	76	89	83	356

Compliance with Duty of Candour

Each BDU should have identified lead/s who are responsible for reviewing their BDU's compliance with Duty of Candour. The Patient Safety Support Team provides data on a monthly basis to the Operational Management Group to support BDUs with monitoring their compliance with Duty of Candour. All Trio managers/leaders have access to live data on Datix Dashboards to aid monitoring. Figure 8 shows the monitoring position which breaks down as below:

- In 83% of cases (296), a verbal conversation has happened with the patient and/or family within 10 working days of the incident occurring or being identified (as per the contract).
- There were 47 cases where Duty of Candour was not completed but exception reasons were given (13%). The number of exceptions has increased from 6% in 2019/20)
- There were 12 cases (3%) where the Duty of Candour monitoring was not completed by the BDU (at 21/4/21), these could include possible breaches. This compares with 14% (44) reported in 2019/20 annual report.
- There was one breach of Duty of Candour reported, representing 0.3% of all applicable incidents. This was due to an incident where a patient sustained a minor injury in their own home when Trust staff were in attendance. The patient had been made comfortable and given support by the attending staff. The following day the patient attended the acute hospital due to pain, and a fracture was reported. The incident was not reported until the fracture was identified to staff. The identification of this incident as applicable for duty of candour was missed. In learning from this breach, all BDU trio staff now have access to Dashboards on Datix to assist them with reviewing all potential duty of candour incidents in a timely manner to ensure breaches do not occur.

Figure 8 Duty of Candour compliance 2020/21

	Barnsley General Community Services	Mental Health Inpatient Services	Kirklees Community Mental Health Services	Wakefield Community Mental Health Services	Barnsley Community Mental Health Services	Calderdale Community Mental Health Services	Forensic Service	Learning Disability services	CAMHS Specialist Services	Total
Stage 1 Duty of Candour - verbal apology completed within 10 days	190	39	16	17	11	12	11	0	0	296
Stage 1 Duty of Candour verbal apology not given following MDT decision (exception)	0	7	9	2	4	2	0	0	0	24
Stage 1 Duty of Candour - not completed (exception)	1	5	10	1	3	3	0	0	0	23
Stage 1 Duty of Candour - not completed (breach)	1	0	0	0	0	0	0	0	0	1
Awaiting BDU monitoring	0	3	0	1	0	0	0	5	3	12
Total	192	54	35	21	18	17	11	5	3	356

Exception reasons include verbal apology not being given following MDT decision due to clinical presentation or being detrimental to patient's wellbeing. 62% of the exception related to self-harm incidents. In other cases, Duty of Candour was not possible with the patient as they were too unwell. In some cases, particularly where patients had died, there were no family contact details known to enable us to contact family members.

During 2020, an audit of Duty of Candour took place by the patient safety support team to ensure that recording of Duty of Candour was accurately recorded, and to identify cases where the BDU monitoring had not been completed and to offer support to BDUs. The team worked closely with BDU colleagues to identify and address gaps in recording. This resulted in improvements in recording. This

is evidenced in the reduction in the number of cases where the BDU monitoring is outstanding (12 cases (3% at 21/4/21); compared with 14% (44) reported in 2019/20 annual report. This may also be related to the increase in exceptions, as the rationale for not completing was updated.

In March 2021, the Care Quality Commission issued revised guidance on Duty of Candour. This is being reviewed against our local guidance.

Section 2 - Serious Incidents reported during 2020/21

Background context

Serious incidents are defined by NHS England as;

> "…events in health care where the potential for learning is so great, or the consequences to patients, families and corers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare." [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 in the NHS must be considered on a case-by-case basis using the description below and include acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

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

Investigations

Investigations are initiated for all serious incidents in the Trust to identify any systems failure or other learning, using the principles of root cause and systems analysis. The Trust also undertakes a range of reviews to identify any themes or underlying reasons for any peaks. Most serious incidents are graded amber or red on the Trust's severity grading matrix, although not all amber/red incidents are classed as serious incidents and reported on the Strategic Executive Information System (StEIS). Some incidents are reported, investigated and later de-logged from StEIS following additional information. Conversely, some incidents are reported as Serious Incidents on StEIS after local investigation. We have an 'watching brief' arrangement with some clinical commissioning groups where we can verbally report a potential serious incident, whilst further information is gathered.

Headlines

During 2020/21, 34 Serious Incidents were reported to the relevant Clinical Commissioning Group (CCG/specialist commissioner) via the NHS England Strategic Executive Information System (StEIS). This compares with 47 in 2019/20.

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

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

- 34 Serious incidents reported
- Serious incidents account for 0.26% of all incidents
- Apparent suicide is the highest serious incident category (16)
- One mental health homicide reported (see note below)
- No Never Events

No 'Never Event[6]' incidents were reported by SWYPFT in 2020/21. The last Never Event reported by the Trust was in 2010/11. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There is a list of Never Events defined by NHS England. Examples of Never Events relevant to SWYPFT include failure to install functional collapsible shower or curtain rails in mental health settings; and in all settings, overdose of insulin due to abbreviations or incorrect device; falls from poorly restricted windows; chest or neck entrapment in bed rails; scalding of patients; unintentional connection of a patient requiring oxygen to an air flowmeter. A list of current Never Events is available on the Trust intranet. There is specific guidance for circumstances of each Never Event.

One homicide by a mental health service user was reported as a Serious Incident during 2020/21 and is included in the SI figures below, however, in May 2021, a decision has been made that this will be removed as a serious incident, and investigated as a mental health homicide, led by NHS England. Where this appears in the tables and graphs below, this is denoted by ^ for the relevant period/category.

Serious Incident Analysis

Figures 9 and 10 below shows all serious incidents reported on StEIS between 1 April 2016 and 31 March 2021, with figure 9 showing breakdown by financial quarter.

Figure 9 Breakdown of serious incidents reported each financial year by financial quarter 2016/17- 2020/21

	2016/17	2017/18	2018/19	2019/20	2020/21
Quarter 1	13	15	8	12	8
Quarter 2	13	18	9	12	11
Quarter 3	15	26	10	8	8
Quarter 4	23	12	17	15	7^
Total	**64**	**71**	**44**	**47**	**34**

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

^ Mental health homicide which will be removed from SI figures, investigation led by NHS England

The data in Figure 9 shows a reduction in the number of serious incidents reported over a 5-year period by financial quarter. During this time we have strengthened our relationships with our Commissioners. In recent years, we have received feedback from them which told us that as a Trust, we had a culture of over reporting serious incidents historically. We took their advice and used other review processes to identify issues at an earlier stage (e.g. structured judgment review (introduced in 2018), and where no learning has been identified during a serious incident investigation, these cases are removed from the serious incident figures. Through clinical risk panel, we may request a structured judgement review or a service level investigation before making a decision to report as a serious incident. Our proportion of serious incidents to all incidents reported remains low (0.26%). We encourage staff to report incidents, and it is recognised that a high reporting rate with high proportion of no/low harm is indicative of a positive safety culture where we are proactive in reporting incidents and near misses. We continue to work on reducing suicides through our suicide prevention work. We learn lessons from incidents to prevent incidents becoming more serious in future. We actively share learning through the Learning Library and where urgent risks are identified, shared through Bluelight alerts. As we progress to implementation of the NHS Patient Safety Incident Response System (expected in 2022), reporting and investigation methodology will change to a focus on learning and improvement.

Figure 10 Total number of Serious Incidents reported by financial year 2016/17 to 2020/21

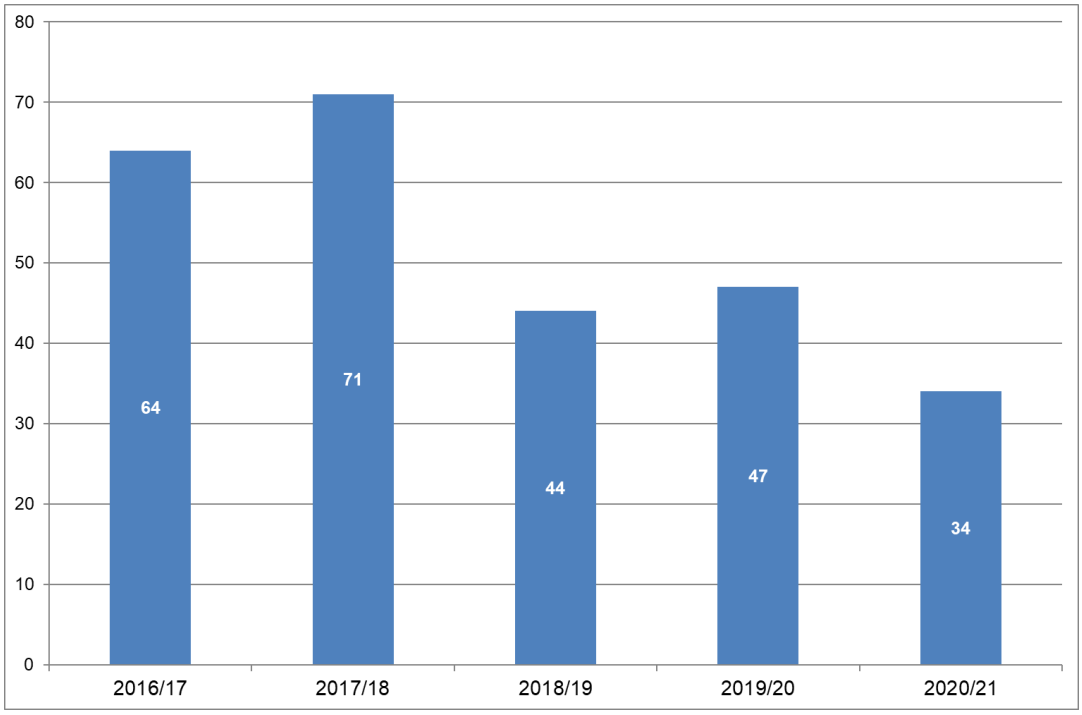
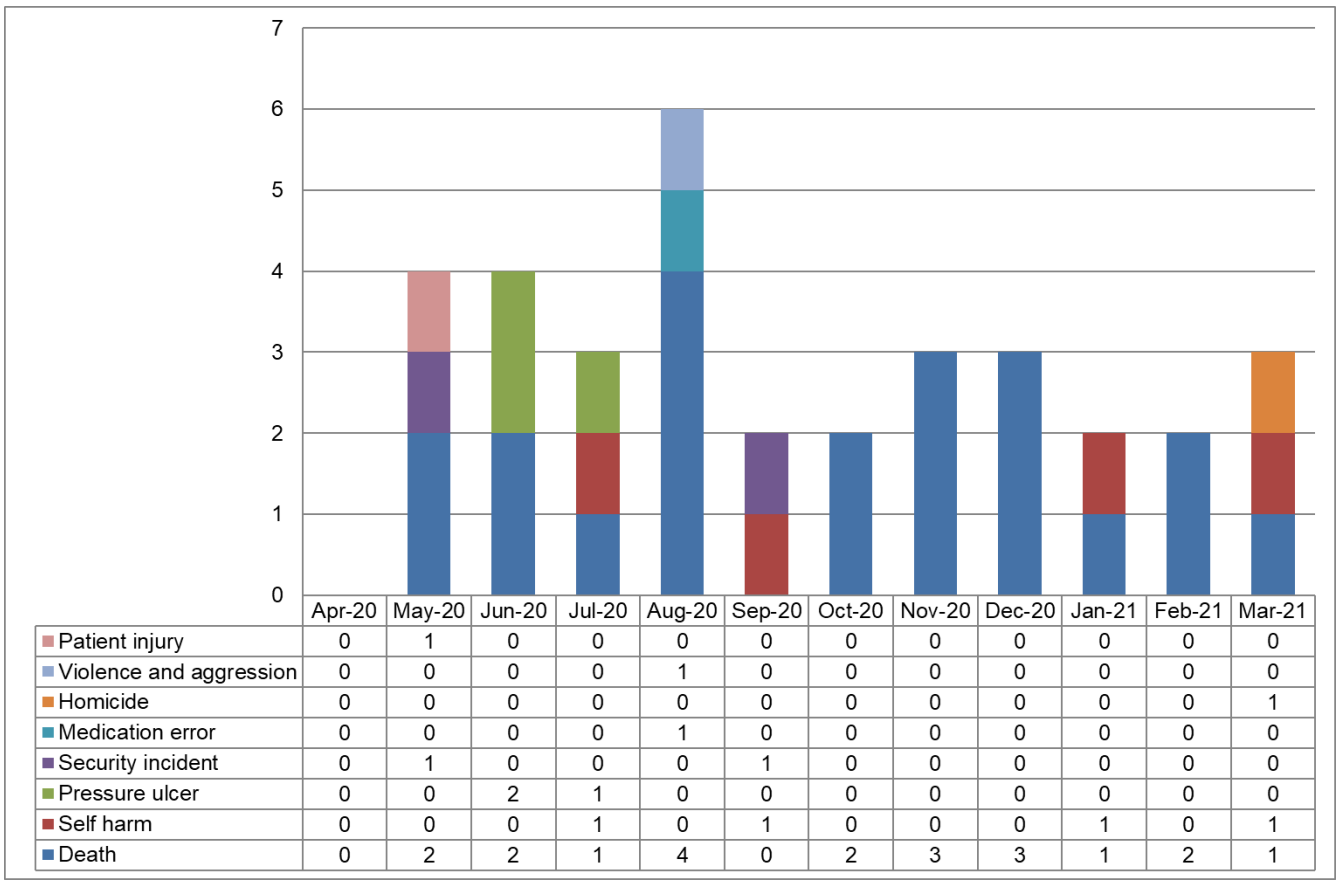


Figure 11 shows a breakdown of the 34 serious incidents reported during 2020/21 by the type of incident and month reported.

Figure 11 Types of All Serious Incidents reported in 2020/21 by date reported on StEIS



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Patient injury	0	1	0	0	0	0	0	0	0	0	0	0
Violence and aggression	0	0	0	0	1	0	0	0	0	0	0	0
Homicide	0	0	0	0	0	0	0	0	0	0	0	1
Medication error	0	0	0	0	1	0	0	0	0	0	0	0
Security incident	0	1	0	0	0	1	0	0	0	0	0	0
Pressure ulcer	0	0	2	1	0	0	0	0	0	0	0	0
Self harm	0	0	0	1	0	1	0	0	0	1	0	1
Death	0	2	2	1	4	0	2	3	3	1	2	1

As in previous years, the highest type of serious incident is death of a service user (21) including death by apparent suicide or unexpected death.

Figures 12 and 13 show the breakdown of the reported serious incidents by category and BDU. The category of incident (a subset of 'type', as shown in Figure 10) provides more detail of what occurred. It shows that apparent suicide of service users in current contact with community teams is the highest reported category with 10 (compared with 2019/20 [24]; 2018/19 [23]; 2017/18 [34]). There are a further six incidents relating to apparent suicide. These include two deaths where the patient was under the care of inpatient services at the time of death and four deaths where the service user had been discharged from community teams at the time of the deaths occurring.

Figure 12 Serious Incidents reported during 2020/21 by reported category

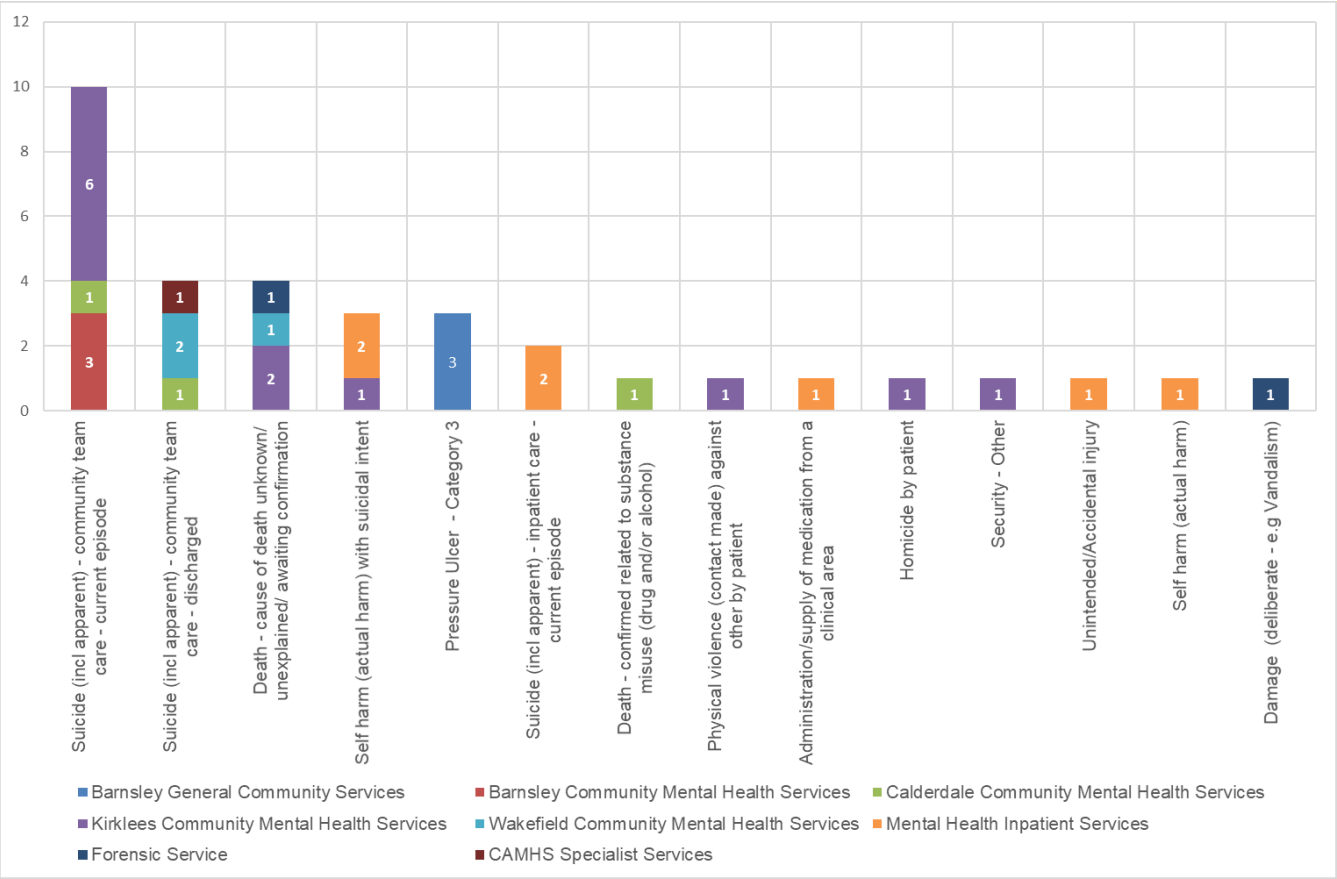


Figure 13 Serious Incidents reported during 2020/21 by BDU

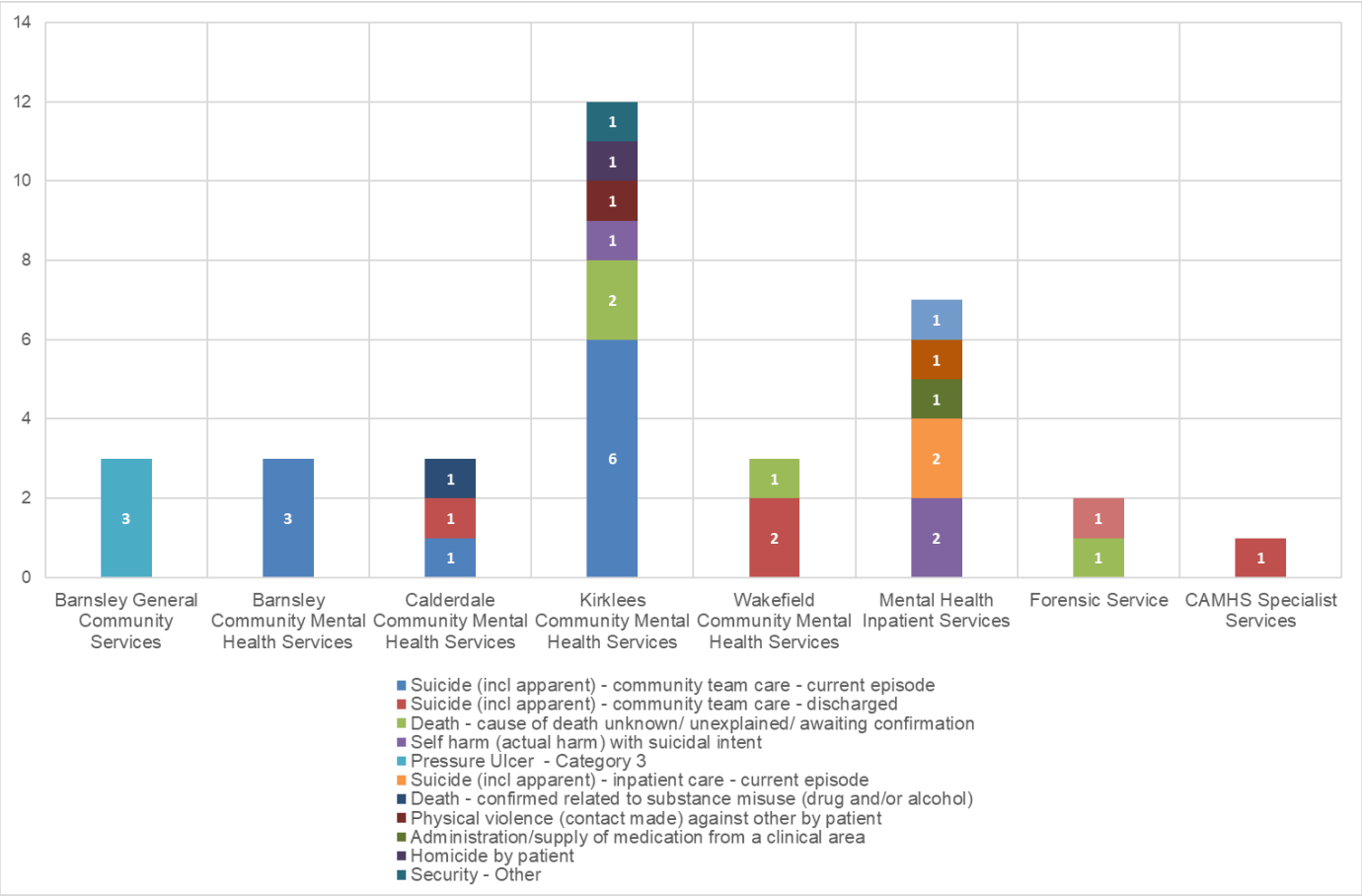


Figure 14 2020/21 Reported Serious incidents by BDU and category

Category	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	CAMHS Specialist Services	Total
Suicide (including apparent) - community team care - current episode	0	3	1	6	0	0	0	0	10
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	0	0	2	1	0	1	0	4
Suicide (including apparent) - community team care - discharged	0	0	1	0	2	0	0	1	4
Pressure Ulcer - Category 3	3	0	0	0	0	0	0	0	3
Self harm (actual harm) with suicidal intent	0	0	0	1	0	2	0	0	3
Suicide (including apparent) - inpatient care - current episode	0	0	0	0	0	2	0	0	2
Unintended/Accidental injury	0	0	0	0	0	1	0	0	1
Security - Other	0	0	0	1	0	0	0	0	1
Physical violence (contact made) against other by patient	0	0	0	1	0	0	0	0	1
Administration/supply of medication from a clinical area	0	0	0	0	0	1	0	0	1
Death - confirmed related to substance misuse (drug and/or alcohol)	0	0	1	0	0	0	0	0	1
Damage (deliberate - e.g. Vandalism)	0	0	0	0	0	0	1	0	1
Self harm (actual harm)	0	0	0	0	0	1	0	0	1
Homicide by patient	0	0	0	1	0	0	0	0	1
Total	3	3	3	12	3	7	2	1	34

As Figures 12, 13 and 14 show, during 2020/21, the area with the highest number of SIs reported was Kirklees with 12 serious incidents, a reduction on 2019/20 (15). In 2019/20 14 of the 15 Serious incidents were the death of service users – in 2020/21 there were 8 deaths. This year, other incident types of serious incident are reported (as shown in figure 14) including two violence and aggression incidents (one alleged homicide by a service user against a relative^ and an incident of physical violence by a patient against a member of the public). Two further incidents occurred in patient's homes when staff were present - a hostage taking situation, and a self-harm incident.

Mental Health Inpatient Services have the second highest number of incidents recorded (7 SIs). This year is the first where these have been recorded together for the Trust as one BDU. In 2019/20 incidents for mental health inpatient areas were included in the respective geographical BDU data. As such, comparison with historical data/reports cannot be made. Of the 7 SIs, two were deaths of inpatients, by apparent suicide, both occurring in Barnsley Mental Health inpatient wards. There were three serious self harm incidents, all occurring in different wards, but in all cases, the patients were on planned leave from the ward at the time. All resulted in severe harm. The other two incidents related to a medication error, and a patient being injured in a seclusion room.

Wakefield has seen a reduction in the number of serious incidents (3). This included two apparent suicides of discharged patients, and one unexpected death.

Forensics had 2 serious incidents, a reduction on 2019/20 (7). These were an unexpected death of an inpatient (low secure Learning Disability unit), and an incident of deliberate damage to property by a patient.

Calderdale Mental health community services had 3 serious incidents, 2 were apparent suicides, and the third an unexpected death.

Barnsley Mental Health community services had 3 serious incidents, all apparent suicides of community patients under current care.

Barnsley General Community has reported 3 SIs in 2020/21 (2019/20 [4]). These were category 3 pressure ulcers, occurring in the same team, so in agreement with the Clinical Commissioning Group, a decision was made to investigate the incidents together as a cluster.

Child and Adolescent Mental Health Services had one serious incident involving the apparent suicide of a discharged client.

Figure 15 shows all reported serious incidents by reporting team (primary involvement at time of the incident) and financial quarter. It should be noted that some incidents involve several other teams.

Figure 15 Serious Incidents reported by Team and financial quarter

Team	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Total
Enhanced Team North 1 - Kirklees	1	1	2	0	4
Early Intervention Service (Insight) - Kirklees	1	2	0	1	4
Neighbourhood Team - North East (Barnsley)	2	1	0	0	3
Assessment and Intensive Home-Based Treatment Team / Crisis Team - Calderdale	1	0	1	0	2
Intensive Home-Based Treatment Team (IHBTT) - Barnsley	0	1	1	0	2
Core Team North - Kirklees	0	0	1	0	1
Crofton Ward (OPS), Wakefield	0	1	0	0	1
Core Team South - Kirklees	1	0	0	0	1
Enhanced Team West - Kendray, Barnsley	1	0	0	0	1
Enhanced Team South 1 - Kirklees	0	0	0	1	1
Intensive Home-Based Treatment Team - Wakefield (OPS)	0	0	1	0	1
Enhanced Lower Valley Team - Calderdale	0	1	0	0	1
Psychiatric Liaison Service, Wakefield	0	0	1	0	1
Melton PICU, Barnsley	0	1	0	0	1
Clark Ward - Barnsley	0	0	1	0	1
Stanley Ward, Wakefield	0	1	0	0	1
Newhaven Forensic Learning Disabilities Unit	0	0	0	1	1
Enhanced Team North 2 - Kirklees	0	0	0	1	1
Beamshaw Ward - Barnsley	0	0	0	1	1
Intensive Home-Based Treatment Team (IHBTT) - Wakefield	0	0	0	1	1
CAMHS (Barnsley)	0	0	0	1	1
Thornhill Ward (The Bretton Centre)	0	1	0	0	1
Ashdale Ward (based at The Dales, Kirklees BDU)	0	1	0	0	1
Ward 18, Priestley Unit	1	0	0	0	1
Total	8	11	8	7	34

Breakdown of all Serious Incidents

Deaths (apparent suicides and unexpected deaths)

Of the 34 serious incidents reported, 21 related to the death of a service user as mentioned earlier. Please note this is not all deaths that were reported on Datix, only those reported on StEIS.

Figure 14 shows the apparent category of death. This is extracted from Datix and was correct at the time of writing, based on information known at the time. This is subject to change as more information comes to light or inquest conclusions are received. Apparent suicide is based on the circumstances of death.

Apparent Suicide

Of the 21 deaths reported as serious incidents, 16 were apparent suicides. Two of these occurred whilst under the care of inpatient settings. Further detailed analysis of all apparent suicides in 2020/21 will be available in Autumn 2021.

Unexpected deaths

Of the 21 deaths, 5 were unexpected deaths, but suicide was not indicated. In most cases, the cause of death and/or coroner's conclusion is awaited. A couple relate to substance misuse. One death occurred in a home fire. There was one unexpected death of an inpatient, and a death of a recent inpatient.

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

Violence and Aggression

During 2020/21 there were two violence and aggression incidents, reported as serious incidents. The first involved a service user assaulting a member of the public; the second a homicide by a service user.

The homicide involved a service user under the care of an Enhanced Team in Kirklees being charged in connection with the death of their spouse. Although this serious incident has been included in the SI figures in this report, it has been agreed in May 2021 that this will be removed as a serious incident and managed through NHS England who will lead the investigation. Where this appears in the tables and graphs below, this is denoted by ^ for the relevant period/category.

Security incidents

During 2020/21 there were two incidents security related incidents. One involved a service user taking staff members hostage in the patient's home, and an incident of deliberate damage to property by a patient in an inpatient unit.

Pressure ulcers

During 2020/21, a total of three category 3 pressure ulcers were reported as Serious Incidents on StEIS. All were reported by one Neighbourhood team in Barnsley General Community Services. These were investigated as a cluster investigation. Two of the three patients affected were male.

Self-harm/attempted suicide

During 2020/21 there were four serious self-harm incidents. Three involved patients who were on leave from wards at the time of the incidents. Two patients jumped/fell from a height and the third injured themselves by cutting. The fourth case was an attempted hanging by a patient in their own home when a staff member was present.

Medication incidents

During 2020/21 there was one medication incident reported as a serious incident, which involved medication being administered via the wrong route.

Health and Safety incidents

During 2020/21 there was one health and safety incident reported as a serious incident which involved a patient who was in a seclusion room being injured.

Affected party demographics

Appendix 1 provides a breakdown of some protected characteristics of those affected in these serious incidents.

Section 3 - Findings from Serious Incident Investigations completed during 2020/21

This section of the report focusses on the **40** serious incident investigation reports were completed and submitted to the relevant commissioner during the period 1 April 2020 to 31 March 2021. Please note this is not the same data as those reported in this period (see Section 3) as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

- 40 serious incident investigations completed (43 2019/20)
- 185 associated actions (174 in 2019/20)
- All investigations include a recommendation to share learning
- Top 3 action themes:
  1) Staff education, training and supervision
  2) Risk Assessment
  3) Record keeping

Headline data

Of the 40 serious incidents investigation reports completed and submitted to the relevant commissioner between 1 April 2020 and 31 March 2021, there were 185 actions made (compared with 174 during 19/20). The 40 investigations related to 42 reported Serious Incidents, as one investigation covered three serious incidents.

Of the 40 Serious incident investigations completed between 1/4/2020 to 31/3/2021, two were completed within the 60 working days. The 60 working days timescale for completing a Serious Incident investigation was suspended in March 2020 due to Covid 19 and remains suspended at 4/5/2021. The progress of all Serious Incident Investigations continues to be reviewed weekly in the Patient Safety Support team. We have continued to liaise with commissioners to agree extensions throughout the year, despite the timescales being suspended. We have also liaised with families to ensure they are aware of delays in completion of investigations.

A standard recommendation to share learning and the outcome of the investigation with staff involved and wider is now in place. All 40 serious incident investigations including sharing learning actions/processes which does increase the number of actions.

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

Figure 16 Breakdown of the number of Serious Incidents completed in 2020/21 per BDU, compared with the number of actions

BDU	SI investigations completed	SI actions
Kirklees Community Mental Health Services	11	46
Mental Health Inpatient Services	6	40
Barnsley Community Mental Health Services	6	31
Forensic Service	5	29
Calderdale Community Mental Health Services	5	16
Wakefield Community Mental Health Services	5	10
Barnsley General Community Services	2*	13
Total	40	**185**

Figure 17 Breakdown of the number of Serious Incidents completed in 2020/21 per team type, compared with the number of actions

Specialty	SI investigations completed	SI actions
Enhanced Pathway	11	44
Crisis/IHBTT (Adult)	9	26
Bretton Centre - Inpatient wards (FSLS)	3	21
Acute Inpatients (Adult)	3	18
Inpatient Service (OPS)	2	15
Early Intervention Services	2	11
Criminal Justice Liaison	1	9
Core pathway	2	9
PICU Inpatient Services (Adult)	1	7
General Community Inpatient wards	1	7
District Nursing	1*	6
Rehabilitation inpatient units - Priestley, Waterton, Chippindale (FOR)	1	5
PICU/Acute inpatient units - Bronte, Hepworth (FOR)	1	3
Intensive Support Team (OPS)	1	3
Liaison Services	1	1
Total	**40**	**185**

Over the last three years the highest numbers of actions have arisen from apparent suicide incidents. This correlates with this being the largest type of Serious Incident reported. During 2020/21 completed serious incident investigations for apparent suicides resulted in 126 actions (68%) (Figure 18).

Figure 18 Breakdown of the number of Serious Incidents completed in 2020/21 per team type, compared with the number of actions

Action theme	Suicide including apparent (community team care)	Suicide including apparent (inpatient)	Other	Assault - serious	Serious self harm	Slip, trip, fall	Pressure Ulcer	Homicide (including alleged)	Unexpected death - community patient	Violence and Aggression	Grand Total
Sharing learning	26	3	3	2	2	1	1	1	1	1	41*
Risk assessment	11	2	3		2	1		3			22
Staff education, training and supervision	8	5	3	2	2	1	1				22
Record keeping	10	2	3		1	1	2		1		20
Policy and procedure - in place but not adhered to	9	1		1	1				1		13
Communication	8	2				1					11
Care delivery	8	3									11
Team service systems, roles and management	7			1			2				10
Carers/family	5	1	1		1			1			9
Organisational systems, management issues	2	3	1	2							8
Policy and procedures, not in place		3	1	1		1					6
Environmental			2	2							4
Care pathway	4										4
Care coordination	2										2
Staff attitude, conduct, professional practice						1					1
Physical healthcare (MH patients)	1										1
Grand Total	101	25	17	11	9	7	6	5	3	1	185

*one SI had two actions for sharing learning

It is important to understand that in undertaking an investigation of an incident, the Trust takes the view that all areas for learning or improvement should be identified and lead to a recommendation being made. These general arise for review of the care and treatment and arise from care and service delivery issues, and are actions to address the contributory factors, which are not considered to have been the direct root cause of the incident.

The majority of the recommendations from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator works closely working with the practice governance coaches and BDUs to produce a report on learning from recommendations where further information/breakdown about each BDU and the lessons learnt is presented. This is called 'Our learning journey from incidents'. This will be available separately.

Categorisation of actions

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

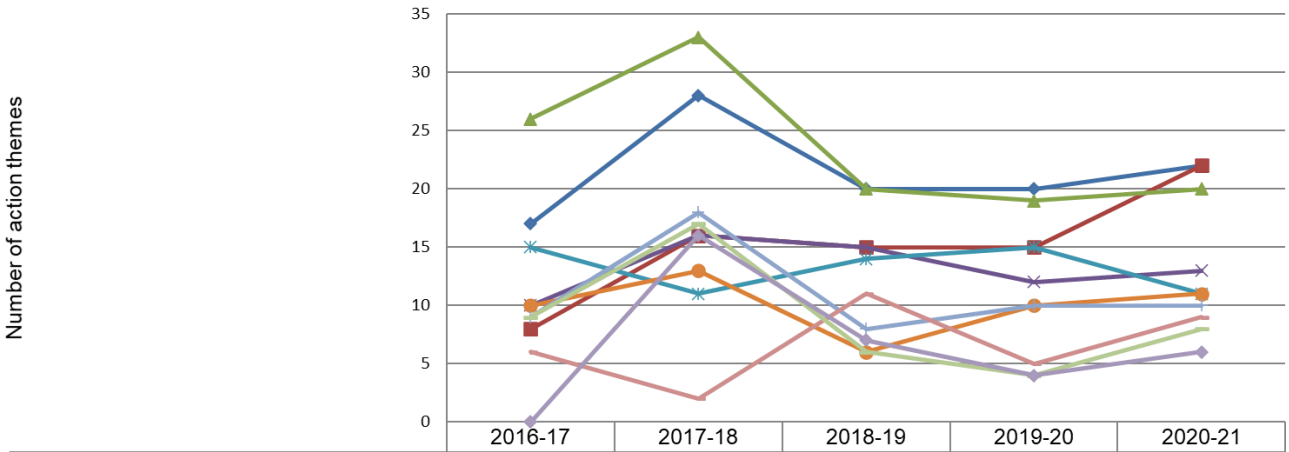
Figure 19 Ordinal list of action themes from 2020/21 compared with position in 2019/20

Top 6 Recommendation types	2020/21	2019/20
F1 Staff education, training and supervision	Joint #1	#1
A4 Risk assessment	Joint #1	joint #3
A5 Record keeping	#2	#2
F2.1 Policy and procedure - in place but not adhered to	#3	#5
B1 Communication	#4	joint #3
A2 Care delivery	#5	joint #6
F4 Team service systems, roles and management	#6	joint #6

The types of SIs completed in the year affects the action themes, for example, an Information governance serious incident, is more likely to have actions related to organisational systems, increasing that figure. Figure 19 illustrates the ranking of the most common themes this year in comparison to last year. The top 3 themes are the same as last year although the order has changed.

The top 10 action themes have also been reviewed over the last five financial years for comparison. As shown in Figure 19, staff education, training and supervision, risk assessment and record keeping have remained the three most common themes.

Figure 20 Top 10 action themes in the 5 years between 1/4/2016 and 31/3/21



	2016-17	2017-18	2018-19	2019-20	2020-21
F1 Staff education, training and supervision	17	28	20	20	22
A4 Risk assessment	8	16	15	15	22
A5 Record keeping	26	33	20	19	20
F2.1 Policy and procedure - in place but not adhered to	10	16	15	12	13
B1 Communication	15	11	14	15	11
A2 Care delivery	10	13	6	10	11
F4 Team service systems, roles and management	9	18	8	10	10
B3 Carers/family	6	2	11	5	9
G1 Organisational systems, management issues	9	17	6	4	8
F2.2 Policy and procedures, not in place	0	16	7	4	6

In 2020/21 the top three most common action themes were 'staff education, training and supervision', 'risk assessment' and 'record keeping'. These are consistent with the top 3 themes in previous years. Below is a summary of the recommendations identified within these themes; these have been grouped together (called subthemes). There is natural overlap between themes and subthemes. Data can be extracted from Datix by subtheme and drilled into.

Serious incidents are very individual and although the overarching themes are similar each year, the detail beneath varies. We have been developing ways of analysing individual themes in depth to provide thematic analysis that can be shared more widely, although this has not progressed as much as we would have hoped this year because of the pandemic. We are looking at how we can develop this idea further and use quality improvement methodology to work on thematic data. We use learning from investigations to influence practice and inform training. We have recently restructured our serious incident investigation reports to give greater focus to the family involve and affected by the incident. BDUs review serious incident reports and summaries in their BDU Governance groups, where they consider evidence to support completion of actions. These groups have continued to be strengthened during the year. Our approach to investigations will be reviewed to reflect the National changes to serious incident investigation that are expected during 2022.

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

Staff education, training and supervision has remained within the top 3 action themes in the last eight years. During 2020/21, there were 22 actions relating to staff education, training and supervision. Where possible these have been grouped by broad sub-theme:

Theme and Subtheme	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	Total
Risk assessment and management						4		4
Induction						1	2	3
Knowledge and Skill Gap		1	1				1	3
Supervision		2		1				3
Safeguarding				1		1		2
Suicide Prevention						1		1
Various Training (Violence and Aggression)	1							1
Access to Information		1						1
Tissue viability and associated practices	1							1
Support for staff							1	1
Various training				1				1
Communicating with other agencies							1	1
Total	2	4	1	3		7	5	22

Below is a summary of the actions identified:

Risk Assessment and Management

The ward should ensure that all professional ward staff undertake the Trust's training in the recently introduced Formulation Informed Risk Management process and that this is fully implemented in routine practice on the ward.

The team managers for the ward and for the community staff should ensure that all staff have signed up to the online e-learning developed to support the roll out of FIRM.
Feedback from teams on any difficulties encountered during this roll out to the organisational leads is recommended.

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 service must bring forward a strategy for increasing staff awareness of the risk of choking (on food) linked to mental disorder including both where this is self-harming behaviour, and where there is suicidal intent. This should include awareness of the requirement to report choking incidents, better definitions of 'seriousness' of choking incidents to assist reporting practice, and better use of data on choking to develop individual risk reduction strategies.

Knowledge and Skill Gap

Staff to be reminded of their responsibility for working in full accordance with the Non-Adherence with Treatment Policy.

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 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

Induction

Clarify whether Bank & Agency Staff are trained in BLS or ILS.

The induction of staff new to the ward should include what is expected of them whilst undertaking of observations and how to operate the lights in the seclusion room

Development of a robust and informative induction pack, which includes information about the Workplace Violence Risk Assessment, that can be discussed with bank and agency staff new to any ward environment in the Forensic BDU.

Supervision

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.

The existing processes of clinical supervision with South Yorkshire Liaison and Diversion Service needs to be reviewed to ensure that service users are not kept on the services caseload for longer than is necessary and that clinical documentation is completed in a timely manner in line with Trust policy.

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.

Safeguarding

With the support of the Trust safeguarding specialists the service should learn how to improve recognition and reporting of patient safety incidents involving abuse of patients by patients, and how to use report data to develop effective approaches to this aspect of patient safety.

Staff are reminded or made aware of how to access specialist Safeguarding advice within the Trust, access Safeguarding supervision if needed, make relevant Safeguarding referrals where needed and are able to access mandatory training and any individually identified refresher training.

Various Training (Violence and Aggression)

To contact the restrictive physical interventions team to create a training package aimed to the needs of the General Community Services inpatient units

Communication with other agencies

Develop a training pack to support staff when communicating with Police for assistance.

Various training

Assurance should be provided that the individual training needs of care coordinators, including those employed by the local authority, have been considered and addressed.

Support for staff

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.

Suicide Prevention

The ward should ensure that training and support are provided to ward staff as required in line with the Trust's Zero Suicide Ambition Statement (2019 – 2022).

Access to Information

For SWYPFT practitioners to have awareness of and access to accurate information, resources and guidance in relation to supporting individuals accessing homelessness services in relevant BDU's

Tissue viability and associated practices

Training sessions to be undertaken around tissue viability

2) *Risk Assessment issues (joint #1):*

Risk assessment issues have been in the top 6 in the last three years. There were 22 actions relating to risk assessment. These have been grouped by broad sub-theme:

Theme and Subtheme	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	Total
Record keeping and Documentation		1		4		1		6
Changes in risk	1		1	1		1		4
Inadequate exploration of risk				1		1		2
Monitoring compliance				2				2
Discharge Planning				1				1
Communication							1	1
Organisational systems				1				1
MDT Working and Meetings						1		1
Monitoring Compliance of the Clinical Record Keeping		1						1
Seek Specialist Advice						1		1
Safeguarding		1						1
Clinical Record Keeping - The System							1	1
Total	1	3	1	10		5	2	22

Below is a summary of the actions identified:

Record keeping and Documentation

The Trust should consider how to make the risk assessment and management documentation more user friendly.

Although the risk posed by S had been assessed and documented in the letter that was sent to his GP no Sainsbury's Risk assessments were completed by the Mental Health Liaison Team.

The Trust should consider ways in which the family's/carer's views on risk signature/early warning signs can be included into the risk document and shared with family members balancing service user views and data protection issues.

Services to provide assurances that a process is in place to monitor the quality of completed risk assessments to ensure they are completed in line with Trust policy.

Risk assessments should be completed by the staff members who have been present at the review where-ever possible to ensure that the clinical details captured accurately reflects the understanding of the patient's need. Where this is not possible staff must make all attempts to review the progress notes added by all professionals involved and reflect the collaborative understanding on clinical risk changes into the template on behalf of the wider team.

The acute mental health inpatient ward to provide assurance that risk assessments are updated to reflect new information received

Changes in risk

When consideration is given to rescinding a CTO, likely non-compliance/non engagement needs to be considered and the likely consequences of this in terms of risk, informed by previous risk/violence. When consideration is given to changing from depot to oral anti-psychotic medication, likely non-compliance/non engagement needs to be considered and the likely consequences of this in terms of risk, informed by previous risk/violence.

When a patient who is at risk of falling is provided with new footwear whilst they are on the unit, they should be examined by staff to ensure that they are suitable and do not create a risk of contributing to a fall.

Staff to be reminded that risk assessment should be reviewed and updated whenever there are changes in clinical risk as per the Clinical Risk Assessment, Management and Training Policy.

The level 2 risk assessments to be reviewed routinely within the ward rounds as part of due process and where required updated at the time of the meeting or at the nearest point after the meeting to avoid loss of key clinical reflections on care needs. This should include the need to consider the change in environment and the formulation on managing risk during leave and future discharge.

Monitoring compliance

There must be a clinical audit in the Enhanced Team 2 to review the current state of risk assessments.

The ward needs to provide assurance that at the points of discharge risk assessments are being conducted in line with Trust policy detailing the changes in risk.

Inadequate exploration of risk

Questioning of suicidal thinking of service users with suicide as an identified risk should routinely take place in ward rounds and exploration of risk, evidenced in the ward round template record.

Assurances to be provided that all staff who perform drug testing are aware of the detection windows for illicit substances that are being tested for in the drug tests.

Communication

Clear, Open and shared dialogue to promote positive risk taking around movement of Service users that pose specific individualised risk, as part of inclusive recovery focussed progression for Service Users.

Seek Specialist Advice

The service should ensure that the expertise of the dietician or the speech and language therapist is requested in a timely fashion to assist in developing detailed preventative plans for individuals and to provide advice on effective implementation of plans as soon as risks around food are identified.

Discharge Planning

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

Safeguarding

When practitioners in the Enhanced team have concerns relating to possible safeguarding issues these should: be documented; be discussed with line manager and/or multidisciplinary team; record the subsequent action plan and rationale.

Organisational systems

To implement the new FIRM risk assessment to improve safety in the following areas:
• Development of risk assessment practice
• Easy access to key indicators in the service user's history to support risk assessment practice
• Development of personalised safety planning to support at risk service users on the core pathway
• Extended service user options for keeping safe

MDT working and meetings

Risks as identified in risk assessments should be reviewed routinely within ward rounds and should include conversations on environmental changes that could increase risk.

Clinical Record Keeping - The System

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).

Monitoring Compliance of the Clinical Record Keeping

That a process is in place to monitor the quality of completed risk assessments to ensure they are completed and updated in line with Trust policy, with accessible additional training available for practitioners. For the service to provide assurance where required.

3) Record keeping (#3):

Record keeping has remained within the top 3 action themes in the last seven years. There were 20 actions relating to record keeping. Where possible these have been grouped by broad sub-theme:

Theme and Subtheme	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	Total
Risk assessment		2		1	1	2		6
Monitoring Compliance of the Clinical Record Keeping	1	1				1		3
Contemporaneous recording	1			1			1	3
MDT discussion / Recording			1		1			2
Care plan	1			1				2
CPA documentation							1	1
Family and Carer Details				1				1
Clinical decision making						1		1
Communication with other agencies				1				1
Total	3	3	1	5	2	4	2	20

Below is a summary of the actions identified:

Risk Assessment and Management

The service must ensure that high level risk assessment and mitigation is multi-disciplinary, brings in specialist advice where indicated, involves patients and families as fully as possible, and is fully recorded. It must ensure that circumstances where these mitigations are revised or relaxed are set out in a written plan with the agreement of the multi-disciplinary team.

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.

To ensure that practitioner's document within the clinical records that assessment of risk has been explored during contacts with service users, particularly where there is a risk of suicide.

Community teams should ensure that risk and comprehensive assessments are updated when a patient is transferred.

It is recommended that an SBAR be created for immediate alert across all the Trust care teams to warn of the risk of overwriting and loss of key clinical data following the failure to save final versions of risk assessments. All staff to ensure that each update of risk assessment documentation is saved as a final version to avoid overwriting and accidental loss of clinical details.

The psychiatric Liaison Team needs to provide assurance that risk assessments are being correctly documented in clinical notes using the Sainsbury's Risk Assessment tool.

Contemporaneous recording

For services to provide assurance that a process for monitoring the quality of clinical record keeping is in place which checks records are being completed in accordance to Trust requirements, and that all staff are reminded of Trust standards for record keeping.

The service needs to provide assurance that incidents are being documented on all platforms in line with Trust policy.

Positive use of timeline recording during the incident as it occurred. Added to the positive review of what on reflection was a well-executed and well-managed incident of serious proportions (to include all above analysis event issues)

Monitoring Compliance of the Clinical Record Keeping

Documentation audit of clinical records to be undertaken

The ward should ensure the quality of clinical records, in particular the FIRM risk management process and ward round templates, is to the required standard.

For the service to provide assurance that a process for monitoring the quality of clinical record keeping is in place which checks records are being completed in accordance to Trust requirements, and that all staff are reminded of Trust standards for record keeping.

MDT discussion / Recording

The multi-disciplinary team should ensure that the responsibility for specific actions arising from discharge meetings is clearly documented and communicated.

South West Yorkshire Partnership NHS Foundation Trust Intensive Home-Based Treatment Teams must ensure that when Multi-Disciplinary Team RAG rating of risks are regraded the individual clinical record should be updated.

Care planning

Review of care planning and documentation of patients on the caseload

Admission care planning should include the development of an engagement and observation care plan which should be updated to reflect any changes.

Clinical decision making

When a service user is placed into seclusion and it has not been possible to explain to them why there are being placed there and the process of being in seclusion works the reasons for this should be documented in their clinical notes.

CPA documentation

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.

Family and Carer Details

Reinforce with the Psychiatric Liaison Team the importance of updating demographic information including next of kin and carers.

Communication with other agencies

When a service user is admitted to a general hospital in response to them self-harming any contact with them by the Enhanced Team should be documented in the service user's clinical notes.

Completion of actions

Between 1 April 2020 and 31 March 2021 there were 185 actions, arising from 40 completed Serious incident investigations. Figures 21 and 22 shows the progression with completion of actions at the date of extraction from Datix (27/4/21):

- 129 actions had been completed (70%)
- 28 actions had not reached the due date at the time of preparing this report (15%)
- 28 actions had passed the due date (overdue) at the time of reporting (15%)

Figure 21 Serious Incident actions from SI investigations completed during 2020/21 by completion status and BDU (at 7/4/21)

BDU	completed within timescale	completed over the timescale	not yet due	not yet completed overdue original timescale	Total
Kirklees Community Mental Health Services	17	20	3	6	46
Mental Health Inpatient Services	14	12	14	0	40
Barnsley Community Mental Health Services	9	10	4	8	31
Forensic Service	8	9	0	12	29
Calderdale Community Mental Health Services	1	8	7	0	16
Barnsley General Community Services	9	3	0	1	13
Wakefield Community Mental Health Services	8	1	0	1	10
Total	**66**	**63**	**28**	**28**	**185**

Figure 22 Serious Incident actions that are overdue completion from SI investigations completed during 2020/21 by BDU and time period overdue (at 7/4/21)

BDU	Working days overdue					Total overdue
	1 - 30 working days	31 - 60 working days	61 - 90 working days	91 - 200 working days	201 - 300 working days	
Barnsley Community Mental Health Services	4	1	0	3	0	8
Barnsley General Community Services	0	0	0	1	0	1
Forensic Service	1	1	3	6	1	12
Kirklees Community Mental Health Services	5	1	0	0	0	6
Wakefield Community Mental Health Services	1	0	0	0	0	1
Grand Total	**11**	**3**	**3**	**10**	**1**	**28**

Section 4 Learning from healthcare deaths

Introduction

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

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

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

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

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

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

Scope

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

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

Learning from Healthcare Deaths reporting

During 2020/21, 4085 deaths (row one in Figure 23) were recorded on our clinical systems (figure correct at 5/5/21). This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems through Business Intelligence software. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number of cases, the Trust was not the main provider of care at the time of death.

Figure 23 Summary of 2020/21 Annual Death reporting by financial quarter*

	2019/20 Total	Quarter 1 2020/21	Quarter 2 2020/21	Quarter 3 2020/21	Quarter 4 2020/21	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	3394	1190	784	1174	937	4085
2) Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	355	132	76	115	102	411
3) Total Number of deaths which were in scope	286	93	71	85	86	335
4) Total Number of deaths reported on Datix that were not in the Trust's scope	51	25	5	30	16	76

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

Not all these deaths were reportable as incidents on Datix. Row 2 in Figure 23 shows that 411 deaths were reported on Datix in the year, with the quarterly breakdown. The yearly total is an increase on 2019/20 (355).

All deaths reported on Datix are reviewed by the patient safety support team to ensure they meet the scope criteria. For 2020/21, 335 deaths were in scope and subject to one of the 3 levels of scrutiny the Trust has adopted in line with the National Quality Board guidance (figure 24):

Figure 24 National Quality Board Levels of mortality scrutiny

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

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

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

Figure 25 shows the 335 in scope deaths reported by BDU.

Figure 25 In scope deaths reported by financial quarter and 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	CAMHS Specialist Services	Trust wide (Corporate support services)	Total
20/21 Q1	2	8	11	27	27	5	0	13	0	0	93
20/21 Q2	3	5	11	17	19	4	0	12	0	0	71
20/21 Q3	4	10	19	16	22	2	0	10	1	1	85
20/21 Q4	2	11	9	25	24	4	1	9	1	0	86
Total	11	34	50	85	92	15	1	44	2	1	335

The 335 in scope deaths were reviewed in line with the National Quality Board levels of scrutiny as outlined in Figure 25. Figure 26 shows the in-scope deaths by financial quarter they were reported in, against the review level and process.

Figure 26 Learning from Healthcare Deaths during 2020/21 by financial quarter and mortality review process

Financial quarter	Level 1	Level 2		Level 3					Total
	Death certified	Manager's 48-hour review	Structured Judgement Review (SJR)	Service Level Investigation /Significant Event Analysis	Serious Incident Investigation	Learning Disability Mortality Review (LeDeR)	Safeguard review	Specialist IPC Root Cause Analysis	
Quarter 1	43	19	7	6	4	14	0	0	93
Quarter 2	33	12	8	0	6	13	0	0	72*
Quarter 3	37	15	5	6	8	10	4	0	85
Quarter 4	39	23	6	2	4	11	0	2	87**
2020/21 total	152	69	26	14	22	48	4	2	337

*One LD death reported to LeDeR is also undergoing an internal SJR to consider any local learning.
** One LD Death reported to LeDeR is also a Serious Incident Investigation

Figure 27 shows the deaths by BDU and category.

Figure 27 Reported deaths by category and BDU reported during 2020/21

	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	CAMHS Specialist Services	Trust wide (Corporate support services)	Total
Death - confirmed from physical/natural causes	7	13	31	41	66	8	0	20	0	0	186
Death - cause of death unknown/ unexplained/ awaiting confirmation	3	11	10	24	12	3	1	14	1	1	80
Death - confirmed from infection	0	1	2	8	7	0	0	10	0	0	28
Suicide (apparent) - community team care - current episode	1	10	2	8	5	0	0	0	0	0	26
Suicide (apparent) - community team care - discharged	0	0	4	3	2	0	0	0	1	0	10
Suicide (apparent) - inpatient care - current episode	0	0	0	0	0	2	0	0	0	0	2
Slip, trip or fall - patient	0	0	0	0	0	1	0	0	0	0	1
Death - confirmed related to substance misuse (drug and/or alcohol)	0	0	1	0	0	0	0	0	0	0	1
Death of service user by homicide (alleged or actual)	0	0	0	1	0	0	0	0	0	0	1
Total	**11**	**35**	**50**	**85**	**92**	**14**	**1**	**44**	**2**	**1**	**335**

Deaths reported as SIs

Of the 335 in scope deaths reported on Datix between 1 April 2020 and 31 March 2021, 22 were reported as serious incidents.

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

Apparent suicides

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

Learning from Deaths findings

A Learning from deaths report is prepared quarterly and included in the Quarterly Incident reports. Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Further work is being undertaken to analyse the data. This will be available separately.

Section 5 - Key Actions and Areas for Development in 2021/22

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

Plans for 2021/22 include:

- Review of the Being Open policy to reflect CQC updated guidance on Duty of Candour
- Planning for implementation of the new national Patient Safety Incident Management System (PSIMS) which will replace NRLS and StEIS systems. Timescales will be given by NHS Improvement.
- Planning for implementation of the new national Patient Safety Incident Response framework (PSIRF) which will replace the serious incident framework. Timescales will be given by NHS Improvement.
- Continue to strengthen governance arrangements between Patient Safety Support Team and BDUs.
- Focus on strengthening learning from thematic review using quality improvement methodology
- Transition of Datix risk management system to being hosted by RLDatix Ltd.
- Further development and improvement work around Datix, eg user experience of Datix incident reporting and data quality.

Patient Safety Support Team
18 May 2021

Appendix 1 Demographic data for patients affected in all incidents reported between 1 April 2020 and 31 March 2021

In line with the Equality Impact Assessments in the incident reporting and management policy and investigating and analysing incidents policy, we have provided data for all incidents and serious incidents occurring during 2020/21. This is to aid discussion in Business Delivery units to give insight into improvement opportunities. Further detail is available from patient safety support team or on Datix at local level.

Data relating to a limited number of protected characteristics for individuals involved in incidents (age, gender, ethnicity) is available on Datix for reported incidents. It should be noted that each person linked to an incident will have some level of demographic data recorded, but for the purposes of this report, we have focussed on the person affected. NHS England and Improvement are developing a new Patient Safety Incident Management System (PSIMS) that will bring together patient safety incident reporting. The development of this system will hopefully strengthen data collection in a standardised format across the NHS. The collection of equality data cannot be mandated locally on Datix because information on any protected characteristics of the patients or staff involved in an incident may not be immediately available to the reporter (as identified by NHSE). Making its collection mandatory could act as a barrier to reporting and lead to fewer incidents being reported. As with the national position, we consider it is more important to collect incomplete information about risks to patients and staff than to potentially block reporting of that information by mandating the inclusion of information that reporters may not have or record inaccurately.

It is hoped that information collection on protected characteristics will be improved at the review/investigation stage of adverse events rather than incident reporting stage. As such, we have provided data related to serious incident investigations below. The new PSIMS system as a whole will improve safety for all patients and further developments in data linkage and collection should make it possible to identify any patient safety concerns that may disproportionately impact on groups with protected characteristics.

Staff are reminded through the above policies to ensure that the equality data fields on the incident report form are completed and when managers are checking for matching contacts in the database that this information is updated to that held in staff and clinical records.

For the purposes of analysing data that we do hold on Datix (age band, gender, ethnicity), we have provided data to breakdown the 12717 incidents reported during 2020/21 by the person/s affected by the incident - this has been separated into incidents affecting staff and those affecting patients. This accounts for 14389 affected contacts (please note this is not the number of unique individuals involved, i.e. one person may be linked to multiple incidents).

Person affected – patient

Figure 28 All incidents 2020/21 where person affected was a patient; by gender and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	age not recorded	Grand Total
Male	367	469	453	314	365	307	420	1759	4454
Female	528	791	342	264	226	240	551	1357	4299
not applicable	7	1	8	4	9	0	3	137	169
Transgender	56	2	2	0	0	0		55	115
Not stated unknown	3	0	2	0	0	1	1	34	41
Form not returned/left blank	0	0	0	0	0	0	0	4	4
not recorded	0	0	0	0	0	0	0	4	4
Grand Total	961	1263	807	582	600	548	975	3350	9086

Figure 29 All incidents 2020/21 where person affected was a patient; by ethnicity and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Not recorded	Grand Total
White - British	645	893	593	385	408	451	683	2087	6145
Not stated	154	146	85	112	125	81	268	661	1632
Pakistani	18	73	46	18	13	2	1	223	394
Unknown	19	13	16	6	13	6	16	67	156
White - other white	14	12	8	16	4	1	2	82	139
Black African	27	9	22	6		0	0	65	129
Black Caribbean	7	19	10	21	24	0	0	25	106
Other Asian	11	31	6	6	2	1	0	45	102
Other ethnic category	8	9	3	2	2	0	0	19	43
Mixed white and black Caribbean	10	6	0	0	0	0	1	17	34
White - Irish	0	2	10	3	6	1	3	9	34
Mixed white and Asian	5	21	0	0	0	0	0	5	31
not recorded	8	4	1	1	2	1	0	9	26
Other mixed	17	3	0	0	0	0	0	6	26
Other Black	1	7	3	0	0	2	0	8	21
Indian	6	0	4	2	0	0	1	3	16
Mixed white and black African	2	0	0	0	1	1	0	11	15
Prefers not to say	6	5	0		0	0	0	3	14
Bangladeshi	0	9	0	0	0	0	0	2	11
Chinese	1	0	0	4	0	0	0	1	6
Form not completed/form left blank (Customer Services only)	2	1	0	0	0	1	0	2	6
Grand Total	961	1263	807	582	600	548	975	3350	9086

Figure 30 All incidents 2020/21 where person affected was a patient; by ethnicity and gender

	Female	not recorded	Male	not applicable	Not stated	Trans gender	Grand Total
White - British	3065	0	2984	32	0	64	6145
Not stated	823	3	710	7	38	51	1632
Pakistani	78	1	205	110	0	0	394
Unknown	54	0	98	1	3	0	156
White - other white	85	0	53	1	0	0	139
Black African	38	0	76	15	0	0	129
Black Caribbean	39	0	67	0	0	0	106
Other Asian	18	0	84	0	0	0	102
Other ethnic category	16	0	27	0	0	0	43
Mixed white and black Caribbean	18	0	16	0	0	0	34
White - Irish	5	0	29	0	0	0	34
Mixed white and Asian	6	0	25	0	0	0	31
Other mixed	4	0	22	0	0	0	26
not recorded	9	5	13	0	0	0	26
Other Black	9	0	9	3	0	0	21
Indian	8	0	8	0	0	0	16
Mixed white and black African	2	0	13	0	0	0	15
Prefers not to say	9	0	5	0	0	0	14
Bangladeshi	2	0	9	0	0	0	11
Chinese	6	0		0	0	0	6
Form not completed	5	0	1	0	0	0	6
Grand Total	4299	8	4454	169	41	115	9086

Figure 31 All incidents 2020/21 where person affected was a patient; by BDU and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	age not recorded	Grand Total
Mental Health Inpatient Services	546	887	377	268	231	234	143	1972	4658
Forensic Service	99	221	270	127	97	40	2	660	1516
Barnsley General Community Services	50	30	33	81	89	160	616	362	1421
Learning Disability services	93	24	21	10	82	13	9	142	394
Wakefield Community Mental Health Services	22	15	18	18	21	40	101	44	279
Kirklees Community Mental Health Services	20	32	44	32	42	28	38	42	278
Calderdale Community Mental Health Services	21	24	15	17	15	23	52	30	197
Barnsley Community Mental Health Services	14	24	22	26	18	8	11	46	169
CAMHS Specialist Services	95	0	0	0	0	0	0	41	136
Trust wide (Corporate support services)	1	2	6	2	5	2	3	9	30
ADHD and Autism services	0	4	1	1	0	0	0	2	8
Grand Total	961	1263	807	582	600	548	975	3350	9086

Person affected – staff (includes SWYPFT employees, Local authority staff, bank and agency staff)

Figure 32 All incidents 2020/21 where person affected was a staff member; by gender and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	not applicable	age not recorded	Grand Total
Female	67	131	117	162	133	6	5	0	2054	2675
Male	20	47	60	79	26	5	3	0	858	1098
not applicable	1	1	3	3	1	0	0	375	525	909
not recorded	0	0	0	0	0	0	0	0	360	360
Not stated unknown	0	0	1	0	0	0	0	0	25	26
Form not returned/left blank	0	0	0	0	0	0	0	0	3	3
Grand Total	88	179	181	244	160	11	8	375	3825	5071

Figure 33 All incidents 2020/21 where person affected was a staff member; by ethnicity and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	not applicable	Not recorded	Grand Total
White - British	54	130	121	146	116	5	6	0	1766	2344
Not stated	23	27	25	48	25	6	1	0	740	895
not applicable	0	0	0	0	0	0	0	375	391	766
not recorded	1	2	2	4	5	0	0	0	426	440
Black African	2	1	17	3	0	0	0	0	264	287
Unknown	0	9	4	12	2	0	0	0	69	96
Pakistani	6	5	3	7	3	0	0	0	44	68
Black Caribbean	1	0	1	1	4	0	0	0	20	27
Indian	0	0	3	1	0	0	1	0	21	26
White - other white	1	1	1	7	0	0	0	0	16	26
White - Irish	0	0	0	7	3	0	0	0	9	19
Other ethnic category	0	0	1	3	1	0	0	0	12	17
Prefers not to say	0	0	0	3	0	0	0	0	12	15
Other Black	0	0	0	0	0	0	0	0	13	13
Other Asian	0	1	0	0	0	0	0	0	11	12
Other mixed	0	0	1	0	0	0	0	0	6	7
Mixed white and black Caribbean	0	1	2	0	1	0	0	0	1	5
Mixed white and Asian	0	2	0	1	0	0	0	0	1	4
Bangladeshi	0	0	0	0	0	0	0	0	2	2
Chinese	0	0	0	1	0	0	0	0	1	2
Grand Total	88	179	181	244	160	11	8	375	3825	5071

Figure 34 All incidents 2020/21 where person affected was a staff member; by ethnicity and gender

	Female	Male	not applicable	not recorded	Not stated unknown	Grand Total
White - British	1739	565	40	0	0	2344
Not stated	591	242	39	3	20	895
not applicable	0	0	766	0	0	766
not recorded	19	5	56	360	0	440
Black African	114	167	6	0	0	287
Unknown	58	31	1	0	6	96
Pakistani	55	13	0	0	0	68
Black Caribbean	16	11	0	0	0	27
Indian	5	21	0	0	0	26
White - other white	20	6	0	0	0	26
White - Irish	18	1	0	0	0	19
Other ethnic category	11	5	1	0	0	17
Prefers not to say	5	10	0	0	0	15
Other Black	1	12	0	0	0	13
Other Asian	9	3	0	0	0	12
Other mixed	7	0	0	0	0	7
Mixed white and black Caribbean	3	2	0	0	0	5
Mixed white and Asian	4	0	0	0	0	4
Bangladeshi	0	2	0	0	0	2
Chinese	0	2	0	0	0	2
Grand Total	2675	1098	909	363	26	5071

Figure 35 All incidents 2020/21 where person affected was a staff member; by BDU and age band

	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	not applicable	age not recorded	Grand Total
Mental Health Inpatient Services	41	65	52	79	60	3	1	164	1619	2084
Forensic Service	25	59	51	64	24	0	0	152	1336	1711
Learning Disability services	9	11	19	22	11	0	0	8	549	629
Barnsley General Community Services	6	12	16	16	25	4	4	12	86	181
Wakefield Community Mental Health Services	0	4	6	12	8	0	2	13	47	92
Trust wide (Corporate support services)	0	1	8	10	13	4	0	9	46	91
Barnsley Community Mental Health Services	2	5	9	13	10	0	1	6	34	80
Kirklees Community Mental Health Services	2	12	9	12	2	0	0	3	35	75
CAMHS Specialist Services	3	8	5	9	3	0	0	3	39	70
Calderdale Community Mental Health Services	0	2	6	7	4	0	0	2	30	51
ADHD and Autism services	0	0	0	0	0	0	0	3	4	7
Grand Total	88	179	181	244	160	11	8	375	3825	5071

Serious Incidents

The tables below give a breakdown of the person affected involved in serious incidents. To note that this data does not include one serious incident which involved two members of staff.

Figure 36 Demographic data for patients affected in serious incidents reported between 1/4/2020 and 31/3/2021, by BDU, team and age band (as recorded on Datix)

BDU and Team	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Total
Barnsley Community Mental Health Services			**1**	**1**	**1**			**3**
Enhanced Team West - Kendray, Barnsley				1				1
Intensive Home-Based Treatment Team (IHBTT) - Barnsley			1		1			2
Barnsley General Community Services					**1**		**2**	**3**
Neighbourhood Team - North East (Barnsley)					1		2	3
Calderdale Community Mental Health Services	**1**	**1**	**1**					**3**
Assessment and Intensive Home Based Treatment Team / Crisis Team - Calderdale	1	1						2
Enhanced Lower Valley Team - Calderdale			1					1
CAMHS Specialist Services	**1**							**1**
CAMHS (Barnsley)	1							1
Forensic Service		**2**						**2**
Newhaven Forensic Learning Disabilities Unit		1						1
Thornhill Ward (The Bretton Centre)		1						1
Kirklees Community Mental Health Services	**2**	**2**	**3**	**1**	**3**			**11**
Core Team North - Kirklees					1			1
Core Team South - Kirklees	1							1
Early Intervention Service (Insight) - Kirklees	1	1	1		1			4
Enhanced Team North 1 - Kirklees		1	2					3
Enhanced Team North 2 - Kirklees					1			1
Enhanced Team South 1 - Kirklees				1				1
Mental Health Inpatient Services	**1**		**3**	**1**	**1**	**1**		**7**
Ashdale Ward (based at The Dales, Kirklees BDU)				1				1
Beamshaw Ward - Barnsley					1			1
Clark Ward - Barnsley	1							1
Crofton Ward (OPS), Wakefield						1		1
Melton PICU, Barnsley			1					1
Stanley Ward, Wakefield			1					1
Ward 18, Priestley Unit			1					1
Wakefield Community Mental Health Services	**1**				**1**		**1**	**3**
Intensive Home-Based Treatment Team - Wakefield (OPS)							1	1
Intensive Home Based Treatment Team (IHBTT) - Wakefield					1			1
Psychiatric Liaison Service, Wakefield	1							1
Grand Total	6	5	8	3	7	1	3	33

Figure 37 Demographic data for patients affected in serious incidents reported between 1/4/2020 and 31/3/2021, by BDU, gender and age band (as recorded on Datix)

BDU and gender	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Total
Barnsley Community Mental Health Services			**1**	**1**	**1**			**3**
Female				1	1			2
Male			1					1
Barnsley General Community Services					**1**		**2**	**3**
Female							1	1
Male					1		1	2
Calderdale Community Mental Health Services	**1**	**1**	**1**					**3**
Male	1	1	1					3
CAMHS Specialist Services	**1**							1
Female	1							1
Forensic Service		**2**						**2**
Male		2						2
Kirklees Community Mental Health Services	**2**	**2**	**3**	**1**	**3**			**11**
Female	1	1	2	1				5
Male	1	1	1		3			6
Mental Health Inpatient Services	**1**		**3**	**1**	**1**	**1**		**7**
Female	1		2					3
Male			1	1	1	1		4
Wakefield Community Mental Health Services	**1**				**1**		**1**	**3**
Female							1	1
Male	1				1			2
Grand Total	6	5	8	3	7	1	3	33

Figure 38 Demographic data for patients affected in serious incidents reported between 1/4/2020 and 31/3/2021, by BDU, ethnicity and age band (as recorded on Datix)

BDU and ethnicity	Under 25	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75 years and over	Total
Barnsley Community Mental Health Services			**1**	**1**	**1**			**3**
White - British			1	1	1			3
Barnsley General Community Services					**1**		**2**	**3**
Not stated					1		1	2
White - British							1	1
Calderdale Community Mental Health Services	**1**	**1**	**1**					**3**
White - British		1	1					2
White - other white	1							1
CAMHS Specialist Services	**1**							**1**
British/mixed British	1							1

Forensic Service		**2**						**2**
Mixed white and black Caribbean		1						1
White - British		1						1
Kirklees Community Mental Health Services	**2**	**2**	**3**	**1**	**3**			**11**
Bangladeshi		1						1
Black Carribean	1							1
Indian			1					1
Mixed white and black African		1						1
Not stated	1			1	1			3
White - British			2		1			3
British/mixed British					1			1
Mental Health Inpatient Services	**1**		**3**	**1**	**1**	**1**		**7**
Other Black			1					1
White - British			2	1	1	1		5
White - other white	1							1
Wakefield Community Mental Health Services	**1**				**1**		**1**	**3**
White - British	1						1	2
British/mixed British					1			1
Grand Total	6	5	8	3	7	1	3	33

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 11.3

Title:	**Annual Safety Services Report 2020/21**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The purpose of the paper is to provide assurance to the Trust Board that robust arrangements are in place around health and safety, security and emergency planning and to provide an overview of arrangements that take place within the Trust.
Mission/values:	The report demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	The Clinical Governance and Clinical Safety Committee have received regular reports from the Safety Trust Action Group (TAG) who meet quarterly to provide oversight to the workings of the safety services teams and their activity.
Executive summary:	The Health and Safety management arrangements across the Trust has contributed greatly to ensuring staff remain safe during the pandemic. The inspections to make spaces Covid secure were undertaken very quickly and since then have been revisited a number of times as legislation and working requirements are altered. These inspections have been done in close cooperation with IPC colleagues to ensure the approach is joined up. The EPRR (emergency planning resilience and response) team have been at the forefront of the Trusts response to the pandemic. They have advised at various command levels and managed the majority of the information flow to and from official Covid accounts as well as undertaking monitoring of information on a seven day a week basis. The annual health and safety monitoring has shown that during the year not only has the Trust maintained its high standards of compliance, it has continued to improve: • The operational health and safety management across the Trust has continued to improve from analysis of the annual health and safety monitoring tool. A programme of audits has been established to ensure continued improvement is maintained. • The learning from the management of the pandemic will be used to improve EPRR and BDU business continuity plans. • The installation of a fire suppression system in the wards continued with installations commencing in the forensic services wards. • The Brexit planning group continued to meet throughout the year.

With **all of us** in mind.

	• The annual plan was delivered in addition to the support given to the management of the Covid pandemic. • The annual flu campaign was successfully delivered, this was particularly important this year as the timing of flu and Covid vaccinations were interdependent. • The consultation on the lone worker device replacement programme was completed to allow a contract to be put in place in financial year 21/22. **Risk Appetite** The safety and emergency planning arrangements are within and consistent with the Trust's risk appetite.
Recommendation:	**The Trust Board is asked to APPROVE the Annual Safety Services Report 2020/21.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Safety Services

Annual Report 2020/21

April 2021 Nick Phillips, Head of Estates & Facilities

Produced in conjunction with Specialist Safety Service Advisers

Contents

Appendices

1. Executive Summary

This report has been produced to provide an overview of the activity within safety and security services in 2020/21 and to provide assurance to the Board on activity in 2020/21. Overall safety and security management has been in line with annual plans with the notable addition of leading on the operational response to Covid-19 which is ongoing. Overall, the following points are of particular note:

- For the fourth year running operational health & safety management across the Trust has improved, this has been shown following analysis of the annual health & safety monitoring tool. A programme of audits has been established to ensure continued improvement is maintained.
- Partnership working continues to be well established with third party Trusts, Local Authorities, the Health & Safety Executive (HSE), CCG's, Police forces and Fire & Rescue Services.
- The successful delivery of the Flu Campaign which has seen the Trust obtain full Flu CQUIN delivery for the fourth year running.
- The 2021/2022 action plans build on the previous years and are designed to:
- Continue to embed a robust risk-based monitoring and audit programme across all areas.
- Review and implement all policies and procedures for safety and resilience, whilst ensuring these continue to be fit for purpose.
- Review all risk assessments following changes in use of buildings and departmental relocations.
- Strengthen further EPRR links and business continuity plans by way of table-top exercises, audits and inspections.

2. Introduction

This report is designed to provide an overview of the key achievements from all respective areas of health & safety, security, fire safety and emergency preparedness, during 2020/2021, and any areas of development within 2021/2022. Areas of development will be provided by way of action plans and added as appendices to this document.

The report will provide the Executive Management Team (EMT) with an up to date summary on Trust activities during the previous financial year and also proposed work streams for 2021/2022.

All teams have worked throughout the year to achieve both internal and external targets and legislation. For instance, Fire Safety Legislation, Mandatory Training targets and Care Quality Commission (CQC) standards; to name a few. Details of such achievements will be referenced throughout the report.

The team works consistently towards implementing national safety legislation into policy, procedure and practice, including the Health & Safety at Work etc. Act 1974 and the Management of Health & Safety at Work Regulations 1999.

3. Health & Safety

2020/21 proved to be a momentous and ultimately a successful year for the Health & Safety Team. The annual action plan provided a solid platform for the prioritisation of work from Q1 onwards, that was dominated by the global Covid-19 pandemic

Despite the pandemic, the Health & Safety Team ensured that traditional, existing risk issues were still addressed. This was accomplished by:

- Continued partnership working with third parties, i.e. Other regional NHS Trusts, Local Authorities, HSE etc.
- Following and adhering to the 2020/2021 Health & Safety Action Plan.
- Services being supported with their ongoing priorities, i.e. Ligature Audits.

The emphasis was broad based, including policy development, incident management and onsite inspections

Achievements

<u>Covid-19</u>

- The Health & Safety Team supported Trust wide services to complete Covid-19 premises assessments, along with providing advice to managers and staff thrust at short notice into safe home working conditions.
- Covid-19 premises assessments were set at three monthly reviews to ensure these could be updated regularly as learning and government guidance evolved throughout the year.
- The Safety & Resilience TAG reverted to MS Teams meetings with attendance from delegates remaining strong and enjoying continued active, constructive participation from all members of the TAG.

Working Normally

- A business as far as reasonably practicable approach was pursued in 2020/2021 with regular contact with other NHS Trusts maintained across the Region to ensure a consistency with provision of advice to Trust services.
- Following on from the excellent Health and Safety Executive inspection team visit in 20/21, the Trust continued to work closely with the HSE.
- The Health & Safety Team also supported Trust wide Ligature Audits, covering in-patient areas and community settings.
- Within Estates & Facilities, Specialist Hand, Arm Vibration and Noise Assessments for Staff were undertaken in accordance with Health & Safety Executive legislative requirements.
- The Trust Lone Worker Device contract and working arrangements were thoroughly reviewed with managers and staff throughout the year to ensure suitable blended options were available, with contemporary technology where this is required.

Annual Health and Safety Monitoring

- The annual audit of health and safety provisions, of all Trust premises and teams was undertaken in Q3 to assess safety provisions across the Trust including areas such as the completion and implementation of risk assessments, training and reporting of accidents/incidents.
- A targeted, direct email approach to identified managers during the 2020/21 audit provided a response of 268 returns. Some managers provided a combined survey for several of their teams, ensuring coverage of all services.
- The 2020/21 audit tool was reviewed and revised as appropriate by the project team this included an additional section about Covid-19. The tool was designed in Survey Monkey, a web-based survey programme. The link to the survey was circulated via a targeted email. Regular updates were placed in the weekly bulletin and on the intranet pages.
- All Business Delivery Units achieved between 82% and 100% compliance, with a Trust wide compliance of 90% a further improvement from 2019 and building on an already strong performance in 2018.
- Performance was measured by the Trust standard measure of percentage compliance scores as described below. Each standard has been assessed against the compliance levels described below:

	91% - 100% compliance achieved (fully compliant)
	81% - 90% compliance achieved (partially compliant requires some improvement)
	Less than 81% compliance achieved (requires further work to achieve significant improvement)

- Teams are expected to address gaps through means of local action plans that can be inspected during audits and inspections.
- A total of 168 responses were received in 2020/21 compared to 164 in 2019/20, these were split as follows:

BDU	n=268	%
Wakefield	33	12%
Calderdale	19	7%
Kirklees	29	11%
Forensics	14	5%
Barnsley Mental Health	16	6%
Barnsley General Ops	74	28%
Specialist Services	23	9%
Corporate/Support Services	60	22%

- The audit results were received and analysed by key specialist advisers with any gaps in assurances being addressed accordingly. Audit results are also shared with the Safety & Resilience TAG.
- Surveys were answered openly and honestly by services resulting in inevitable minor gaps in health & safety provision as services evolve. These are all being addressed by pro-active support and communication between the health & safety team and services concerned to aim for full compliance.

Future Planning

The following areas have been highlighted as priority for the financial year 2021/2022, many of which are listed in the Health & Safety Action Plan at Appendix 2:

- Update of the Trust Health & Safety Training offer. The Health & Safety Team are aware that with the low uptake of face to face Health & Safety Training additional training platforms could ease friction contributing to limited attendance. This work stream will include revised H&S/COSHH workbooks and an exploration of e-learning options, especially with the impact of Covid.
- Awarding of the new Trust Lone Worker Device contract in order that Lone Working devices on offer can be refined further with contemporary technology. This coincides with development of bespoke usage estimations from individual services/teams, following on from Trust wide work in 2020/2021 covering Lone Working procedures & risk assessments.
- Undertake audits and inspections, based on the outcomes of the 2020/2021 annual monitoring tool, providing support to teams where required.
- Update Health & Safety Intranet pages, ensuring policies & guidance along with all H&S Information are current with correct contact details. This will ensure Trust staff have continued reliable and pertinent access to accurate Health & Safety Information as the roll out of new services evolve and working practices modernise.

4. **Fire Safety**

The Annual Certificate of Fire Safety Compliance has been submitted to EMT for approval. The certificate confirmed that no fire safety enforcement action was taken against the Trust by the Fire Authority, and that fire safety risk assessments have been reviewed and remedial action taken where necessary.

Achievements

Increased fire safety resilience by installing water mist in Newton Lodge wards, including enabling works to extend the system in future years

A reduction in false alarms and unwanted fire signals that required partial evacuation of buildings or fire service attendance to our sites

2020/21 totals

False alarms no fire service attendance West 46 South 51 Total 97

Unwanted fire signals fire service attendance West 4 South 1 Total 5

No reportable fires causing damage to buildings and requiring fire service intervention

Minor Fires No damage to buildings of fire service intervention 5

Date	Datix	Premises	Use of Building	Details
3 July 2020	119899	Enfield Down	In patient unit (grounds)	Accidental ignition of waste skip
25 Aug 2020	120635	Ashdale Ward	Secure garden	Deliberate ignition of clothing
26 Sep 2020	121771	Elmdale Ward	Bedroom en-suite	Deliberate ignition of shower curtain and paper
22 Mar 2021	128087	Stanley Ward	External courtyard	Deliberate ignition of waste bin
23 Mar 2021	128079	Enfield Down	Grounds	Accidental ignition of waste bin

Maintaining fire safety management in Trust sites with no reportable fires causing damage to the estate or requiring fire service intervention.

Achieving a significant reduction in smoking incidents in bedrooms (monthly average reduced from 31 to 12 incidents) , reducing fire risks and minor damage to decorations or room contents. Reduction is due to relaxation of the smoke free policy so service users can smoke in safe external areas during Covid-19.

Good level of consultation with Estates and Capital Planning to ensure fire safety precautions are considered in all building projects, and that fire safety is considered in the annual capitals plan.

Fire Training

47 Instructor lead (including TEAMS sessions) for essential fire training were delivered with 354 attendees

2388 staff completed fire safety training via e-learning

Trust-wide attendance 85.85% (against a target of 80%)

Identified Significant Risk 2021-2022

Although we have achieved 86.9% fire training, it has only been possible to offer fire safety e-learning because of Covid -19 restrictions.

Reduction in staffing levels throughout the year following resignation of a fire safety adviser and delays in recruitment of a suitable replacement

Restriction in access to ward and other healthcare areas to undertake fire risk assessment reviews because of Covid-19

Reduction in the number of fire evacuation drills on Trust sites because of Covid-19 restrictions in patient care areas ,and that many offices are currently unoccupied

Training needs (face to face or practical training) where staff have not been able to access fire training specific to their own workplace or job role during Covid-19

Risk of increased smoking related incidents and fire risks on wards through covert smoking if the controlled and supervised external smoking facilities are withdrawn post Covid

We are not expecting any significant change in fire safety legislation in healthcare premises. However following Covid-19 restrictions, we should expect an increased number of enforcement inspections from the Fire and Rescue Service to our premises

Future Planning

- Fire Safety Objectives 2021-22

Continue to provide sufficient fire training opportunities in order to meet Trust requirements for a minimum attendance of 80% (95% for ward-based staff). This will require a future increase provision of class-based sessions as to maintain services during the COVID 19 crisis, only e-learning fire training is available. The Fire and Training policies do not accept e-learning on consecutive years or any time for ward-based staff.

Promote and provide practical fire training in the fire training unit at Fieldhead (subject to COVID 19 restrictions and staff availability).

Initiate a programme of fire evacuations drill in ward and office areas in order to comply with the requirements of the Fire Safety Order and Firecode.

With the support of the Capital Planning team, continue the programme to extend the provision of water mist fire suppression systems to additional in-patient areas.

5. Security

The security team has had a challenging year, however robust planning has enabled us to deliver targets throughout the year and provide support to staff and patients across the Trust.

Achievements

- Continued relationship with the external security contractor Active Response Security Ltd who provides key holding, alarm response and patrol services to numerous properties across the Trust geographical footprint. Ongoing monitoring of Key Performance Indicators and monthly reviews indicate a successful partnership, and continuous meeting of targets.
- Supporting the Capital team with the management and securing of unoccupied
- buildings and premises. We are continuously involved in the day to day management of the Keresforth site while it is still part occupied.
- Security assessments throughout the Trust continue to identify issues. These are then discussed at capital meets and monies allocated as required.
- Completed and supported capital schemes for improvements at various receptions across the trust, improved and upgraded CCTV systems at Kendray Hospital, New Street, Grange Lane, Horizon Centre and Newton Lodge. This continues to be an evolving part of security tasking. Capital project planned for upgrade to CCTV at Fieldhead and Kendray next year to allow for remote monitoring and better coverage.
- Focused on improving Police liaison relationships and the team have secured a named contact in each of the BDU's that will act as a partnership liaison at high level within the police. This is underpinned by the Assault on Emergency Workers Act.
- Continuing with Crime Reduction Surveys across the organisation as per rolling program and reported to Estates TAG.

Lessons Learned

- A number of Trust premises have either been sold or vacated. This has placed an added burden on security services due to long term conveyancing process. The team recognised that by having a better exit strategy some of this burden can be alleviated.
- Continue to effectively monitor in-house security staff and external providers to ensure best fit.

Future Planning for 2021/22

- Implementation and review of lockdown processes and procedures across various locations of the Trust; strengthening of relationships with departments is key to achieve this.
- Strengthen police liaison relationships.
- Focus resources to support Trust staff involved in violence and aggression incidents and also a review on how incidents are reported to the police and followed up in line with Secretary of State Directions 2018 "Assaults on Emergency Workers (Offences) Act 2018".
- The review and support of AWOL's from Trust locations.
- Ongoing support to community premises to address safety concerns when self-presenters attend sites and continued support for Lockdown procedures.
- Retender and renew the external security provider provision and review the role of in-house security provision.
- Work with all invested parties to ensure the recently published Violence Reduction Standards are met.

6. Emergency Preparedness

Achievements

- EU Exit Working Group continues to meet and provide support to the Trust to maintain critical services and monitor potential impacts through regional and national workstreams.
- A full record of Business Continuity Plans across the Trust now established to enable a system to be established and implemented for the appropriate review of plans, testing of plans and reporting of lessons learned.
- Recruitment of EPRR Assistant to support the Emergency Planning Adviser in the delivery of Emergency Planning and Business Continuity agenda across the Trust.
- Strengthened partnership working across all Local Authority areas, building relationships with partner health agencies, the Police and the Fire Service.
- Creation of a Trust-wide Business Continuity Plan due to be embedded during 2021.
- Successful delivery of the annual staff Influenza Vaccination campaign, with the Trust's highest ever recorded uptake at 89.4%; achieved within 3 months.

Potential Risks

- Inability to progress against outstanding EPRR standards and maintain compliance against EPRR standards during COVID-19 due to pressure on resources and response to incident post October 2020.
- Reduction in assurance against NHSE Core Standards for EPRR.
- Workloads due to COVID-19 response.

Future Planning for 2021/22

- Potential continued impacts from COVID-19 and EU Exit, however the expansion of the EPRR Team will help reduce impacts.
- Conduct a Training Needs Analysis for all levels of the Trust to identify a training programme for implementation for all areas of Business Continuity Planning and Emergency Preparedness.
- Following the COVID-19 Pandemic, conduct a review of all policies, procedures and Business Continuity plans to ensure lessons learned have been identified and embedded in planning arrangements.
- Review all workstreams to identify leaner ways of working and review the departmental level Business Continuity Plan to make more user friendly.
- Prepare for the release of the Core Standards, reviewing progress and updating against current standards, and sourcing information for the new Deep Dive standards along with a rumoured new core standard relating to implementing lessons learned during an incident.

7. Conclusion

2020/2021 has been a productive and challenging year across the Safety Service function, with a number of notable achievements recognised from each work stream. The success of the Health & Safety Monitoring Tool roll out; the Fire Safety Specialist Adviser involvement and input into the sprinkler system installations and works at the new Unity Centre; the strengthening of the external Security contract; and achieving the Trust Flu CQUIN target of 75%, are a number of key achievements discussed within this report.

2021/2022 will be even more challenging if not more for staff within the function, with need to redesign training packages to meet the changing workforce, especially from the Covid-19 pandemic repercussions; the creation of suitable support mechanisms for community premise staff and service users and also the implementation of new standards to achieve compliance against. New targets will be implemented to enable the teams to meet the requirements of the Trust, its staff and external standards throughout the next reporting year.

Appendix 1

Health & Safety Action Plan – 2020/2021 – Summary of Achievements

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target for Completion	Comments
1. Audit/Inspection spreadsheet held by Health & Safety Team to be updated from results of H&S 19/20 Monitoring programme. Visits To be planned for 20/21	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	To ensure support can be accurately and promptly targeted to services & teams	Q1	Planned audits, inspections and visits to teams are a fundamental element of the Trust's approach to HSG65. ***(Completed)***
2. Revise & Update Trust Health & Safety Policy	Alan Davis/Nick Phillips	Roland Webb	A written Health & policy is a legal requirement. – The present policy being due for formal review in May 2021, however, the Director of HR & OD in discussions with Nick & Roland has determined the policy would benefit from a mid-term review	Q1	Revised policy will take into account transformation and reflect Governance arrangements required for 2020 onwards ***(Completed)***

3. Update Health & Safety Training offer	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	With low uptake of face to face Health & Safety Training additional training platforms can ease friction contributing to limited attendance	Q1	To include revised H&S/COSHH work books and explore e-learning options. ***(Ongoing)***
4. Revise & Update Trust Lone Worker Device Contract	Alan Davis/Nick Phillips	Roland Webb	Following on from Trust wide work in 2019/2020 with Lone Working procedures & risk assessments, the existing provision of Lone Working devices can be refined	Q2	Revising & Updating the Trust Lone Worker Device Contract coincides with development of bespoke usage estimations with individual services/teams ***(Completed in Q4 – delayed by Covid)***
5. HAV & Noise Assessments for Estates & Facilities Staff	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	Strengthening further risk management of Estates & Facilities Staff	Q3	Complies with current Health & Safety legislation, underpinned by the Trust HSE inspection from 2019/2020 ***(Completed in Q4 – delayed by Covid)***
6. Implement and complete audit/inspection programme by end of March and prepare for 2021/2022 monitoring programme	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	Ensure effective Trust wide approach to health & safety monitoring & inspections for Trust Board assurance.	Q4	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust. ***(Completed)***
7 Update Health & Safety Intranet pages and ensure policies and all H&S Information is current with correct contact details	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	To ensure Trust staff have reliable and pertinent access to Health & Safety Information	Q4	As the roll out of new services evolve and working practices modernised Health & Safety information will be updated as required. ***(Completed)***

Appendix 2

Health & Safety Action Plan – 2021/2022

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target for Completion	Comments
1. Inspection spreadsheet held by Health & Safety Team to be updated from results of H&S 20/21 Monitoring programme. Visits To be planned for 21/22.	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding	To ensure support can be accurately and promptly targeted to services & teams.	Q1	Planned audits, inspections and visits to teams are a fundamental element of the Trust's approach to HSG65.
2. Revise & Update Trust RIDDOR Policy & Guidance.	Alan Davis/Nick Phillips	Roland Webb	The Trust RIDDOR Policy & Guidance supports a reasonable and pragmatic approach to enable, effective & prompt reporting in line with government legislation.	Q1	The Trust RIDDOR Policy & Guidance details SWYPFT's approach to fulfilling its duties and will incorporate new guidance on Covid-19 RIDDOR notifications.
3. Award new Lone Worker Contract.	Alan Davis/Nick Phillips	Roland Webb	Previous contract has matured, with aging lone working devices coupled with new ways of working.	Q1	The revised contract will offer options for a blended approach in terms of lone working devices incorporating the latest technology and revised lone working risk assessments.

4. Revise & Update Trust Travel at Work Policy & Guidance.	Alan Davis/Nick Phillips	Roland Webb	The Trust Travel at Work Policy & Guidance supports a reasonable and pragmatic approach ensuring safe and effective travel at work support & advice is available.	Q2	The Trust Travel at Work Policy & Guidance details SWYPFT's approach to meeting its legal duties and responsibilities. The policy is due for update in August 2021
5. Joint Working Protocols.	Alan Davis/Nick Phillips	Roland Webb	Update two H&S Joint Working protocols, i.e. Calderdale, & Wakefield.	Q3	Ensures proof of joint cooperation with partner organisations in line with HSE expectations.
6. Implement and complete audit/inspection programme by end of March and prepare for 2022/2023 monitoring programme.	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding	Ensure effective Trust wide approach to health & safety monitoring & inspections for Trust Board assurance.	Q4	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust.
7. Update Health & Safety Intranet pages and ensure policies and all H&S Information is current with correct contact details.	Alan Davis/Nick Phillips	Roland Webb	To ensure Trust staff have reliable and pertinent access to Health & Safety Information.	Q4	As the roll out of new services evolve and working practices modernised Health & Safety information will be updated as required.

Appendix 3

Fire Safety Action 2021/2022

No.	Action	Lead	RAG Rating/ Progress	Target Date for Completion	Comments
1	Resume face to face fire training (including practical training) to meet the Regulatory and Trust requirements as soon as Covid restrictions permit.	Ian Cass		Ongoing	With the exception of fire warden training, fire safety training for all staff has been restricted to e-learning only during Covid.
2	Recruit a suitable replacement Fire Safety Adviser to fill the vacancy at Kendray.	Ian Cass /Martin Brandon		Quarter 1	No suitable candidates when the post was previously advertised.
3	Continue the programme of premises fire safety inspections and review/update of fire risk assessments.	Ian Cass		Ongoing	Access to ward areas restricted to essential visits only during Covid.
4	Liaise with local management to ensure sufficient fire wardens are appointed and trained, taking into account possible changed working practices in Trust buildings post Covid.	Ian Cass		Quarter 1	Taking into account re-location of teams together with potential for flexible working.
5	Continue to provide high quality fire safety technical support to Capital Planning regarding development of Trust buildings.	Ian Cass		Quarter 1	Identify premises to be included in the next phase of installing fire suppression systems in high risk ward areas.

Appendix 4

Security Action Plan 2021/2022

No.	Action	Lead	RAG Rating/ Progress	Target Date for Completion	Comments
1	Continue to support trust staff involved in Violence and aggression incidents and also a review on how incidents are reported to the police and followed up in line with Secretary of State Directions 2018 “Assaults on Emergency Workers (Offences) Act 2018”.	John Sanderson /Johan Celliers		Ongoing	Continued liaison with Police Partnership Officers to establish external support for Procedure for Reporting of Violent and Anti-social Offending.
2	Police liaison and partnership.	John Sanderson /Johan Celliers		Ongoing	Continued liaison with Police Partnership Officers to establish external support for Procedure for Reporting of Violent and Anti-social Offending.
3	Ongoing support to community premises to address safety concerns when self-presenters attend sites and continued support for Lockdown procedures. Develop rolling program for emergency and lockdown tests to be completed throughout the trust.	John Sanderson /Johan Celliers		Ongoing	A separate rolling program, similar to Crime Reduction Surveys program, will be developed for emergency response and lockdown tests and training.

4	Complete Self Review Tool to ensure we are in line with security standards.	John Sanderson /Johan Celliers		Nov 2021	Review current Security work plan in line with historic security Management Standards.
5	Support to Capital team with management of vacant or decanted premises.	John Sanderson /Johan Celliers		Ongoing	Review lessons learned and ongoing issues at vacant sites.
6	Complete Annual Audit on Reported Physical Assaults with support from Patient Safety Team.	John Sanderson /Johan Celliers		May 2021	Review in line with new NHS Violence Reductions Standards.
7	Review internal security service to bring in line with trust requirements.	John Sanderson /Johan Celliers		August 2021	COVID and other operational requirement have created the need to review the service to ensure it provides service in line with trust requirements.

Key

	Complete
	On Target
	In progress, some risks
	Not on target
	Not yet started

Appendix 5

Emergency Preparedness, Resilience & Response Action Plan 2021/22

No.	Action	Lead	RAG Rating/ Progress	Target Date for Completion	Comments
1	Conduct a Training Needs Analysis for all levels of the Trust to identify a training programme for implementation for all areas of Business Continuity Planning and Emergency Preparedness.	Emma Hilton		July 2021	Work in partnership with the L and D centre. Funding bid put forward for Command and Control Training.
2	Ensure a review of all policies, procedures and Business Continuity plans to ensure lessons learned have been identified and embedded in planning arrangements in relation to a pandemic outbreak.	Emma Hilton		March 2022	Work with the performance and improvement department and operational Deputy Directors and general managers.
3	Review all workstreams to identify leaner ways of working and also review the departmental level Business Continuity Plan to make more user friendly.	Emma Hilton		October 2021	

4	Prepare for the release of the Core Standards, reviewing progress and updating against current standards, and sourcing information for the new Deep Dive standards along with a rumoured new core standard relating to implementing lessons learned during an incident.	Emma Hilton		August 2021	
5	Prepare and deliver the 2021 Staff Influenza campaign, ensuring appropriate representation from all BDU's and resources and expectations are met.	Emma Hilton		Feb 2022	

Key

	Complete
	On Target
	In progress, some risks
	Not on target
	Not yet started

Appendix 6

Incident Statistics

Safety Related Incidents

A total of ***5550*** of safety related incidents were recorded in 2020/2021, ***down 6.6 %*** on 2019/2020 with **66%** of incidents throughout the year relating to violence and aggression (***3693).*** The Health & Safety and RPPI Teams continue to work closely together with excellent attendance at both the Safety & Resilience & RPPI TAG's, with active staff side involvement supporting the safety agenda

Health & Safety related incidents maintained an encouraging **9%** reduction of **750** from **822** in 2018/2019 although the main category of reported staffing issues due to acuity, sickness etc. accounting for **29%** of this total during 20/21, which is on a par with 19/20.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

RIDDOR requires the Trust to report all over seven day injuries to the Health & Safety Executive; To be updated at end of Q4

RIDDOR Notifications 1st April 2020 - 31st March 2021	Barnsley General Community Services	Kirklees Community Mental Health Services*	Mental Health Inpatient Services	Forensic Service	Learning Disability services	Total
Injuries/concerns following restraint	0	0	2	0	0	2
Slip, trip or fall - staff member	0	0	2	1	0	3
Unintended/Accidental injury	1	0	2	0	0	3
Physical aggression/threat (no physical contact): by patient	0	0	1	0	0	1
Physical violence (contact made) against staff by patient	0	0	8	4	8	20
Physical violence (contact made) against patient by patient	0	0	0	1	0	1
Total	1	0*	15	6	8	30

All but 1 Trust RIDDOR notifications resulted from incidents in ward settings. The one community notification came following a staff member suffering an MSK injury whilst delivering a mattress up a narrow staircase in a private dwelling.

***** Whilst the Trust did not have to submit any RIDDOR notifications for Kirklees Community Mental Health Services, it should be noted that two Local Authority were seriously assaulted whilst working in the joint SWYPFT/LA Team. Injuries were reported under RIDDOR by the Local Authority. Trust staff offered support to all affected members of the team.

Slips, Trips & Falls

A total of **637** reports of Slips, Trips and Falls reflected the continuing downward trend in recent years (**719** - 17/18, **652** - 18/19 & **648** in 19/20) and is testament to ongoing joint working with Health & Safety/Clinical staff to ensure work environments and procedures continue to support safe working conditions as far as reasonably practicable.

The majority of reported Slips, Trips & Falls (93%/592) affected clients within clinical settings, followed by staff members sustaining injury whilst undertaking their daily tasks, but did account for 10% (3) of all over seven day RIDDOR notifications during the year

Security Related Incidents

There was a 7% recorded increase from 19/20 to 470 security related incidents during last year's pandemic. The increase was fueled primarily by building related issues, i.e. vandalism and property loss as services had to retreat from normal full-time occupancy and use of buildings.

All incidents however, were thoroughly investigated and support provided where necessary to affected staff members after personal safety and security had been compromised.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 11.4

Title:	**Initial Premises Assurance Model (PAM) Submission**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The purpose of the paper is to seek approval from the Board for the submission of the Trusts' first Premises Assurance Model (PAM) into NHS I/E
Mission/values:	The report demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	The PAM submission is included in the report. This has been prepared by the compliance manager within Estates and Facilities. The submission has been approved for accuracy at Estates TAG and has been considered by EMT prior to Board submission
Executive summary:	The PAM is a large data collection exercise undertaken to prove that Board are sighted on the running of the Estate. The data collection undertaken is against a set of key questions which the Trust must answer and provide evidence of compliance. The return is a self-assessment and requires that the Trust considers itself from Requires Improvement to outstanding against all questions. The lowest score is then the Trusts' PAM score. The question set is the one used for acute Trusts as a proposed mental health and community services, specific collection has been delayed due to the pandemic. The overall score proposed to be submitted is that the Trust rates itself as Good. Given that this is a first submission and is against criteria for large acute hospitals should give Board further assurance that the estates and facilities function within the Trust is well managed.
Recommendation:	**The Trust Board is asked to APPROVE the submission of the PAM submission for 2021.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Premises Assurance Model

1. Introduction

The NHS has for some time operated the Premises Assurance (PAM) model in its acute hospitals as a tool to provide Board assurance on Estate matters. The model is now being rolled oy to mental health and community services providers as a mandatory submission to NHS I/E from July of this year.

As part of this further rollout a revised PAM reporting model was planned to be introduced in 2020 for Trusts such as us. This for understandable reasons has not happened but is still planned. In the interim we have completed the acute model

2. Description

The return which is at appendix 1 is a very comprehensive look at all aspects of estates and facilities activity and has been in preparation for some months as the first iteration done requires large amounts of information from many sources to be brought together into a single document.

The Trust is measured in key areas and must assess itself. The categories range from requires improvement through to outstanding and any response which is shown as requiring improvement or minor improvement means that the whole submission is marked as that.

Whilst this is a self-assessment it is a requirement that strong evidence is provided and the return contains many links to this evidence base, the return is subject to potential audit.

The submission is undertaken within estates and facilities and has been agreed as correct at Estates TAG and Executive Management Team scoring is as follows:

	Hard FM	Soft FM
Good	107	69
Outstanding	45	3
Requires improvement	0	0

This means that the Trust can return an overall score of “good”. This is particularly pleasing for a first submission as many Trusts which have been reporting for some time are still marked as requiring some level of improvement. The difference in outstanding scores does nor reflect that the hard and soft services are operating at vastly different levels. It more reflects where we are in providing evidence on the service.

This shows very much on where the Trust is with its CAFM (Computer Aided Facilities Management) system which is more mature in its use in hard FM and is now being developed in the same manner for soft services.

The lead on this is Cecilia Crump who is widely consulted on how the Trust have implemented the system across the NHS and has informally advised many trusts to help them successfully use CAFM systems and has specifically helped DBHFT and SHSC Trust locally when they found themselves in need of improvement. Our score is very much reflected on her work in bringing together evidence of how Estates and Facilities within the Trust operate.

3. Recommendation

Trust Board is recommended to:

- **Approve the submission of the Premises Assurance Model return to NHS I/E Estates.**

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH1	**SH1: With regard to the Estates and Facilities Operational Management can the organisation evidence the following?**	Applicable	Applicable	
SH1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Outstanding	1. Outstanding	1. The Department has a range of Policies and Procedures including Asset management, Asbestos Management, Emergency Preparedness, Fire Safety, Health & Safety, Loan Working & Permits to Work. If Pertinent to all Trust staff they are stored in a Document Management system on the Trust Intranet. (http://nww.swyt.nhs.uk/Pages/Policies-and-procedures.aspx) or if only pertinent to estates & Facilities on the department's shared drive L:\Prop-Serv\Estates Data\Compliance.PAM.CQC Evidence\2020\Policies These all have expiry dates and are updated accordingly by the responsible manager and are monitored by the Admin Manager for review dates using a Monitoring spreadsheet.
SH1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	1. Outstanding	1. Outstanding	2. All staff have a job description with clear defined Roles and Responsibilities and include a management structure for their department. Individuals are assigned and trained as Competent Persons (CP), Authorised Person (Ap) or Authorising Engineer (AE). Annual Appraisals are carried out which list individuals agreed objectives for the period utilising WorkPal as it provides weekly updates of outstanding actions.
SH1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	2. Good	3. Risk Assessments for the Operations Team are electronically added to all Work Orders carried out by the staff and stored on the Estates Shared Folder (L:\Prop-Serv\Estates Data\Risk Assessments, Permits, RAMS & Work Instructions) . All Risk Assessments are available Trust wide on the intranet (http://nww.swyt.nhs.uk/facilities/Pages/CQC-fundamental-standards-%e2%80%93-Regulation-15-premises-and-equipment.aspx). The overall Trust Risk Register is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site (http://nww.swyt.nhs.uk/search/Pages/Results.aspx?k=risk%20register&cs=This%20Site&u=http%3A%2F%2Fnww.swyt.nhs.uk). Risk Assessments and Method Statements (RAMS) are collected from Contractors prior to any work commencing and are stored in hard copies on the relevant site; Fieldhead or Kendray. Contractor signing in software includes a confirmation section to check if RAMS and DBS documentation has been completed. Contractors will not be allowed to work on site until this information is received.

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH1	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	2. Good	1. Outstanding	4. The Estates Department hold an Asset Register on their CAFM system; Planet FM which ensures plant and equipment is adequately managed with all service reports / Inspection records being attached to the asset detailing dates of service and who it was carried out by. All work is issued electronically via Planned Preventative Maintenance (PPM) Work Orders and any follow on repairs required are linked to the original Work Order in order to give a full audit trail. All service reports are stored by discipline, site and building on the Department's shared P Drive. P:\Planet Reports - DO NOT MOVE so they can be read by all staff that do not have access to Planet. A full PPM schedule is on the Planet software system which contains questions pertinent to the work being carried out to enable a full report to be exported on the quality of work carried out and the condition of the equipment involved. These are reviewed for quality and compliance by the relevant managers/APs/CPs. KPIs are produced weekly with statistical analysis of departmental performance split into individual sites and Trust wide as a whole and also show response times against targets for both Reactive and PPM works. These are stored centrally on P:\Estaes Data\Stats 2020.
SH1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	5. The Department has a Training Plan and Matrix which tracks Mandatory Training which is stored on the Department's shared drive L:\Prop-Serv\Estates Data\Training and also on the department's CAFM system; Planet FM. Training is pertinent to the trade of each individual and mandatory requirements of the Trust and Statutory requirements. Training and Development opportunities are discussed during appraisals to ensure all staff have input into their own professional development via the Workpal system which provides weekly updates on outstanding actions. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. Training Attendance Records and Certificates are kept on individual Personnel Files.
SH1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	The Department have a Resilience, Emergency Planning & Business Continuity Policy stored on the Department's shared Drive L:\Prop-Serv\Estates Data\Compliance.PAM.CQC Evidence\2020\Policies\Resilience, Emergency & Business Continuity Planning and staff responsible for this area of work. The department also has a number of Business Continuity Plans which are stored on the Department's shared drive L:\Prop-Serv\Estates Data\Compliance.PAM.CQC Evidence\2020\BCP . Test of these plans are carried out Annually and reports stored in the same location. The result of these test are used to assess and update the plans and where appropriate are added to the overall Trust Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site (http://nww.swyt.nhs.uk/search/Pages/Results.aspx?k=risk%20register&cs=This%20Site&u=http%3A%2F%2Fnww.swyt.nhs.uk)
SH1	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	The Review Process takes place via Risk Assessments which are carried out Annually for electrical and Asbestos and 2 yearly for water or when there is a significant change to a building or a change of occupancy. There is a Task and Finish Group which reviews all Policies and Procedures and monitors expiry and renewal dates.

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
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Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH1	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	3. Requires minimal improvement	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. A Dedicated member of the Finance Department now sits within the Estates Department to ensure budgets are set and maintained which include investment to deliver un-resolved actions. These are also included in the Estates Strategy Document. Any work requiring escalation would in the first instance be escalated to Estates TAG
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
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Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH2	**SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/?**	Not applicable	Applicable	
SH2	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	1. The Capital Projects Procedure is compliant with Legislation and Guidelines in regards to occupation and vacating of premises. It has a current Estates Strategy and a Security Management Policy L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Estates Strategy which identifies Critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs. In addition Full Business Cases are submitted which identifies the above needs for individual projects. The Department also has a standard specification and prelims L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence The Trust has a number of policies and procedures which influence this such as standards for privacy & dignity, Equality Strategy and a Dementia Toolkit L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Design, Layout and Use of Premises, and a Travel Plan which is stored on the Trust Intranet (http://nww.swyt.nhs.uk/ipc/Pages/Travel.aspx) and all are regularly reviewed.
SH2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	2. Good	2. The Trust have a dedicated Capital projects Team and staff are suitably qualified and have individual Job Descriptions with clear defined Roles and Responsibilities and departmental management structure (L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Management Structure). 3. Annual Objectives are agreed during their Annual Appraisals and during the capital projects allocation plans. 4. When work is outsourced a Tender Specification is drawn up (under CDM where applicable) and work carried out according to HTMs and HBNs and tendered appropriately identifying key roles and responsibilities. 5. Appropriate qualified experts in fields such as Asbestos are identified via the Trust's Approved Contractor list which collects qualifications and references.
SH2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	1. Outstanding	1. All work where appropriate is carried out under the CDM regulations. Risk Assessments are carried out by various teams to ensure the design, layout and use of the premises are safe, suitable and meets the needs of the service. 3. Where appropriate these are added to the Trust's Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site (http://nww.swyt.nhs.uk/search/Pages/Results.aspx?k=risk%20register&cs=This%20Site&u=http%3A%2F%2Fnww.swyt.nhs.uk). 4. Six Facet Surveys are carried out and stored on the departments shared drive (L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\6 Facet with costed and risk rated backlog.

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH2	**4: Maintenance** Are relevant assets, equipment and plant adequately maintained? (Note 1)	Not applicable	1. Outstanding	On completion of all projects the Operational & Maintenance (O&M) files are handed over to the department along with the Health & Safety files that contain all equipment specifications and a maintenance schedules L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Design, Layout and Use of Premises. The Capital Projects Procedure has a procedure for occupying and vacating premises and identifies the need for asset tagging of equipment which is then added to the PPM schedule to ensure it is adequately maintained. All Service and repair reports are attached to the assets which enables and asset replacement programme and Lifecycle costings to be produced from the CAFM system on individual types of equipment. . L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Design, Layout and Use of Premises. The Estates Department hold an Asset Register on their CAFM system; Planet FM which ensures plant and equipment is adequately managed with all service reports / Inspection records being attached to the asset detailing dates of service and who it was carried out by. All service reports are stored by discipline, site and building on the Department's shared P Drive. P:\Planet Reports - DO NOT MOVE so they can be read by all staff that do not have access to Planet. A full PPM schedule is on the Planet software system which contains questions pertinent to the work being carried out to enable a full report to be exported on the quality of work carried out and the condition of the equipment involved. These are reviewed for quality and compliance by the relevant managers/APs/CPs. KPIs are produced weekly with statistical analysis of departmental performance split into individual sites and Trust wide as a whole and also show response times against targets for both Reactive and PPM works. These are stored centrally on P:\Estaes Data\Stats 2020.

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
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Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	5. The Department has a Training Plan and Matrix which tracks Mandatory Training and also discuss Training and Development opportunities during appraisals. L:\Prop-Serv\Estates Data\Training\Training, which ensures all staff are able to input into their professional development. The Trust also has a dedicate training department that records all mandatory training and attendance reports. The department has recently implemented a Contractor Management system; RESET to ensure all contractors have the correct competencies, Risk Assessments Method Statements (RAMS) and permits prior to commencing any works. Specialised contractors are tendered to ensure technical expertise and suitably qualified personnel for example Asbestos consultants; Lucion.
SH2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	6. The Department have a Resilience, Emergency Planning & Business Continuity Policy and staff responsible for this area of work. The Department produce a monthly Dashboard Report and this is one of the items that is tracked for performance against targets. The department also has a number of Business Continuity Plans which are stored on the Department's shared drive L:\Prop-Serv\Estates Data\Compliance.PAM.CQC Evidence\2020\BCP . Test of these plans are carried out Annually and reports stored in the same location. The result of these test are used to assess and update the plans and where appropriate are added to the overall Trust Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site (http://nww.swyt.nhs.uk/search/Pages/Results.aspx?k=risk%20register&cs=This%20Site&u=http%3A%2F%2Fnww.swyt.nhs.uk) . The Trust also utilise the DATIX system giving managers the tools to review Incident Data and to learn lessons. • To be able to devise reports in order to analyse information produced • To be able to pull relevant information to identify trends • To identify patterns and trends to identify any areas requiring further action Where appropriate these are added to the Trust's Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site (http://nww.swyt.nhs.uk/search/Pages/Results.aspx?k=risk%20register&cs=This%20Site&u=http%3A%2F%2Fnww.swyt.nhs.uk)

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	7. The Review Process takes place via Risk Assessments which are carried out when there is a significantly change to a building or a change of occupancy or on an annual basis. The six facet survey is used to identify work required alongside cost which allows for capital finance bids on a risk rated approach. Access Audits and Inclusive Built Environment Surveys are carried out and audited annually. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\6 Facet
SH2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	8. Backlog maintenance is submitted which makes up part of the Capital Plan, along with the 6 Facet Survey where Costed Action Plans are formulated. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\6 Facet. Any work requiring escalation would in the first instance be escalated to Estates TAG L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Escalations
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH3	**SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?**	Applicable	Applicable	
SH3	**1: Document Management System in Place** Does the Organisation have an effective and efficient document management system in place proportional to the level of complexity, hazards and risks concerned?	Not applicable	2. Good	The Trust intranet is available to all staff whether on or off Trust property and has a document store which is the repository for all Trust Policies. Policies pertinent to the Estates Department only are stored on the departments shared drive (L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020). These all have expiry dates and are updated accordingly by the responsible manager. All Documents come under the Data Protection Policy, incorporating Information Sharing. The Trust has a Capital Asset Register which is maintained by Finance and a Trust Asset Register maintained by the Estates Department which is held on the CAFM system; Planet FM. The Estates Terrier is held and produced by the Capital Team (L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Estates Strategy). The Departments has a variety of risk assessments which are stored on the department shared drive so they are accessible to all staff (L:\Prop-Serv\Estates Data\Risk Assessments, Permits, RAMS & Work Instructions). Dynamic Risk assessments are automatically attached to all Work via the CAFM System; Planet FM and contractor Risk Assessments are managed and stored on the RESET system. All test certificates and records are stored on the trust Central drive (P:\Planet Reports - DO NOT MOVE) and are linked to the assets on the Planet FM software. The system logs the last service date allowing it to be easily audited to ensure compliance. Insurance test certificates are also attached in the same way. The document storage is sorted into appropriate year, site, building and discipline covered.
SH3	**2: Approval of documents** Are documents approved for adequacy prior to issue?	Not applicable	1. Outstanding	Test certificates and service reports that require sign off are sent to the appropriate CP/RP or AP (L:\Prop-Serv\Estates Data\Cecilia Crump\2020\Compliance\Gas Boilers\Signed Off Sheets). These records are included in an annual audit to ensure compliance
SH3	**3: Review of documents** Are documents reviewed and updated as necessary with changes identified?	Not applicable	2. Good	Unless otherwise specified on the document all policies and procedures are reviewed annually or after any major changes that affects the policy or procedure. Procedures and Local Work Instructions are constantly reviewed to ensure they are still appropriate and meets the needs specified. Task and Finish Groups are organised where appropriate. The Admin Manager has a policy monitoring document to remind managers when policy become due for renewal.
SH3	**4: Availability of documents** Are all relevant versions of applicable documents available at points of use?	Not applicable	2. Good	A printed copy of all relevant documents are filed in the Trade Staff Workshop to ensure easy and immediate access for all staff not able to immediately access a PC. When documents are updated the Supervisors print off a copy to replace the previous version. As documents are stored by year, it is easy to check if there is a relevant updated copy each year.
SH3	**5. Legibility of Documents** Are all relevant documents legible and readily identifiable?	Not applicable	2. Good	Documents are available on the Trust Intranet site or the Departments Shared Drive and are produced in a standard format to make them easy to read and understand. Where staff have limited access to a PC; such as Trade Staff, there are folder available in the workshop which are updated by their Supervisors.
SH3	**6: Document Control** Are all internal and external documents identified and their distribution controlled?	Not applicable	2. Good	Documents are identified and circulation controlled, hence the documents only pertinent to Estates not being published on the Trust's Intranet. The Admin Manager has a policy monitoring document to remind managers when policy become due for renewal.

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◄◄ Back to instructions		

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SH3	**7: Obsolescence** Is there a process to prevent the unintended use of obsolete documents and apply suitable identification to them if they are retained for any purpose?	Not applicable	2. Good	As Documents are stored in folders pertinent to the current year they are checked when being moved to ensure that they are still in date and relevant. All documents have Version Numbers to track changes and to ensure it is easy to identify obsolete documents. The Estates Admin Manager keeps a spreadsheet of all policies and when they are due and will remind Managers to update documents which, where appropriate go to EMT for approval which on approval are updated on the intranet or in the Estates Document folder. Staff are reminded not to save copies to their local folder, to always use from the main document folder L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Document Management
SH3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	As staff are in place and funded no costs would need to be found for this. Also as the servers where documents are stored is the responsibility of the I.T Departments, again the department would not have to find any associated costs or produce any action plans.
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

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SH4	**SH4: With regard to Health & Safety at Work can the organisation evidence the following?**	Applicable	Applicable	
SH4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	The Trust has a Health & Safety Policy written to incorporate the Health and Safety at Work Act 1974: and other relevant policies pertaining to the working environment. Link to Evident including Health and Safety at Work Regulations 1999: Approved Code of Practice & guidance. L21 2nd edition. 2000. These are regularly reviewed and after any significant changes to buildings or staffing. These are monitored centrally to ensure documents are controlled .The Trust has a Heath & Safety Department with Managers responsible for the various areas as well as an overarching manager to ensure that the various legislations are understood and applied by all teams. Various meetings are held including the Safety Resilience TAG, Medical Devices & Safety Alerts Sub Group and the Estates TAG each with their own Terms of Reference and there is an annual Health & Safety Monitoring programme - The Trust uses the Contract Management system RESET which collects professional liabilities, indemnities and insurances along with individual competencies and DBS checks. The H&S Department ensure H&S regulations are understood by all teams involved by carrying out Tool box talks
SH4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	Not applicable	1. Outstanding	The Trust has Job Description and Person Specification which includes organisational chart and all staff have a job description outlining their roles and responsibilities. Annual Objectives are agreed during their Annual Appraisals . Appraisals using the new Work Pal system which send weekly updates. The Health & Safety Department are responsible for COSHH Assessments and Health and Safety inspections where documents are produced for the relevant department and the Trust as a whole and when a service move a Base Line Assessment will be undertaken. The Health & Safety staff have a page on the trust intranet which has all the relevant information on the department, structure, COSHH, Risk Assessments etc. http://nww.swyt.nhs.uk/health-safety/Pages/default.aspx . Maintenance is the responsibility of the Operational Maintenance Departments but under guidance of the H&S staff and is detailed in the section below. The Trust also has a Transport department responsible for the safe arrangements for the use, handling, storage and transport of articles, materials and substances and also have a page on the Trust Intranet site http://nww.swyt.nhs.uk/facilities/Pages/Portering.aspx with useful information and links. Safe Access and egress is a combined responsibility of the department with input from Capital, Maintenance and security teams.
SH4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Not applicable	1. Outstanding	Various risk assessment are carried out according to the service or activity being undertaken. For example Lone Working, DSE, COSHH, Building, personal etc but all are listed on the Trust Intranet site http://nww.swyt.nhs.uk/search/Pages/Results.aspx?sq=1&k=Risk%20Assessment%20Forms as evidenced here. Risk Assessments are regularly reviewed and when new equipment is purchased or a change of use occurs. Where appropriate risks will be included in the Trust Risk Register . Building, Fire and Security Risk Assessments are carried out for every building within the Trust.

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SH4	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	Not applicable	2. Good	The Trust has a Training & Development Department and a dedicated page on the Trust intranet. Health and safety training is mandatory but the Estates Operational department also carry out a range of Health & Safety training from COSHH, Asbestos Awareness, Nosie, Confined spaces to health & Safety Basics to ensure sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, all which are recorded on the departments CAFM system and on a training matrix. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. .Attendance Records and Certificates are kept on individual Personnel Files. Training relating to professional development and required for job role is also undertaken as well as membership to professional bodies such as CNMI, CIMW,IEng ACIBSE. The Health & Safety department also provide training Trust wide and to ensure bespoke training can be given where necessary the department has a Risk Assessment/Training officer who has recently undertaken bespoke lifting and handling training to be able to provide this training through the Facilities department that ensures it meets the needs of the department. They also sit on various committees and meetings such as the Medical Devices all Equipment Group and the Estates Tag.
SH4	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The staff within H&S are classified as Specialist Advisors and as such are Essential staff that are multi-skilled in order to provide Business Continuity. Although the Tryst Head Quarters are at Fieldhead the staff are able to work remotely in order to support Business Continuity. They have a dedicated Emergency Planning staff who are responsible for ensuring the NHS Core Standards for Emergency Preparedness, Resilience and Response Guidance which includes annual testing of emergency responses. The I.T department is responsible for Continuity Planning and Disaster recovery for all I.T System which are also tested annually. The Department has a dedicated page on there Trust Intranet site including an Emergency Planning section which aims, where possible, to prevent emergencies occurring, and when they do occur, good planning should reduce, control or mitigate the effects of the emergency. It is a systematic and ongoing process which should evolve as lessons are learnt and circumstances change. The department use the RESET system for contractor management whereby all contractor must be a member of Reset as information on Insurances, Competencies and DBS Checks are pre-vetted and stored ensuring all contractors have the relevant skills to carry out the work. All work has to be pre-planned and a job put on Reset along with a copy of the RAMS to ensure a safe system of works. Service and Repair reports are provided per asset along with relevant insurance inspection certificates.

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SH4	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Policies and procedures have review dates but are also reviewed when significant change in a building or occupation occurs. The Estates Admin Manager has a control document to manage changes and monitor when reviews and updates are required. Incident reports are reviewed in the appropriate meetings such as the Estates TAG and Action Plans agreed and investigations approved where appropriate
SH4	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	The department produce Building, Fire and Security Assessments with a costed action plan for essential works to meet the needs of the occupants and service. The nature of the work undertaken is reactive and any major issue identified is added to the Minor Capital Bid Procedure or put on the Risk Register which is reviewed quarterly with a 'Challenge and Confirm' process via the Trust Board.
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

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SH5	**SH5: With regard to Asbestos can the organisation evidence the following?**	Applicable	Applicable	
SH5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	1. The Trust has an Asbestos Policy and Management Plan. It also has an Operational Protocol and Local Work Instruction. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Asbestos These are reviewed by the Lucion who are the Department's asbestos consultant and approved contractor and the department hold bi-monthly asbestos management meetings where minutes and Action Logs are produced L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\H&S\Asbestos. H&S, Capital and Minor Works departments attend as do the Consultant to ensure procedures are constantly reviewed. The Trust has an Asbestos Register which is linked to the Estates CAFM software and information on asbestos present in any room is automatically added to any work issued to either In-House staff or contractors. To ensure H& S Regulations are understood all staff whether trade, management or admin who have any dealings with asbestos information or may issue work (ensuring the relevant asbestos information is attached) undertake Asbestos Awareness training. This is logged on the department's training matrix and automatically alerts when anyone's training is due. The CAFM System requires acknowledgement of the asbestos warning before it allows the staff to proceed with the work and is regularly checked for compliance and any concerns or exceptions highlighted. 4. The Policy is approved and ratified by EMT and contains Terms of Reference and a Management Structure (Page 7) outlining Roles and Responsibilities and AP and RP Duties. 5. The department utilise the Contractor Management software; RESET where contractors have to provide a copy of their H& S Policy, Asbestos Policy, Public liability insurance, professional indemnities and all staff's asbestos training certificates before staff are allowed to work on site. 6. The Full Trust Asbestos Register is available via web portal, individual building reports are also stored on the Department's shared drive L:\Prop-Serv\Estates Data\Asbestos and information can be exported from the Planet system.
SH5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	1. Outstanding	1. The Trust has an Asbestos Policy and Management Plan contains a Management Structure (Page 7) outlining Roles and Responsibilities and AP and RP Duties. 2. Both the Policy and Management Plan outline the roles and responsibilities for all staff and how work should be undertaken, issues reported and escalation procedures. 3. The Trust's Asbestos Advisors (Lucion) provide an annual review of Policy and Management Plan which contains a traffic light report on areas of concern and key objectives for the year. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\H&S\Asbestos. 4. All staff whether trade, management or admin who have any dealings with asbestos information or may issue work (ensuring the relevant asbestos information is attached) undertake Asbestos Awareness training. Key staff also have P405 training to ensure they have an underpinning knowledge of what is required by law for anyone involved with asbestos. The Trust uses the Contractor system RESET and require evidence of contractor competencies including asbestos training. The departments asbestos advisors Lucion carry out all licenced work for the Trust including all permits. 6. Due to the importance of asbestos management Lucion are employed as advisors with the Head of Estates and Facilities (Senior Responsible Officer) and Head of Estates Operations. (Responsible Officer).

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SH5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Not applicable	1. Outstanding	1-6 The Trust's Asbestos Management Plan L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\H&S\Asbestos details the asbestos survey register which contains information that sets out the details of the survey together with details of any caveats and any areas not accessed, or any environmental conditions that affected the survey. The register is also a database of all samples taken including a description of the location of the sample point, extent or amount and – where appropriate - a digital photograph of the sample point together with the results of the laboratory analysis and the risk assessments. The survey register is available electronically via the Trust's Planet FM Enterprise system. A copy of the register for all the sites is available to all estates & facilities staff and engaged contractors to enable maintenance and other works to be planned & undertaken safely. It is the duty of all staff and engaged contractors to report amendments accordingly so that the register is updated to record such work done to either maintenance/protection or removal of the ACM's or the results of re-inspections. The database carries the building plans and a record of samples taken showing all points, all visually similar materials, all positive & negative samples as well as all areas not accessed. The Trust aims to hold all plans in CAD/PDF format, where the full extent of different ACM's may be overlaid and the layers switched on or off to aid interpretation, or to enable photocopies to be marked by hand. The Trust will continue to monitor known ACM's and carry out periodic re-assessments to its portfolio as appropriate within the above regulations. All planned surveys of buildings/structures services, fixed plant, equipment and machinery in accordance with Regulation 4 CAR and ACoP L127 - The Management of Asbestos in Non-Domestic Premises. Where appropriate any Risks will be excalted for inclusion on the Trust's Risk Register.
SH5	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	1. Outstanding	1. All staff whether trade, management or admin who have any dealings with asbestos information or may issue work (ensuring the relevant asbestos information is attached) undertake Asbestos Awareness training. Key staff also have P405 training to ensure they have an underpinning knowledge of what is required by law for anyone involved with asbestos. The Trust uses the Contractor system RESET and require evidence of contractor competencies including asbestos training. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. .Attendance Records and Certificates are kept on individual Personnel Files. The departments asbestos advisors Lucion carry out all licenced work for the Trust including all permits. 6. Due to the importance of asbestos management Lucion are employed as advisors with the Head of Estates and Facilities (Senior Responsible Officer) and Head of Estates Operations. (Responsible Officer). 2. The Head of Estates Operations carries out a training needs analysis identify in the level of training for all relevant staff. Where classroom based an attendance register is kept and where electronic, regular reports are downloaded to show attendance. All certificates are stored and information inputted both an the CAFM system; Planet and on the department's master training matrix database.

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SH5	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	1. Outstanding	Reasonable steps are taken to find out if there are materials containing asbestos and it condition as each year management surveys are undertaken by the trust's asbestos consultants who present a risk rated report on all asbestos and its condition. This information is imported into the department's CAFM system which automatically adds details of any asbestos to staff's Work Orders. Full reports are available on a web portal provided by our consultants Based on the evidence for sections 1 to 4 reliance is fully covered with relevant documents, trainings, meetings and updates.
SH5	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	The department's consultants review the policy and Management plan annually as part of the Management Surveys to ensure it is kept up to date with any legislative changes and best practice advice. Action plans are produced both by the Consultant and after each Asbestos meeting held Bi-Monthly. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Asbestos. The department's CAFM system automatically adds details of any asbestos to In-House staff's and contractors Work Orders. If it is capital works full reports are available on a web portal provided by our consultants that are downloaded for each project. Copies are also stored centrally L:\Prop-Serv\Estates Data\Asbestos\2020\Surveys.
SH5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. Lucion also provide the Trust Risk Rated Management reports which allow the trust to prioritise order of removals or encapsulations. Any work requiring escalation would in the first instance be escalated to Estates TAG L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Escalations
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

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SH6	**SH6: With regard to Medical Gas Systems can the organisation evidence the following?**	Not applicable	Not applicable	
SH6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	Not applicable	Not applicable
SH6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	Not applicable	Not applicable
SH6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	Not applicable	Not applicable
SH6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	Not applicable	Not applicable
SH6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	Not applicable	Not applicable

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SH6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	Not applicable	Not applicable
SH6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	Not applicable	Not applicable
SH6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	Not applicable
	Capital cost to achieve compliance	£0	Not applicable	Not applicable
	Revenue consequences of achieving compliance	£0	Not applicable	Not applicable

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SH7	**SH7: With regard to Natural Gas and specialist piped systems can the organisation evidence the following?**	Applicable	Applicable	
SH7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	2. Good	The Trust has a Gas Safety Management Plan which is updated every 3 years or following any major changes to premises or equipment. It is monitored for expiry by the Admin Manager via a Policy and Procedure Management spreadsheet.
SH7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	1. Outstanding	The Department has a Management Structure and all Individuals are employed with the relevant Job Description, Person Specification, Gas services training, skills and experience and following appropriate training and familiarisation are assigned as Competent Persons (CP). Most gas works are carried out by Trust approved contract companies in line with gas safety regulations 1998 GS(I&U)R. Annual Appraisals are carried out which list individuals agreed objectives for the period via WorkPal which send updates to both Line Manager and employee. The department utilise s a contractor Management system RESET which manages Competencies, RAMHS and Permits to Work.
SH7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	2. Good	Various task specific Risk Assessments have been carried out for routine work which are stored on the departments shared drive to ensure access for all staff. Local Work Instructions are provided to ensure staff have the relevant information to work safely. Risk Assessments are regularly reviewed and where appropriate risks will be included in the Trust Risk Register
SH7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	1. Outstanding	The Estates Department hold an Asset Register on their CAFM system; Planet FM which ensures plant and equipment is adequately managed with all service reports / Inspection records being attached to the asset detailing dates of service and who it was carried out by. All work is issued electronically via Planned Preventative Maintenance (PPM) Work Orders and any follow-on repairs required are linked to the original Work Order in order to give a full audit trail. All service reports are stored by discipline, site and building on the Department's shared P Drive. P:\Planet Reports - DO NOT MOVE so they can be read by all staff that do not have access to Planet. A full PPM schedule is on the Planet software system which contains questions pertinent to the work being carried out to enable a full report to be exported on the quality of work carried out and the condition of the equipment involved. These are reviewed for quality and compliance by the relevant managers/APs/CPs. KPIs are produced weekly with statistical analysis of departmental performance split into individual sites and Trust wide as a whole and also show response times against targets for both Reactive and PPM works. These are stored centrally on P:\Estaes Data\Stats 2020.

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The department has a training needs analysis for Estates staff and all training is documented on Planet; the Estates CAFM system and also a Training Matrix spreadsheet stored on a central drive in PDF format accessible by all staff . Training includes Basic Health & Safety Awareness, COSHH, Environmental Awareness, Noise and PPE as servicing is carried out by specialist contractors. Training and CPD is discussed during appraisals to enable all employees to contribute positively to their own safety and development. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. .Attendance Records and Certificates are kept on individual Personnel Files.
SH7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The Department have a Resilience, Emergency Planning & Business Continuity Policy and staff responsible for this area of work. The Department produce a monthly Dashboard Report and this is one of the items that is tracked for performance against targets. The department also has a number of Business Continuity Plans which are tested Annually The result of these test are used to assess and update the plans and where appropriate are added to the overall Trust Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site (http://nww.swyt.nhs.uk/search/Pages/Results.aspx?k=risk%20register&cs=This%20Site&u=http%3A%2F%2Fnww.swyt.nhs.uk) . The Trust also utilise the DATIX system giving managers the tools to review Incident Data and to learn lessons. • To be able to devise reports in order to analyse information produced • To be able to pull relevant information to identify trends • To identify patterns and trends to identify any areas requiring further action Where appropriate these are added to the Trust's Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT).
SH7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Policies and procedures have review dates but are also reviewed when significant change in a building or occupation occurs. These are managed by the Admin Manager via a monitoring spreadsheet. The department works closely with Capital Projects and Minor works to ensure that all new systems or equipment are asset tagged and are included in PPM, Servicing and Insurance Inspections where appropriate. All Service Reports detail any significant findings and recommend follow on works which are reviewed on completion of servicing and a plan produced whether this is to apply for capital funding, carry out the works as a Minor Capital Scheme, Minor Works on In-House repairs. The department utilise the RESET contractor management system where contractor competencies are managed.

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SH7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. A Dedicated member of the Finance Department now sits within the Estates Department to ensure budgets are set and maintained which include investment to deliver un-resolved actions. These are also included in the Estates Strategy Document. Any work requiring escalation would in the first instance be escalated to Estates TAG
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
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SH8	**SH8: With regard to Water Safety Systems can the organisation evidence the following?**	Applicable	Applicable	
SH8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	The Trust employs an external Authorising Engineer who, in conjunction with the Trust's AP writes the Water Safety Plan. which is updated every 3 years or following any major changes to premises or equipment. It is monitored for expiry by the Admin Manager via a Policy and Procedure Management spreadsheet. The Trust utilises the Contractor Management system RESET which documents and stores competencies to ensure work is undertaken by suitably qualified personnel with the correct competencies, indemnities and insurances. In House staff are trained as appropriate which is documented on the CAFM system to ensure work is only issued to staff with the correct competencies and qualifications. The CAFM system also holds a complete water PPM schedule to comply with all Legionella legislation and all failures are passed daily to the AP for rectification works to be issued with a master spreadsheet tracking progress and completions.
SH8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	1. Outstanding	The Department has a Management Structure and all Individuals are employed with the relevant Job Description, Person Specification, Individuals are employed with the relevant Legionella/water hygiene training, skills and experience and following appropriate training and familiarisation are assigned and trained as Competent Persons (CP) or Authorised Person (Ap), the Authorising Engineer (AE) is appointed from outside the organisation to provide independent services. Annual Appraisals are carried out which list individuals agreed objectives for the period and utilises Work Pal which send weekly updates regarding progress and outstanding actions. A water Safety group meet quarterly and consist of responsible persons to fulfil appropriate duties from all pertinent departments
SH8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Not applicable	2. Good	Various task specific Risk Assessments have been carried out for routine work. and local work instructions to ensure staff have the relevant information to work safely. Water Regulations 1999, Water Hygiene Safety Guidance HTM 04-01/03-01 and Approved Code of Practice (HSE L8) are in operation where relevant plumbing/mechanical tasks are undertaken. Risk Assessments are regularly reviewed internally and externally and where appropriate risks will be included in the Trust Risk Register
SH8	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	Not applicable	1. Outstanding	The Estates Department hold an Asset Register on their CAFM system; Planet FM which ensures plant and equipment is adequately managed with all service reports / Inspection records being attached to the asset detailing dates of service and who it was carried out by. All work is issued electronically via Planned Preventative Maintenance (PPM) Work Orders and any follow-on repairs required are linked to the original Work Order in order to give a full audit trail. All service reports are stored by discipline, site and building on the Department's shared P Drive so they can be read by all staff that do not have access to Planet. A full PPM schedule is on the Planet software system which contains questions pertinent to the work being carried out to enable a full report to be exported on the quality of work carried out and the condition of the equipment involved. These are reviewed for quality and compliance by the relevant managers/APs/CPs. KPIs are produced weekly with statistical analysis of departmental performance split into individual sites and Trust wide as a whole and also show response times against targets for both Reactive and PPM works.

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SH8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The department has a training needs analysis for Estates staff and all training is documented on Planet; the Estates CAFM system and also a Training Matrix spreadsheet stored on a central drive in PDF format accessible by all staff . Training includes Basic Health & Safety Awareness, COSHH, Environmental Awareness, Legionella and PPE . Training and CPD is discussed during appraisals to enable all employees to contribute positively to their own safety and development via the WorkPal system which provides weekly updates on progress. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. .Attendance Records and Certificates are kept on individual Personnel Files.
SH8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The Department have a Resilience, Emergency Planning & Business Continuity Policy and staff responsible for this area of work. The Department produce a monthly Dashboard Report and this is one of the items that is tracked for performance against targets. The department also has a number of Business Continuity Plans which are stored on the Department's shared drive so all staff have access.. Test of these plans are carried out Annually and reports stored in the same location. The result of these test are used to assess and update the plans and where appropriate are added to the overall Trust Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site . The Trust also utilise the DATIX system giving managers the tools to review Incident Data and to learn lessons. • To be able to devise reports in order to analyse information produced • To be able to pull relevant information to identify trends • To identify patterns and trends to identify any areas requiring further action Where appropriate these are added to the Trust's Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT).
SH8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Policies and procedures have review dates but are also reviewed when significant change in a building or occupation occurs. These are managed by the Admin Manager via a monitoring spreadsheet. The department works closely with Capital Projects and Minor works to ensure that all new systems or equipment are asset tagged and are included in PPM, Servicing and Insurance Inspections where appropriate. All Service Reports detail any significant findings and recommend follow on works which are reviewed on completion of servicing and a plan produced whether this is to apply for capital funding, carry out the works as a Minor Capital Scheme, Minor Works on In-House repairs. The department utilise the RESET contractor management system where contractor competencies are managed.
SH8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. A Dedicated member of the Finance Department now sits within the Estates Department to ensure budgets are set and maintained which include investment to deliver un-resolved actions. These are also included in the Estates Strategy Document. Any work requiring escalation would in the first instance be escalated to Estates TAG

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SH9	**SH9: With regard to Electrical Systems can the organisation evidence the following?:**	Applicable	Applicable	
SH9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	2. Good	The department has a number of policies such as the LV Policy, Electrical Rules, which are monitored by the Admin Manger for review dates using a Monitoring spreadsheet. It also has a Portable Appliances Testing Management Plan which is also monitored by the Admin Process. The Trust has HV which is managed externally by specialist contractors via a 5 year contract
SH9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	1. Outstanding	The Trust has Job Description and Person Specification which includes organisational chart -. All are employed with the relevant electrical training, skills and experience and following appropriate training and familiarisation are assigned and trained as Competent Persons (CP) or Authorised Person (Ap). A Authorising Engineer (AE) is appointed from outside the organisation to provide independent services. Annual Appraisals are carried out which list individuals agreed objectives for the period using the new Work Pal system which send weekly updates.
SH9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	2. Good	Various task specific Risk Assessments have been carried out for routine work and local work instructions to ensure staff have the relevant information to work safely. Electrical Safety Guidance HTM 06-02 is in operation where complex electrical tasks are undertaken. Risk Assessments are regularly reviewed and where appropriate risks will be included in the Trust Risk Register. All PPM is carried out via the Estates CAFM System which includes Dynamic Risk Assessments and all contract work is issued via the CAFM System and RAMS and collected via the Contract Management system RESET.
SH9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	1. Outstanding	The Estates Department hold an Asset Register on their CAFM system; Planet FM which ensures plant and equipment is adequately managed with all service reports / Inspection records being attached to the asset detailing dates of service and who it was carried out by. All work is issued electronically via Planned Preventative Maintenance (PPM) Work Orders and any follow on repairs required are linked to the original Work Order in order to give a full audit trail. All service reports are stored by discipline, site and building on the Department's shared P Drive. P:\Planet Reports - DO NOT MOVE so they can be read by all staff that do not have access to Planet. A full PPM schedule is on the Planet software system which contains questions pertinent to the work being carried out to enable a full report to be exported on the quality of work carried out and the condition of the equipment involved. These are reviewed for quality and compliance by the relevant managers/APs/CPs. KPIs are produced weekly with statistical analysis of departmental performance split into individual sites and Trust wide as a whole and also show response times against targets for both Reactive and PPM works and are stored centrally on P:\Estaes Data\Stats 2020. Copies of Test Inspection Reports and Insurance Certificates are also stored against each asset on the CAFM System.

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SH9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The department has a training needs analysis for Estates staff and all training is documented on Planet; the Estates CAFM system and also a Training Matrix spreadsheet stored on a central drive in PDF format accessible by all staff . Training includes Basic Health & Safety Awareness, COSHH, Environmental Awareness, Noise and PPE as servicing is carried out by specialist contractors. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. Training Attendance Records and Certificates are kept on individual Personnel Files. Training and CPD is discussed during appraisals to enable all employees to contribute positively to their own safety and development.
SH9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The Department have a Resilience, Emergency Planning & Business Continuity Policy and staff responsible for this area of work. The Department produce a monthly Dashboard Report and this is one of the items that is tracked for performance against targets. The department also has a number of Business Continuity Plans which are tested Annually The result of these test are used to assess and update the plans and where appropriate are added to the overall Trust Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site (http://nww.swyt.nhs.uk/search/Pages/Results.aspx?k=risk%20register&cs=This%20Site&u=http%3A%2F%2Fnww.swyt.nhs.uk) . The Trust also utilise the DATIX system giving managers the tools to review Incident Data and to learn lessons. • To be able to devise reports in order to analyse information produced • To be able to pull relevant information to identify trends • To identify patterns and trends to identify any areas requiring further action Where appropriate these are added to the Trust's Risk Register which is managed to mitigate the risks and is reviewed by the Operations Management Group (OMG) then escalated to Executive Management Team (EMT).
SH9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Policies and procedures have review dates but are also reviewed when significant change in a building or occupation occurs. The Trust Admin Manager has a tracker to alert managers when these need updating. The department works closely with Capital Projects and Minor works to ensure that all new systems or equipment are asset tagged and are included in PPM, Servicing and Insurance Inspections where appropriate. All Service Reports detail any significant findings and recommend follow on works which are reviewed on completion of servicing and a plan produced whether this is to apply for capital funding, carry out the works as a Minor Capital Scheme, Minor Works on In-House repairs.

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SH9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. A Dedicated member of the Finance Department now sits within the Estates Department to ensure budgets are set and maintained which include investment to deliver un-resolved actions. These are also included in the Estates Strategy Document. . Any work requiring escalation would in the first instance be escalated to Estates TAG
	Capital cost to achieve compliance	£0	£0	
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SH10	**SH10: With regard to Mechanical Systems and Equipment e.g. Lifting Equipment can the organisation evidence the following?**	Applicable	Applicable	
SH10	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	The Trust has a number of passenger, goods and scissor lifts, vehicles with tail lifts and grounds lifting equipment and has a safe use of lifts and lifting equipment management plan This is regularly reviewed and the next review date is 2023 but will be reviewed sooner if the Trust purchases any new equipment that is significantly different to the types already in use or the purpose of the equipment changes.
SH10	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	2. Good	Responsible Person is identified in the Management Plan which also includes roles and responsibilities for all staff . The Department has an Organisational Structure and all staff have a Job Description and Person Specification which lists key roles and responsibilities. Annual Appraisals are carried out which list objectives with timescales and review dates. The new WorkPal system send automated updates indicating outstanding work and progress towards targets.
SH10	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Not applicable	2. Good	Various risk assessment are carried out according to the type of lifting equipment it is and who will be using it L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence and Local Work Instructions to ensure staff have the relevant information to use the equipment L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\LOLER. Risk Assessments are regularly reviewed and when new equipment is purchased or a change of use occurs. Where appropriate risks will be included in the Trust Risk Register L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Risk Assessments
SH10	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	Not applicable	1. Outstanding	All Lifts and Lifting equipment are assets on the Estates Asset Register and are on both a PPM schedule for serving with a written scheme of examination/Procedure and where appropriate an Insurance Inspection. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\LOLER. The Estates CAFM system hold the Asset Register and all service reports have the asset number listed and are updated with the Service Report being attached. All remedial works have a follow on Work order to maintain and audit trail. The CAFM system easily identifies any equipment out of date for servicing and also is able to provide an asset replacement schedule. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\LOLER.

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SH10	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The department has a training needs analysis for Estates staff and all training is documented on Planet; the Estates CAFM system and also a Training Matrix spreadsheet stored on a central drive in PDF format accessible by all staff. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Training. Training includes IPAF, Lift Release and PASMA. Local Work Instructions are also produced to enable staff to safely use equipment and avoid hazards. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Risk Assessments. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. Training Attendance Records and Certificates are kept on individual Personnel Files. Training and CPD is discussed during appraisals to enable all employees to contribute positively to their own safety and development.
SH10	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The Trust has a minimum of lifts but they have a number of Evacuation Chairs that can be used to move patients, staff, visitors etc in the case of emergencies or mechanical breakdown. These are regularly serviced and the Fire Officer holds the service reports. Information on safe use of Lifts and safe patient access and egress are in all Fire Evacuation Plans and Fire Risk Assessments. The Department has a Safe Use of Lifting Equipment Management Plan and Business continuity is covered in both the Fire and Workplace Risk Assessments .L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Security. The Trust also has a dedicated Emergency Planning Team dedicated to this work.
SH10	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Trust Policies, Procedures and Management Plans are regularly reviewed and also when any equipment is changed or any significant alterations made. Insurance Inspections are carried out by Contractors and where appropriate any unresolved risks would be added to the Trust's Risk Register
SH10	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Vehicles with Tail Lifts are now leased rather than purchased to ensure costed action plans are produced and expenditure is consistent and ring fenced. Lifts are included in six facet survey were costed action plans and produced. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\6 Facet. Any work requiring escalation would in the first instance be escalated to Estates TAG L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Escalations.
	Capital cost to achieve compliance	£0	£0	
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SH11	**SH11: With regard to Ventilation, Air Conditioning and Refrigeration Systems can the organisation evidence the following?**	Applicable	Applicable	
SH11	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	2. Good	Air Conditioning and refrigeration is serviced according to CIBSE TM44:2007 L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation and Refrigeration and guidance is regularly reviewed and procedures updated accordingly for a Mental Health setting. Ventilation in this instance is pertinent to joinery workshops and podiatry where dust has to be extracted and is covered under Regulation 9 of COSHH.L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation and Refrigeration
SH11	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	2. Good	The Department identifies the relevant AP and CPs which are included in the management structure and their Job Descriptions L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Management Structure and key objectives are discussed during annual appraisals which are now done through the WorkPal system which provides weekly updates of outstanding work or progress to targets.
SH11	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	2. Good	Ventilation is serviced by a contractor who provide service reports and risk based Where a risk is identified that requires additional funding not immediately available, the risk would be added to the Trust Risk Register and a mitigation and safety strategy put into place.L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation and Refrigeration
SH11	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	1. Outstanding	All Air Conditioning and refrigeration assets are tagged and added to the Trust's Asset Register and are serviced according to CIBSE TM44:2007, HTM 03-01 part B and Regulation 9 of COSHH. . L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation via a contract carried out 6 monthly by asset and a service report is uploaded to each asset to maintain a service history. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation and Refrigeration . Ventilation systems are also asset tagged and serviced annually and the service reports identifies HSE Safety Guidance/ Safe Working Practice and COSHH LEV Guidance, recommending any works required utilising a risk based assessment. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation and Refrigeration . AHUs for input and extract are also maintained according to HTM04-01 and serviced and disinfected bi-monthly via a PPM automatically issued from the CAFM system L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation and Refrigeration

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH11	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The department has a training needs analysis for Estates staff and all training is documented on Planet; the Estates CAFM system and also a Training Matrix spreadsheet stored on a central drive in PDF format accessible by all staff L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Training. Training includes Basic Health & Safety Awareness, COSHH, Environmental Awareness, Noise and PPE as servicing is carried out by specialist contractors. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. Training Attendance Records and Certificates are kept on individual Personnel Files. Training and CPD is discussed during appraisals to enable all employees to contribute positively to their own safety and development. Training and CPD is discussed during appraisals to enable all employees to contribute positively to their own safety and development.
SH11	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	As all servicing is carried out by specialist contractors the Department has a Approved Contractors list and the Trust have various framework agreements whereby if the appointed contractor could not carry out the servicing another contractor could be brought straight in. The contracts have emergency call outs, in the event of essential equipment fails repairs can be expedited quickly and effectively. In the case of refrigeration pertaining to vital drugs, the pharmacy department have their own contingencies in place although the department does have a number of small drugs fridge's it can loan out in emergencies.
SH11	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Policies and procedures have review dates but are also reviewed when significant change in a building or occupation occurs. The department works closely with Capital Projects and Minor works to ensure that all new systems or equipment are asset tagged and are included in PPM, Sercing and Insurance Inspections where appropriate. All Service Reports detail any significant findings and recommend follow on works which are reviewed on completion of servicing and a plan produced whether this is to apply for capital funding, carry out the works as a Minor Capital Scheme, Minor Works on In-House repairs.
SH11	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Ventilation reports contain detailed costed action plans L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation and Refrigeration Air Conditioning and Refrigeration reports issues and remedial action required and a quote is then supplied L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Air Con,Ventilation and Refrigeration this would then be checked against the Asset Register for age of equipment and an Purchase Order raised where appropriate and also checked against the Capital Works programme. Where any repair or replacement exceeds available budgets, this would be reported to TAG and if necessary put on the Trust Risk Register. Any risk such as Ventilation Risk and Covid would also be escalated to TAG L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Escalations
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
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SH12	**SH12: With regard to Lifts, Hoists and Conveyance Systems can the organisation evidence the following?**	Applicable	Applicable	
SH12	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	2. Good	In accordance with HTM-08-02 L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\LOLER the Trust has a Management Plan for the use of Lifting Equipment: L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Policies\Lifting Equipment. . All Lifts are identifiable as they are asset tagged and on the Asset Register . Vehicles with Tail Lift are identified as are harnesses and lifting equipment such as Cherry Pickers.
SH12	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	2. Good	The Department identifies the relevant AP and CPs which are included in the management structure and their Job Descriptions L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Management Structure and key objectives are discussed during annual appraisals. Local Work Instructions are produced to ensure everyone known their responsibilities and how to carry out works. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Risk Assessments
SH12	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Not applicable	2. Good	Lifts, including Tail Lifts have an Insurance Inspection where any issues would be highlighted using a traffic light Risk Assessment. Lifts are also serviced and maintained by a Contract at various timescales depending on the nature of the lift (i.e. passenger or goods). Contract are tendered and competencies checked. RAMS are collected for all works undertaken,L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Risk Assessments
SH12	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	Not applicable	1. Outstanding	All Lifts and Lifting equipment are assets on the Estates Asset Register and are on both a PPM schedule for serving and where appropriate an Insurance Inspection. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\LOLER. The Estates CAFM system stores all certificates of conformity and service records.L:\Prop-Serv\Estates Data\Cecilia Crump\2020\Compliance\Loler & Lifts\Lifts. An asset replacement programme can be produced against age of asset and also the history of breakdowns and repairs. The Contracts and PPM specify how the equipment will be serviced, maintained and repaired L:\Prop-Serv\Estates Data\Cecilia Crump\2020\Compliance\Loler & Lifts\Lifts. Quotes for any remedial works are received based on a risk assessment approach and a PO raised with work issued via the CAFM system. Where the quotes exceeds current funding available the risk would be escalated and added to the Trust Risk Register if required.

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
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SH12	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The department has a training needs analysis for In-House staff along with a training matrix and all training is stored o the CAFM system.L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Training. Training includes Lifting & Handling, working at heights etc. Contract are tendered and competencies checked. RAMS are collected for all works undertaken,L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Risk Assessments. All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. Training Attendance Records and Certificates are kept on individual Personnel Files. Training and CPD is discussed during appraisals to enable all employees to contribute positively to their own safety and development.
SH12	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The Trust has a minimum of lifts but they have a number of Evacuation Chairs that can be used to move patients, staff, visitors etc in the case of emergencies or mechanical breakdown. These are regularly serviced and the Fire Officer holds the service reports. Information on safe use of Lifts and safe patient access and egress are in all Fire Evacuation Plans and Fire Risk Assessments. The Department has a Safe Use of Lifting Equipment Management Plan L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Policies\Lifting Equipment . and Business continuity is covered in both the Fire and Workplace Risk Assessments':\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Security. The Trust also has a dedicated Emergency Planning Team dedicated to this work.
SH12	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Policies and procedures have review dates but are also reviewed when significant change in a building or occupation occurs. The department works closely with Capital Projects and Minor works to ensure that all new systems or equipment are asset tagged and are included in PPM, Sercing and Insurance Inspections where appropriate. All Service Reports detail any significant findings and recommend follow on works which are reviewed on completion of servicing and a plan produced whether this is to apply for capital funding, carry out the works as a Minor Capital Scheme, Minor Works on In-House repairs.
SH12	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. A Dedicated member of the Finance Department now sits within the Estates Department to ensure budgets are set and maintained which include investment to deliver un-resolved actions. These are also included in the Estates Strategy Document. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Estates Strategy. Any work requiring escalation would in the first instance be escalated to Estates TAG L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Escalations
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

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SH13	**SH13: With regard to Pressure Systems can the organisation evidence the following?**	Applicable	Applicable	
SH13	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	2. Good	The Trust has a Pressure Systems Management Plan aligned to the Pressure Safety Regulations 2000, The Pressure Equipment Safety Regulations 2016 and the Simple Pressure Vessel Regulations 2016 which would be updated every 3 years or following any significant changes to property or equipment and is monitored by the Admin Manger for review dates using a Monitoring spreadsheet.
SH13	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	2. Good	Individuals are employed with a Job Description, Person Specification and the relevant mechanical training, skills and experience. Authorised Person (Ap) liaises with relevant Trust appointed Insurance Inspectors. An Authorising Engineer (AE) should be appointed from outside the organisation to provide independent services. Annual Appraisals are carried out which list individuals agreed objectives for the period on the WorkPal system which provides weekly status reports.
SH13	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Not applicable	2. Good	Various task specific risk assessments have been carried out for routine work and local work instructions to ensure staff have the relevant information to work safely. Pressure Equipment Regulations 1999 and Systems Safety regulations 2000 are in operation where work on pressure systems is undertaken. Risk Assessments are reviewed and where appropriate risks will be included in the Trust Risk Register
SH13	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	Not applicable	1. Outstanding	The Estates Department hold an Asset Register on their CAFM system; Planet FM which ensures plant and equipment is adequately managed with all service reports / Inspection records being attached to the asset detailing dates of service and who it was carried out by. All work is issued electronically via Planned Preventative Maintenance (PPM) Work Orders and any follow on repairs required are linked to the original Work Order in order to give a full audit trail. All service reports are stored by discipline, site and building on the Department's shared P Drive. so they can be read by all staff that do not have access to Planet. A full PPM schedule is on the Planet software system which contains questions pertinent to the work being carried out to enable a full report to be exported on the quality of work carried out and the condition of the equipment involved. These are reviewed for quality and compliance by the relevant managers/APs. Equipment is carried out by the Trust appointed Contractor and Insurance certificates issued. KPIs are produced weekly with statistical analysis of departmental performance split into individual sites and Trust wide as a whole and also show response times against targets for both Reactive and PPM works. These are stored centrally on P:\Estates Data\Stats 2020.

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SH13	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	Not applicable	2. Good	The department has a training needs analysis for Estates staff and all training is documented on Planet; the Estates CAFM system and also a Training Matrix spreadsheet stored on a central drive in PDF format accessible by all staff . Training includes Basic Health & Safety Awareness, COSHH, Environmental Awareness, Noise and PPE , All work whether reactive or PPM is issued electronically via the Planet system which automatically asks 3 safety questions regarding being adequately trained and having the correct PPE to enable staff input into the own safety and decision making. Hazards and risk are also automatically linked to their Work orders which have to be acknowledge by them prior to starting any work. Training Attendance Records and Certificates are kept on individual Personnel Files. Training and CPD is discussed during appraisals to enable all employees to contribute positively to their own safety and development.
SH13	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The Department have a Resilience, Emergency Planning & Business Continuity Policy and staff responsible for this area of work. The Department produce a monthly Dashboard Report and this is one of the items that is tracked for performance against targets. The department also has a number of Business Continuity Plans which are tested Annually The result of these test are used to assess and update the plans and where appropriate are added to the overall Trust Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT). It is available on the Trust Intranet site . The Trust also utilise the **DATIX** system giving managers the tools to review Incident Data and to learn lessons. • To be able to devise reports in order to analyse information produced • To be able to pull relevant information to identify trends • To identify patterns and trends to identify any areas requiring further action Where appropriate these are added to the Trust's Risk Register which is managed to mitigate the risks and is reviewed by the Executive Management Team (EMT).
SH13	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Policies and procedures have review dates but are also reviewed when significant change in a building or occupation occurs. The Trust Admin Manager has a tracker to alert managers when these need updating. The department works closely with Capital Projects and Minor works to ensure that all new systems or equipment are asset tagged and are included in PPM, Servicing and Insurance Inspections where appropriate. All Service Reports detail any significant findings and recommend follow on works which are reviewed on completion of servicing and a plan produced whether this is to apply for capital funding, carry out the works as a Minor Capital Scheme, Minor Works on In-House repairs.
SH13	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. A Dedicated member of the Finance Department now sits within the Estates Department to ensure budgets are set and maintained which include investment to deliver un-resolved actions. These are also included in the Estates Strategy Document. . Any work requiring escalation would in the first instance be escalated to Estates TAG
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

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SH14	**SH14: With regard to Fire Safety can the organisation evidence the following?**	Applicable	Applicable	
SH14	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	In accordance with the Regulatory Reform (Fire Safety) Order and the Management of Health and Safety at Work and Fire Precautions (Workplace) (Amendment) Regulations 2003 the Trust has a Fire Policy which was approved by the Executive Management Team on 26 March 2020 and is due for review in May 2023. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety. The policy includes the Trust Fire Safety Strategy which identifies relevant Duty Holders. The strategy outlines procedures for fire safety management compliance with the Fire safety Order and NHS Fire code. Fire safety performance is monitored by the Health Safety and Resilience TAG and the Estates TAG. Fire safety maintenance and similar works are only undertaken by specialist approved contractors working in accordance with our control of contractors policies and permit to work systems':\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety
SH14	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	1. Outstanding	The Department has a management structure and the Fire safety management roles are outlined in the Fire Safety Policy.L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety A designated Director is accountable for fire safety and a Fire Safety Manager (Head of Estates and Facilities) is appointed, Fire safety adviser (competent person) and other relevant duty holders are identified. Job descriptions outline general responsibilities. *L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety*
SH14	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Not applicable	2. Good	Fire safety risk assessments in accordance with the requirements of the Regulatory Reform (Fire Safety) Order 2005 have been undertaken for all premises owned or occupied by the Trust and copies have been issued to the responsible local manager.L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety Fire risk assessments are reviewed on a regular basis and amended as required. Minor remedial works identified during inspections are actioned without delay. Any significant upgrading works are included in the minor capitals plan for consideration and approval. The annual statement of fire safety compliance is submitted to EMT in Jan each year.

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SH14	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	Not applicable	1. Outstanding	All fire safety installations including fire alarms, emergency lighting systems, fire doors, access control systems, fire dampers, emergency generators, fire suppression systems , portable fire equipment etc are asset tagged and subject to a planned preventative maintenance programme which is monitored by the Planet electronic ppm system. General maintenance and inspections are undertaken by competent Trust staff. Service contracts are in place with competent external contractors for specialist maintenance of fire safety engineering systems.L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety
SH14	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	Not applicable	2. Good	Continual professional development training for the safety team is included within the annual appraisal plan for each individual, and sufficient resources are provided. Staff fire training is included within the mandatory training programme. Fire training is based on a training needs analysis but all staff are required to undertake training appropriate to their role on an annual basis. Initial first day familiarisation training is undertaken by the line manager, followed by face to face training with a fire adviser as soon as practicable. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety. Fire training is delivered in the workplace supported by e-learning (not for ward based staff). Additional fire warden training, practical training is a dedicated fire training unit, evacuation training (including use of ski pads and evac chairs where applicable) is provided. Fire training attendance is kept under constant review and monitored monthly against a target of 80% Trustwide (95% for ward based staff). Current Trustwide attendance at 1 Oct 2020 is 93.45%. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety. During the Covid pandemic face to face meetings were banned for a period of time and the Trust had to rely solely on e-learning and peer to peer training by colleagues in the same working area.
SH14	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	Fire safety issues are referenced within the Estates and Facilities risk register, Fire safety strategy and local business recovery plans .L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety. Emergency planning is within the same team as fire safety and fire response or evacuation is included in desktop scenarios within the Trust together with inter agency exercises. All reported fire safety related incidents are recorded within the Datix incident reporting systems L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety and are investigated by the fire safety adviser. Incident are formally reported to EMT within the annual Health, safety and resilience report
SH14	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures? (Note 1)	Not applicable	2. Good	Fire related policies and procedures are kept under constant review and updated as required. Fire risk assessments are reviewed annually and minor works are authorised and undertaken without delay. There are no outstanding fire safety compliance requirements at the current time. Any minor actions identified during fire service audits were rectified immediately without the need for intervention. Any major capital expenditure related to improvement of fire safety provision is included within the minor capital schemes, which includes provision for further extending the provision of watermist fire suppression to a further two higher risk mental health wards

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SH14	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Proposals for improvement or upgrades to fire safety provisions within existing Trust buildings are submitted for approval as part of the Annual Minor Capital plan for approval by the Estates TAG via Bid Template and tender document L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Fire Safety Where following inspections or risk assessments, immediate action for replacement of fire systems or remedial work to active or passive fire protection measures is required, costed proposals are submitted for approval via the Head of Estates from the Estates revenue budget. Where appropriate any unresolved issues would be added to the Trust Risk Register. Any work requiring escalation would in the first instance be escalated to Estates TAG
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

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SH15	**SH15: With regard to Medical Devices and Equipment can the organisation evidence the following?**	Applicable	Applicable	
SH15	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	The Trust has an approved Medical Devices, Equipment & Safety Alerts Management Policy which outlines Managing medical devices, including reusable diagnostic and therapeutic equipment, safely and effectively, and acting on safety alerts from external agencies is an essential element of maintaining health and safety. It identifies robust procurement and disposal procedures, asset tagging requirements, decontamination, relocation and servicing needs. All Estates Policies are monitored by the Admin Manager who has a Control Document to monitor and track changes and to alert when updates are required
SH15	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	1. Outstanding	2. All staff have a job description with clear defined Roles and Responsibilities and include a management structure for their department (L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Management Structure). Individuals are assigned and trained as Competent Persons (CP), Authorised Person (Ap) or Authorising Engineer (AE). These are listed on the Estates shared folder (L:\Prop-Serv\Estates Data\Ops Management). Annual Appraisals are carried out which list individuals agreed objectives for the period.
SH15	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	1. Outstanding	The Trust has Guidelines for the use of the Risk Management Framework including the Risk Register and Risk Matrix outlining Duties, roles and responsibilities, Risk reporting mechanism, Risk recording via Datixweb risk assessment record , Updating risks, Escalating risks, Mitigating Risks and Risk Registers. Regular Medical Device and All Equipment Group Meetings where any Safety Alerts or Risks will be discussed and escalated as appropriate
SH15	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	1. Outstanding	All Medical equipment are listed as assets on the Estates Asset Register and are on a PPM schedule for serving with an external NHS EMBE . The Estates CAFM system hold the Asset Register (with EBME also including them on their own CAFM system) and all service reports have the asset number listed and are updated with the Service Report being attached. The CAFM system easily identifies any equipment out of date for servicing and also is able to provide an asset replacement schedule. The Trust utilises the DATIX system to record and monitor safety alerts pertinent to medical devices and these are also discussed during the Medical Devices and All Equipment Group meetings.
SH15	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The Trust has a Learning and development department and all staff have to undertake mandatory training and they have a dedicated Intranet Page. As the maintenance and repair of medical devices is outsourced to an external NHS EBME Department competencies and training are monitored via the Trust RESET system.

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH15	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The Performance and Information Department are responsible for the delivery, maintenance and upkeep of the Trust-wide Clinical Information System In order to ensure the continuation of this service, in the event of a major incident, the Trust has developed the following downtime forms which are used in conjunction with the Performance and Information Department Contingency (Continuation) Plan. •Activity form •Appointments form •Business Continuity Plan •Change of details form Referral form •Downtime registration form •Inpatient admission downtime form •Medical records enquiry form •Medical records procedures •Mental Health Clustering Tool •Patient discharge form •Progress note downtime form
SH15	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Reviews are undertaken in conjunction with the Medical Devices All Equipment Group. Any unacceptable risks would be escalated onto the Trust Risk Register.
SH15	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Medical Devices are listed on the Estates Department's Asset Register and a detailed Asset Replacement Programme is provided to the Medical Devices All Equipment Group.
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

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SH16	**SH16: With regard to Resilience, Emergency and Business Continuity Planning can the organisation evidence the following?**	Applicable	Applicable	
SH16	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	The Trust has in place the following policies and procedures (plans) to comply with the NHSE Standards for Emergency Preparedness, Resilience and Response: •EPRR Policy •Major/Critical Incident Plan – Extended deadline for review due to COVID Incident •Pandemic Influenza Plan •Bomb Threat and Suspect Packages Procedure •Business Continuity Management Procedure •Heatwave Plan •Adverse Weather Plan •HAZMAT Procedure •Lockdown Policy - Link to Evidence
SH16	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	1. Outstanding	The Trust has Job Description and Person Specification which includes organisational chart - Link to Evidence. Key Objectives are agreed during Annual Appraisals using the new Work Pal system which send weekly updates.
SH16	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	2. Good	Risks are reviewed in the E&F Risk Register on a regular basis where mitigation strategies will be developed according to level of risk. Link to Evidence
SH16	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	1. Outstanding	The Trust has an Estates Asset Register and a PPM module with schedule for serving with a written scheme of examination/Procedure and where appropriate an Insurance Inspection. The Estates CAFM system hold the Asset Register and all service reports have the asset number listed and are updated with the Service Report being attached. All remedial works have a follow on Work order to maintain and audit trail. The CAFM system easily identifies any equipment out of date for servicing and also is able to provide an asset replacement schedule
SH16	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The department has a training needs analysis for In-House staff along with a training matrix Link to Evidence Contract are tendered and competencies checked. RAMS are collected for all works undertaken,L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Risk Assessments
SH16	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	Annual assurance for EPRR core standards undertaken. 2019/20 standards attached. 2020/21 did not host new standards due to the COVID pandemic and therefore an assurance against previous action plan was made. The results have been reviewed by Trust Board and have been marked as Substantial Compliance.

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH16	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	The nature of the work undertaken is reactive and any major issue identified is added to the Minor Capital Bid Procedure or put on the Risk Register which is reviewed quarterly with a 'Challenge and Confirm' process via the Trust Board.
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

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SH17	**SH17: With regard to the reporting of safety related issues and actioning of safety related alerts for estates and facilities issues can the organisation evidence the following?**	Applicable	Applicable	
SH17	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	1. Outstanding	The Trust use the DATIX system for reporting, recording and issuing Safety Alerts . This is available via the Trust Intranet site. The Trust has a Datix/Patient Safety Support Team who are responsible for producing, reviewing and updating safety related policies and procedures. Each Service has a Safety Alert Responder who is responsible for cascading alerts to the teams in the service line and collating the responses. The Health & Safety Manager receives all estates related alerts and issues them accordingly as well as being a member of numerous meetings where safety alerts are discussed. Where appropriate these would be reported to RIDDOR following the Trust's Reporting of Injuries Diseases & Dangerous Occurrences Regulations (RIDDOR) Notification Policy and Guidance
SH17	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	1. Outstanding	The Department has a management structure with defined roles which are outlined in Job descriptions and Person Specifications. The Trust has an Appraisal system where objectives are set and review each year and weekly update e-mails are automatically sent and received
SH17	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	1. Outstanding	The Trust has Guidelines for the use of the Risk Management Framework including the Risk Register and Risk Matrix outlining Duties, roles and responsibilities, Risk reporting mechanism, Risk recording via Datixweb risk assessment record , Updating risks, Escalating risks, Mitigating Risks and Risk Registers
SH17	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	1. Outstanding	The Trust has a Health & Safety Risk Assessment Policy & Guidance which clarifies training needs for staff involved in Health and Safety risk assessments and provides information and guidance to all staff on Health & Safety risk assessments. The Estates Department also has a training needs analysis and Matrix which includes Health & Safety Basics and COSHH.
SH17	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	1. Outstanding	The Estates Department has a Risk Assessment Officer who is responsible for undertaking resilience risks, training including Tool Box Talks and the Trust has a Business Continuity Plan template for use by all departments. The Estates Department has a Business Continuity Management Plan which is a management led process which identifies and mitigates risks and disruptions that could affect the capability of the organisation to continue to deliver its prioritised activities during a disruptive incident . Plans are tested on an annual basis and a report produced which list findings, outcomes and actions.

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SH17	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	All Policies and procedures have review dates but are also reviewed when significant change in a building or occupation occurs. The Estates Admin Manager has a control document to manage changes and monitor when reviews and updates are required. Incident reports are reviewed in the appropriate meetings such as the Estates TAG and Action Plans agreed and investigations approved where appropriate
SH17	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. A Dedicated member of the Finance Department now sits within the Estates Department to ensure budgets are set and maintained which include investment to deliver un-resolved actions. These are also included in the Estates Strategy Document. Any work requiring escalation would in the first instance be escalated to Estates TAG
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	
SH18	**SH18: With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services can the organisation evidence the following?**	Applicable	Applicable	
SH18	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	2. Good	The Trust has an Accommodation and Space Allocation Policy which is reviewed annually or following any major changes to premises or equipment. It is monitored for expiry by the Admin Manager via a Policy and Procedure Management spreadsheet. Where services are in buildings not owned by the Trust, a copy of Asbestos Surveys are required and Annual PA Testing to be carried out.
SH18	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	Not applicable	1. Outstanding	The department has a Capital Projects & Estate Planning Manager who is responsible for the Management of tenancy and other contractual arrangements and maintains a properties spreadsheet listing responsibilities within each property. He has a Job Description and Person Specification outlining his roles and Responsibilities, Annual Appraisals are undertaken using the WorkPal system which provides weekly updates on outstanding actions.
SH18	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	2. Good	Risk Assessments such as Fire and Security are carried out in all premises where Trust staff work, whether they are owned by the Trust or not. These would be added to the Trust Risk Register in the same way as any Trust property.

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2019-20	2020-21	Comments
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SH18	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	2. Good	Where Leases specify the Trust carries out maintenance in the same way as any other Trust Premises using the CAFM system and utilising the departments KPI Reports.to monitor response times, outstanding work etc. Where maintenance is carried out by the property owner Trust staff utilises their system for logging repairs and contact the Estates department for support with any on-going issues.
SH18	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	2. Good	The Trust has a Learning and development department and all staff have to undertake mandatory training and they have a dedicated Intranet Page. Estates staff also carry out training according to their profession which is monitored and reported on the departments Training Matrix. Local inductions are carried out in all Non-Trust properties to ensure staff are aware of any procedures such as Fire Evacuation etc.
SH18	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	The Trust has in place the following policies and procedures (plans) to comply with the NHSE Standards for Emergency Preparedness, Resilience and Response whether staff are based in Trust or Non-Trust properties. •EPRR Policy •Major/Critical Incident Plan – Extended deadline for review due to COVID Incident •Pandemic Influenza Plan •Bomb Threat and Suspect Packages Procedure •Business Continuity Management Procedure •Heatwave Plan •Adverse Weather Plan •HAZMAT Procedure •Lockdown Policy - Link to Evidence
SH18	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	2. Good	The department has a Capital Projects & Estate Planning Manager who is responsible for the Management of tenancy and other contractual arrangements and maintains a property Terrier listing responsibilities within each property which are reviewed annually or after any significant change in the property or staff. PA Testing is carried out in Non-Trust Properties as are Fire reports including COSHH and security reports. Where waste is the responsible of the Trust, this is collected and removed in accordance with the Trust Waste Policy. The Trust has Job Description and Person Specification which includes organisational chart -. All are employed with the relevant electrical training, skills and experience and following appropriate training and familiarisation are assigned and trained as Competent Persons (CP) or Authorised Person (Ap). A Authorising Engineer (AE) is appointed from outside the organisation to provide independent services. Annual Appraisals are carried out which list individuals agreed objectives for the period using the new Work Pal system which send weekly updates.

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SH18	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	Costed Action Plans are formulated as part of the six facet survey which are then escalated to relevant committees for funding decisions or for addition to the Trust Risk Register. A Dedicated member of the Finance Department now sits within the Estates Department to ensure budgets are set and maintained which include investment to deliver un-resolved actions. These are also included in the Estates Strategy Document. . Any work requiring escalation would in the first instance be escalated to Estates TAG
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

NHS Premises Assurance Model: Safety Domain (Combined	The organisation provides assurance for Estates, Facilities and its support services that the	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
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SH19	**SH19: With regard to Contractor Management for Soft and Hard FM services can the organisation evidence the following?**	Applicable	Applicable	
SH19	**1: Policy** Does the organisation have a current and approved policy and if applicable, a set of underpinning set of procedures relating to contractor management.	Not applicable	1. Outstanding	Procurement have an Approved Contractors lists and various frameworks where information such as Public Liability Insurance, size of workforce, Company policies etc and pre checked. The Estates Department has a Control of Contractors Policy L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Policies\Contractors which is due for renewal in 2023 and also Contractors General Conditions which are attached to every Contractor Work Order issued L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors identifying how to sign in and out of site, security, Risk Assessments, behaviour etc. The department use the RESET system for contractor management whereby all contractor must be a member of Reset as information on Insurances, Competencies and DBS Checks are pre-vetted and stored ensuring all contractors have the relevant skills to carry out the work. All work has to be pre-planned and a job put on Reset along with a copy of the RAMS.
SH19	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood who are responsible for the management of contractors?	Not applicable	2. Good	2. All staff have a job description with clear defined Roles and Responsibilities and include a management structure for their department (L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Management Structure). Individuals are assigned and trained as Competent Persons (CP), Authorised Person (Ap) or Authorising Engineer (AE). These are listed on the Estates shared folder (L:\Prop-Serv\Estates Data\Ops Management). Annual Appraisals are carried out which list individuals agreed objectives for the period.
SH19	**3: Risk Assessment** Are contractors risk assessments and if applicable, method statements (RAMS) requested from the contractor(s) prior to works commencing and reviewed for their appropriateness?	Not applicable	2. Good	The department use the RESET system for contractor management L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors whereby all contractor must be a member of Reset as information on Insurances, Competencies and DBS Checks are pre-vetted and stored ensuring all contractors have the relevant skills to carry out the work. All work has to be pre-planned and a job put on Reset along with a copy of the RAMS. All Work Orders issued are from the CAFM system which has a Risk Assessment attached on all Work Orders. For Capital Works CDM would be followed where appropriate L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors . Where work does not come under CDM a full tender specification would be written along with Contingency Planning. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors

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SH19	**4: Maintenance** Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services.	Not applicable	2. Good	The Trust has a PPM schedule in place for all of its contractor work which is issued via the CAFM system to ensure a procedure is issued (in-house or SFG20) , General Contractor Conditions and a Dynamic Risk Assessment is attached .L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors. Contractors log in via the RESET system to ensure safety and compliance and that all RAMS are received and agreed. All large contracts are tendered via Procurement to ensure the company has the relevant qualifications and experience and also to specify response times, out of hours working and schedule of rates. All Maintenance Contractors have to provide a Service Report and Invoice to Estates L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors. All Service Reports have to list the Trust's asset numbers and the individual asset will be updated on the CAFM System and the service report attached. A copy is also attached to the Work Order along with a copy of the invoice so all work can be fully audited. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors. Following Capital projects a Post Project Evaluation would be carried out to evaluate work and agree any residual defects and timescales. O&M Manuals are passed to the maintenance department following completion of capital projects. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors To ensure communication there are regular meetings for example the Minor Capital & Estates Project Working Group to ensure In-House communication between departments, Project Meetings between SWYT Project Manager and Contractors (it is up to the Main Contractor to invite any sub contractors if required. All communication goes via the main contractor), Maintenance Meetings etc. Prior to 2020 these would all be face to face but due to Covid many meetings and now carried out on Microsoft Teams allowing a greater flexibility L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors)
SH19	**5. Contractor Competence** With regards to the competence of the contractors - has the organisation checked that contractors are using suitably competent persons to carry out the contracted services?	Not applicable	2. Good	The department use the RESET system for contractor management L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors whereby all contractor must be a member of Reset as information on Insurances, Competencies and DBS Checks are pre-vetted and stored ensuring all contractors have the relevant skills to carry out the work. Contracts that are tendered via Procurement also collect the above including public liability and references.. Work is monitored via the relevant Manager in Estates to ensure compliance against KPI etc. Where work does not meet agreed standards or KPIs Procurement would facilitate a meeting to ensure all concerns are discussed and addressed. If further issues arose, the work would be re-tendered.
SH19	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	2. Good	Where suppliers provide vital systems a Business Continuity and Disaster Recovery plan must be submitted with an annual test taking place.L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		
SH19	**7: Review Process** Is there a robust regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	Not applicable	2. Good	All Trust Policies have a review date and are regularly reviewed especially following a significant change. All Maintenance work is issued via the Estates CAFM system and a Purchase order is raised quoting the PO number prior to the work being issued with the corresponding Service Report and Invoice attached to the Work Order once the work is complete. If Follow on Work is required a quote would be received and a new PO raised with a Follow On Work Order being raised to ensure it is fully auditable. All Servicing and repairs are listed against the asset on the CAFM system to ensure monitoring of repairs and to enable an Asset Replacement Programme to be produced:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors If there are any disputes or concerns the department would meet with the Contractor in the first instance followed if required by Procurement facilitating an official meeting to ensure all concerns are discussed and addressed on both sides. Where performance remains a concerns evidence logs are created. L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Contractors
SH19	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	2. Good	The main meeting for identifying Capital investment is the Estates TAG L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Escalations . Revenue meetings are held monthly between the Head of Estates & Facilities and Finance L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Escalations. This includes budget management and budget setting. Overarching this is the Trust annual planning process which the above meetings feed into. The department have an Estates Strategy L:\Prop-Serv\Estates Data\Compliance.PAM,CQC,Policies\2020\Evidence\Estates Strategy which is used to assess the effect of prior identified investments and achievements against this and used to prepare the strategy for the next period.
	Capital cost to achieve compliance	£0	£0	
	Revenue consequences of achieving compliance	£0	£0	

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 11.5

Title:	**Interim governance arrangements**
Paper prepared by:	Director of Finance and Resources
Purpose:	The purpose of this paper is to provide Trust Board with updates to the interim governance arrangements during the Covid-19 pandemic.
Mission / values:	To ensure that the Trust meets its governance requirements, and to allow the Trust to fulfil with mission and values during the pandemic.
Any background papers / previously considered by:	Trust Board papers – March, April and July 2020, March 2021 Interim Governance arrangements paper circulated separately to executive and non-executive directors. Audit Committee papers – April, July, and October 2020
Executive summary:	Following Trust Board on 31 March 2021 the following outcomes have been achieved since the circulation of the "reducing the burden" letter from Amanda Pritchard in response to the Covid-19 pandemic in January 2021: • The Integrated Performance Report (IPR) has continued to be produced and developed. • The Annual report and accounts have been produced. A two-week extension was required from NHS England / Improvement (NHSEI) to enable the process to be completed. • The effectiveness review of Trust Board Committees has taken place to inform the 2020/21 Annual Governance Statement. • Trust Board and Members' Council agendas have continued in line with workplans. • Committee chairs and lead executives have reviewed work plans and agendas until the end of June 2021 to determine if they can resume to normal business. • There have been significant updates made to both the Board Assurance Framework and Organisational Risk Register in line with internal audit recommendations. • Committees have updated any deferred items on workplans for audit purposes. • Internal auditors provided a Head of Internal Audit Opinion of Significant Assurance at Audit Committee on 18 June 2021. • Ongoing work with West Yorkshire provider collaboratives continued in line with national guidance. The Adult Secure Lead Provider go-live date is now 1 July 2021 with a final business case being submitted to Board in June 2021. • In May 2021 the DHSC reported that the deadline for the Quality Account would not be extended and submission is required by 30th June 2021. It was agreed that should Trusts be unable to meet this deadline, no penalties would be incurred. At Trust Board in May it was agreed to submit the Quality Account in August 2021 to allow time for the report to be produced, go through our internal

	governance framework, and provide sufficient time to consult with stakeholders. In May 2021 in response to the decline of the pandemic, the Command Structure was stood down with some duties being delegated continue through the Organisational Management Group. A review of governance arrangements is to take place at the start of July 2021. **Risk appetite** The Trust has a declared risk appetite for compliance risks to score 1-6. It is considered the processes in place mean the Trust is operating within its risk appetite for this issue.
Recommendation:	**Trust Board is asked to NOTE the update to the interim governance arrangements as outlined in the paper.**
Private session:	Not applicable.

Interim Governance Arrangements Update

Introduction

The purpose of this paper is to update Trust Board on the interim governance arrangements during the Covid-19 pandemic. Initially these plans were required for the three to six months from March 2020 onwards. Other papers previously provided on this subject for reference are:

- Trust Board – March, April and July 2020, March 2021.
- Non-Executive Meeting – 3 April 2020.
- Audit Committee – April, July and October 2020.

The arrangements agreed during the above periods of time are not covered by this paper. The focus is on any updates and current arrangements.

It is noted that Board and Committee meetings continue to be held virtually whilst social distancing guidance remains in force.

During the course of the year the agendas and work plans for committees returned to something approaching normal and this continues to be the position.

2021 Update

Following the increase in prevalence of Covid-19 in Winter Amanda Pritchard, Chief Operating Officer of NHS England wrote to all NHS trusts in January 2021 asking them to reduce the burden and release capacity to manage the response to the Covid-19 pandemic.

On 29 January 2021, the Trust Chair, Chief Executive, Director of Finance and Resources and chair of the Audit Committee met to discuss the content of the communication.

A number of outcomes were agreed and presented to Trust Board on 30 March 2021.

Updates since the March 2021 Board meeting:

- The Integrated Performance Report (IPR) has continued to be produced and developed.
- The annual report and accounts have been produced. An extension of up to two weeks was required from NHS England / Improvement (NHSEI) to enable the process to be completed. This was required given the complexities of the financial arrangements during the year and associated with conducting the full audit remotely
- The effectiveness review of Trust Board Committees has taken place to inform the 2020/21 Annual Governance Statement.
- Trust Board and Members' Council agendas have continued in line with workplans.
- Committee chairs and lead executives have regularly reviewed work plans and agendas to determine they remain appropriate and enable focus on the Covid-19 response
- Updates have been made to both the Board Assurance Framework and Organisational Risk Register in line with internal audit recommendations.

- Committees have updated any deferred items on workplans for audit purposes.
- Internal auditors provided a Head of Internal Audit Opinion of Significant Assurance for 2020/21 at the Audit Committee on 18 June 2021.
- Ongoing work with West Yorkshire provider collaboratives continued in line with national guidance. The Adult Secure Lead Provider go-live date is now 1 August 2021 with a final business case being submitted to Board in July 2021.
- Committee membership has been updated to account for leadership changes

Trust Board
Following the initial outbreak of the pandemic in 2020, Trust Board agendas were temporarily reduced during the initial outbreak of the pandemic dealing with Covid-19 business as a priority during this time.

In June 2020 Trust Board returned to a full agenda and these were agreed by the Chair and Chief Executive.

Trust Board meetings continued to take place virtually with plans being put in place to enable members of staff and the public to listen to the meetings and submit questions at the end of the meeting.

Minutes and papers continue to be provided on the Trust's website. The referenced 'emergency powers and urgent decisions' process referred to in the March board paper, has not been used to date.

Delegated authority was agreed at the May Board to allow the Chief Executive and Chair to approve the final annual report and accounts in order to allow submission to parliament in a timely manner.

From February 2021 Trust Board agendas considered executive director capacity and the statutory responsibilities of the Board. The Trust Board workplan has been updated to show any deferred items for monitoring purposes. The Trust Board workplan is currently being realigned to ensure it reflects the strategic risks set out in the Board Assurance Framework.

Clinical Governance & Clinical Safety (CGCS) Committee
At the start of the pandemic national guidance stated there was an expectation that Quality Committees would continue to meet. The chair and lead director of the Committee discussed how the Committee would operate during this period.

The frequency remained as originally planned and meetings were scheduled to last a maximum of two hours. The agenda sections remained the same with the clinical risk section focusing on Covid-19.

The Committee continued to receive assurance through the first wave of the pandemic. Reports continued to be received and in September 2020 there was a full return to normal Committee function.

In January 2021 the "releasing the burden" letter from NHSE/I reported the Quality Account preparation deadline is 30 June 2021. The Department of Health and Social Care was reviewing whether regulations should be amended to extend this deadline.

In March 2021 the NHS foundation trust annual reporting manual 2020/21 reiterated the above message and the Trust received a communication from NHS Providers which also indicated the timing of the Quality Account report was likely to be delayed.

Therefore, given the continuing priorities associated with the Covid-19 pandemic including the vaccination programme the Trust quality account report was not prioritised for immediate action.

The DHSC provided updated guidance on expectations in relation to the quality account for 2021 on 4th May 2021, when it was reaffirmed that the Quality Account submission date would remain at 30th June 2021. Trust Board agreed a process for submission of the Quality account for 2020/21 by August at its May Board meeting. This will enable it to go through our internal governance framework and provide sufficient time to consult with stakeholders. It is understood flexibility exists with no penalties envisaged.

Verbal reports have been taken to the Committee where necessary and minutes continued to be taken in the meeting to record items discussed. Attendees were asked to read papers in advance and workplan monitoring will take place at Committee meetings as part of the agenda. The workplan was amended and deferred items noted for monitoring purposes.

Audit Committee

During 2020 the Audit Committee operated with largely the same agenda as the work plan.

On 5 January 2021, the Audit Committee went ahead with a full agenda and an update was provided to Trust Board on 29 January 2021.

The Director of Finance and Resources agreed timescales and the agenda for the year-end Audit Committee with the Committee Chair and both the Chief Executive and Trust Chair to enable the Audit Committee to recommend the annual accounts and report for approval in line with Trust Standing Financial Instructions and Committee terms of reference.

The external audit has been conducted remotely in its entirety. On 18th June 2021 the Audit Committee met to recommend approval of the year-end accounting and reporting requirements. The submission will be made to NHSE&I before 29th June 2021. The external auditor's certificate will not be received until September 2021. This is in order to complete the "value for money" work which is new for this year. On receipt of the auditor's certificate the annual report and accounts can be laid before Parliament and then presented to the Annual Members Meeting scheduled for October 2021.

Audit Committee agendas have in the main, remained as business as usual with few items being deferred or taken verbally.

Finance, Investment & Performance (FIP) Committee

There continued to be a range of financial governance and reporting requirements during the first wave of the Covid-19 pandemic. In April and July 2020 there were also notable changes in terms of the financial and contracting arrangements. Other than these a number of the existing agenda items were deferred.

Frequency of meetings remained as planned.

Meeting frequency and agendas are regularly discussed by the Chair of the Committee and Director of Finance & Resources. Focus has been applied to performance and benchmarking reporting in recent months.

Workforce & Remuneration Committee

In 2020, the chair and lead director of the Committee discussed and recommended that operation of this Committee would be suspended during the initial part of the Covid-19 outbreak. Given the more regular frequency of Trust Board meetings coupled with the fact all Board members are very interested in the impact of the pandemic on the workforce it was agreed the Board would be the most appropriate forum to review workforce issues during this period of time. This approach ensured any duplication was reduced as far as possible. Clear focus was applied to staff wellbeing, attendance and Covid-19 testing.

Committee meetings took place in January and February 2021 with a focus on the vaccination programme and associated risks, the workforce strategy update and Committee allocated risks.

The Committee has streamlined its agenda and papers using a presentational format. The Committee's focus has been on the impact of the Covid-19 pandemic, the health and wellbeing of staff and maintaining key business items. The workplan has been reviewed and any deferred items have been logged. Meetings continued to take place bi-monthly and were flexible around timing of papers, however, the meeting agenda, actions and minutes were sent out within normal timescales.

Mental Health Act Committee

The chair and lead director of the committee discussed and agreed the following approach:

- The meeting and agenda were to be significantly shorter than usual with a maximum of one hour anticipated, with many items deferred or cancelled.
- The only agenda items to be taken were specific to Covid-19.
- There are currently no external attendees e.g. local authority, acute trust colleagues, hospital managers, although they are able to submit questions in advance (related to Covid-19).
- Associate hospital managers will be asked for feedback on problems / challenges in advance and this will be an agenda item.
- Only two executive directors need to attend (for quoracy).

In January 2021 the chair, lead director and assistant director of legal services agreed the following measures for the Committee until June 2021:

- Maintain virtual meetings until June 2021.
- Maintain two-hour meetings with a view to returning to 2.5hrs in August 2021, or before if capacity allows.
- Verbal updates to be received rather than written papers wherever possible

In relation to external partners, Local Authority & acute colleagues and hospital managers will continue to be invited to attend but can submit written feedback via a proforma if they prefer.

Items agreed to be deferred or cancelled until Autumn 2021 include:

- Act in Practice presentation to be deferred or provided by Yvonne French / Julie Carr.
- Mandatory training update (included in performance report).
- Trust-wide CQC improvement plan (CQC MHA visits updates will continue).
- Audits.
- Policies (noting what has been agreed at EMT).

Any workplan changes have been recorded for audit purposes and deferred items logged as per previous practice during Covid-19 waves. Tracked changes denote changes to the plan

and a column references Covid-19 deferred items and the dates when will return to the Committee for review.

Equality & Inclusion Committee

During the first wave of the pandemic the Committee continued to meet with a reduced agenda. On 22 September 2020, the Committee returned to a standard agenda and meeting times.

In 2021, the Committee returned to a reduced agenda with shorter meetings. Focus has been on staff networks, business delivery unit (BDU) equality forums and service user / carer feedback. Verbal reports have been taken where appropriate and further review will take place in June 2021.

Any items deferred as a result of Covid-19 were logged on the workplan in line with previous practice during the first wave of the pandemic.

The Committee has also continued to focus on equality and inclusion in relation to Covid-19 and in particular the risk of the disproportionate effect of Covid-19 on service users with protected characteristics.

Charitable Funds Committee

Similarly, to other committees, the chair and lead director reviewed frequency and agendas for these meetings. It was agreed to keep the existing planned meetings in place, but to operate with a shortened agenda, with several items deferred until later in the year.

In January 2021 the chair and lead executive streamlined the Committee agenda and workplan to reflect the current circumstances. These continue to be monitored at each agenda setting meeting.

West Yorkshire Mental Health Collaborative Committees in Common

The Committee continued to meet with a reduced agenda and attendance during the first wave of the pandemic. It focussed on workstream status, provider collaboratives and wider work being undertaken across the collaborative during the Covid-19 period, and business continuity.

The January 2021 Committee meeting was shortened due to the pandemic response. The decision was taken to postpone a strategic workshop planned for February to reduce the burden.

The refreshed Memorandum of Understanding was reviewed and was circulated to Trust Board in March 2021. The Committee continues to focus on the delivery of collaborative programmes of work across the system.

Members' Council

The Chair and corporate governance team keep in regular contact with all governors and provide them with updates, through the monthly Brief, weekly Headlines and Coronavirus update, weekly View, and monthly live Q&A sessions on Teams with the Chair and Chief Executive.

The Member's Council in January 2021 proceeded with a full agenda. The Members' Council in May 2021 had a slightly reduced agenda, but due to the number essential items required for sign off a full meeting took place. Any items deferred as a result of Covid-19 have been logged on the workplan.

The Members' Council elections began on 11 January 2021 and continued as planned. The outcome has been the appointment of seven new governors and one re-appointed governor.

Command Structure

Silver command has senior manager representation across the Trust and in the first peak of the pandemic met daily. During the weekend an update call by exception also took place each day at the same time.

In January 2021 a Bronze Command for the vaccination programme was established, this group meets three times per week and supporting task and finish Groups once per week.

Two other Bronze groups h continued throughout, testing and PPE. These have now been stood down.

In December 2020 a Workforce Bronze was established.

Gold command largely consists of EMT members plus the Deputy Director of Nursing and Head of Estates & Facilities Management.

Standard on call arrangements are in place for evenings and weekends.

This command structure receives instruction and / or guidance from regional and national bodies to determine what action needed to be taken. Actions are escalated where required and are logged for information, ratification or approval on a weekly basis.

As described above, Silver Command has been part of the command structure to oversee our response to Covid-19. Given that we are now taking steps to move towards the current situation being nearer to usual business, silver has taken the opportunity to review which topics continue to be discussed in Silver Command, and which might be better held in the Operational Management Group (OMG).

This following was agreed from March 2021:

Agenda item	Suggestion
IP&C / Clinical cases	Retain in Silver Command
Bronze Staff Testing Update (Wed, feedback to Gold Thurs)	Retain in Silver Command
Gold feedback	Retain in Silver Command
Bronze Covid 19 Vaccination Programme Update	Retain in Silver Command
Workforce & staffing bronze (Wed)	Move to business as usual, overseen by OMG
Bronze EU Exit Update	Retain in Silver Command
Cohorting Task and Finish Group (Friday)	Move to business as usual, overseen by OMG
New guidance/SPOC Update Directorate of NQ&P	Retain in Silver Command
Decision & Action Log	Retain in Silver Command
Equality and inclusion	To mirror in OMG
OPEL level update	Retain in Silver Command

Communications	Retain in Silver Command
Escalations to Gold	Retain in Silver Command

In May 2021 in response to the decline of the pandemic, the Command Structure was stood down with some duties being delegated and continuing through the Organisational Management Group and Executive Management Team.

Rapid Decision-Making
In the first wave of the pandemic a paper was shared with executive directors, non-executive directors and the Audit Committee which outlined a process to enable decisions to support the response to Covid-19 to be made rapidly.

The process involved the use of a senior internal group reviewing required decisions on a weekly basis and either agreeing or making a recommendation. All such decisions were logged and forwarded on to the Chief Executive and non-executive directors within twenty-four hours.

Weekly meetings in which the director of finance provided an update on governance decisions to non-executive directors, and if required sought approval or ratification have now been stood down, with the option to reintroduce if required.

External Guidance
Approaches being taken by other trusts have been shared and considered with guidance from a number of sources being taken e.g. NHS Providers.

Summary and Recommendation
Interim governance arrangements have been in operation since the onset of the pandemic, which have been summarised in this paper.

Trust Board and Committees will now review their agenda's as part of reset and recovery.

Trust Board is asked to note the update to the interim governance arrangements as outlined in the paper.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 11.6

Title:	**Committee Membership changes for 2021/22**
Paper prepared by:	Chair
Purpose:	The purpose of this paper is: To provide assurance to Trust Board that following changes to Board membership, its committees operate effectively and meet the requirements of their terms of reference.
Mission / values:	A strong and effective Board and committee structure enables the Trust to achieve its vision and goals and maintain a sustainable and viable organisation.
Any background papers / previously considered by:	The proposals for each committee were considered at the following meetings: • Executive Management Team on the 17th June 2021
Executive summary:	Trust Board committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. Following the agreement for Mark Brooks to be interim Chief Executive while Rob Webster is on secondment to the West Yorkshire and Harrogate Health Care Partnership, the chair is proposing the revised memberships of the Board committees as per the attached document from 5th July 2021 to 1 August 2021. A further paper will be presented to Trust Board at the July meeting to reflect further changes to Committees from 1 August 2021. On agreement by Trust Board, Committee Terms of Reference will be updated to reflect the changes in membership. **Risk Appetite** The committees are fulfilling their terms of reference; and integration between committees avoids duplication.
Recommendation:	**Trust Board is asked to:** • **APPROVE the update to the Membership for the:** ○ **Audit Committee;** ○ **Workforce and Remuneration Committee;** ○ **Equality and Inclusion Committee;** ○ **Finance, Investment & Performance Committee**
Private session:	Not applicable.

With **all of us** in mind.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board and Corporate Trustee committee membership
(from 5 July 2021)

	Audit Committee	Clinical Governance & Clinical Safety Committee	Equality & Inclusion Committee	Mental Health Act Committee	Workforce & Remuneration Committee	WYMHLDASC Committees in Common	Finance, Investment & Performance Committee	Charitable Funds Committee (committee of the Corporate Trustee)
Angela Monaghan		Member	**Chair**		Member	Member		Member
Natalie McMillan		**Chair**			Member		Attends	
Mike Ford	**Chair**		Member					Member
Chris Jones	Member		Member				**Chair**	
Erfana Mahmood			Member	Member				**Chair**
Kate Quail		Member		**Chair**			Member	
Samantha Young	Member				**Chair**		Member	
Interim Director of Finance	Attends **(LD)**						Member **(LD)**	
Tim Breedon		Member **(LD)**		Member			Member	
Dr Subha Thiyagesh		Member		Member **(LD)**			-	
Mark Brooks			Member		Member (NV)	Member **(LD)**	Member	
Alan Davis		Member	Member		Attends **(LD)**			
Carol Harris		Attends		Member			Attends	
Sean Rayner								Member
Salma Yasmeen			Member **(LD)**					Member **(LD)**
Andy Lister	Attends							
QUORUM	**2 NEDs**	**2 NEDs, LD & 1 ED**	**1/2 Members inc. 1 NED & 1 ED**	**2 NEDs, LD & 1 ED**	**2 NEDs**	**1 Member**	**2 NEDs & 2 EDs**	**3 Members**

Non-Executive Director (NED)
Executive Director
Executive Director (non-voting)
Company Secretary
LD Lead Director
NV Non-voting committee member

WYMHLDA SC – West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative

Members' Council, ICS/ICP and other Trust Board roles

NHS
South West Yorkshire Partnership
NHS Foundation Trust

	Members' Council	Members' Council Coordination Group	Members' Council Quality Group	Nominations' Committee	ICS/ICP and Other Trust Board Roles *(ICS/ICP roles shown in italics)*
Angela Monaghan	**Chair**	Member		**Chair**	*WYHHCP Partnership Board; SYBICS Collaborative Partnership Board; Barnsley Integrated Care Partnership Group; SYB MHLDA Alliance; WYH Climate Change Steering Group;*
Natalie McMillan	Attends				Patient Safety;
Mike Ford	Attends				
Chris Jones	Attends	Member			Deputy Chair; Senior Independent Director; FTSUG Lead; MHPS investigations
Erfana Mahmood	Attends				
Kate Quail	Attends				
Samantha Young	Attends				Staff Wellbeing Lead
Interim Director of Finance	Attends				
Tim Breedon	Attends		**Chair**		
Dr Subha Thiyagesh	Attends				
Mark Brooks	Attends			Attends	
Alan Davis	Attends			Attends	
Carol Harris	Attends				
Sean Rayner	Attends				
Salma Yasmeen	Attends				
Andy Lister	Attends	Attends		Attends	

Non-Executive Director (NED)
Executive Director
Executive Director (non-voting)
Company Secretary

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021
Agenda item 12 – Assurance from Trust Board Committees

Audit Committee

Date	18 June 2021
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• External audit report (ISA 260) for 2020/21 received. The Trust has received an unqualified opinion. Some recommendations received which management is reviewing • The annual accounts and annual report have been recommended by the Audit Committee for approval • The head of Internal Audit Opinion provided significant assurance and the annual internal audit report was received
Approved Minutes of previous meeting/s for receiving	Minutes to follow.

Clinical Governance & Clinical Safety Committee

Date	8 June 2021
Presented by	Natalie McMillan Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Alert:** • CAMHS: Youth Offender Institutions (YOI) continue to raise concern around seclusion and the need to raise awareness • CAMHS: Risk to escalate that the Tier 4 provision is not expected to increase overall and instead it is a redistribution of the existing provision. • Continue to note the significant risk around ADHD/ADS commissioning and delays • FIP asked to undertake analysis of the increase in activity at SPA to understand the causes. • FIP undertaking analysis of the Barnsley Community Services with increased demand and long waiters **Advise:** • Safer Staffing remains an ongoing area to develop effective metrics and data to give the level of assurance or understand the risks. This is one of the quality priorities and remains on the workplan of this committee. • Infection Prevention & Control Annual Report to be received at the Assurance Session **Assure:** • The progress and improvements delivered by the Drug and Alcohol team were acknowledged and the team were thanked for their hard work and achievements. • The Annual Incident report was received: • Quality Improvement Strategy timescale of 12 months supported and agreed

	• Clinical Audit and Service Effectiveness (CASE) Annual Plan 2021/22 approved
Approved Minutes of previous meeting/s for receiving	Minutes of 6th April 2021 attached.

Equality, Inclusion & Involvement Committee

Date	1 June 2021
Presented by	Angela Monaghan, Chair (Chair of Committee)

Key items to raise at Trust Board	• Reviewed the corporate, organisational-level risks assigned to this committee
	• Received the first insight report. This will be received quarterly and will provide a high-level account of all the feedback the Trust has received from various sources, plus themes and actions arising. To support this, the engagement team has set up a dedicated inbox involvingpeople@swyt.nhs.uk.
	• Reviewed the film and easy-read version of the Equality, Involvement, Communication and Membership Strategy.
	• Received performance reports on:
	  ○ the urgent actions to address 8 inequalities in NHS provision and outcomes;
	  ○ the equality and involvement action plan (exception and highlight report); and
	  ○ a presentation from the business intelligence team on the new datasets now available for reporting on population health inequalities against protected characteristics, which will be used to populate the performance dashboard.
	• Discussed progress against our WRES (workforce race equality standards) and WDES (workforce disability standards) plans.

Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 2 March attached. Item 3 Minutes 2 March 2021 AM TB1!

Finance, Investment & Performance Committee

Date	24 May 2021 and 28 June 2021
Presented by	Chris Jones, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Inpatient wards and staffing – good assurance on how data is being used • Adult secure lead provider collaborative – a shortfall in funding remains and discussions continue with the regional commissioner • CAMHS lead provider – recommendation is to proceed with some feedback to the lead provider on areas for further detail and strengthening to be provided. • Recognise reduction in risk relating to cash • Note the increased usage of out of area bed placements and the national expectation that usage will reduce to zero by the end of Q2.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting are to follow.

Mental Health Act Committee

Date	11 May 2021
Presented by	Kate Quail, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Advise:** • No new issues idWorkplan identifies ongoing audit and compliance issues **Assure:** 1. Act in Practice – 'Caring for people with eating disorders within acute hospitals'. Very helpful input from Lisa Kelly, Clinical Lead, SWYPFT Mental Health Liaison Team, Calderdale/Kirklees, whose team works very closely with Acute Trust staff, supporting them to provide complex care and treatment to often very dangerously ill people with extreme eating disorders. Our team also work closely with the Leeds-based CONNECT Team and their consultant, who provides additional support to our consultant Dr Ashar. Committee heard that the passion and commitment conveyed by Lisa is shared by the whole team. There has been an increase in young people with eating disorders detained under the Mental Health Act, who are being detained to the acute hospitals. Julie Carr and the MHA Team support both the Mental Health Liaison Team and and the acute trust staff. 2. Committee received 3 Audit and Compliance Reports MHAC agreed that given the improvement shown and the maintained high compliance rate for each of these issues, ongoing assurance will be provided in the quarterly Performance Report to MHAC, with any exceptions being noted and associated assurances provided, rather than carrying out a separate annual audit for each of them, as has been done historically. 1. S17 leave forms • Some deterioration in the completion of page 2 of S17 Leave form as responsibility for monitoring their completion returns from the MHA Team to ward staff. • MHAC gained assurance that appropriate action has been taken and planned. • NB Noted however the huge improvement in Forensics (44% last year, now 7%) - huge thanks given for all their hard work. 2. Consent to Treatment Compliance • Improvement since previous audits. Report accepted by MHAC as assurance of compliance with use of correct statutory T form and prescribing consistent with the authorised treatment. • In preparation for the resumption of CQC scrutiny of consent to treatment records and the identified themes raised by CQC, it was agreed that a QI style approach be used to address the report's recommendations. • Noted the positive involvement of pharmacy colleagues in the wards and the impact of the new Electronic Prescribing and Medicines Administration (EPMA) in strengthening governance arrangements. 3. Audit on S17 cancellation of escorted leave • Noted that QI work has resulted in reduction of cancellations to 53 (63 last year) and an overall small number pf cancellations. Praise for staff achievement, especially during Covid restrictions.

	• Most cancellations were in Forensics (34) particularly Priestly ward (which had 17 of the 34), and in Specialist Services (9). 3. Care Quality Commission Visits (MHA 1983), actions & updates. Continue to find issues with care planning and individual risk assessments, both of which are being addressed by Trust-wide work. All actions or recurring themes have an action plan or workstream addressing them. Advocacy being addressed by the MHA Code of Practice Group **Risks discussed:** • S17 leave forms – completion of page 2 • Consent to Treatment Compliance - T forms and prescribing consistent with the authorised treatment. • Audit on S17 cancellation of escorted leave
Approved Minutes of previous meeting/s for receiving	Minutes of 9th March attached.

Workforce & Remuneration Committee

Date	18 May 2021
Presented by	Sam Young, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Consideration of the Trust Board succession planning paper. The rest of the agenda items have been deferred to the next meeting on the 20th July.
Approved Minutes of previous meeting/s for receiving	The draft minutes will also be discussed at that meeting.

West Yorkshire Mental Health Services Collaborative Committees in Common

Date	1 June 2021
Presented by	Angela Monaghan, Chair.
Key items to raise at Trust Board	• Verbal update to be given at meeting.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held in April attached.

Members' Council

Date	11 May 2021
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	• Approval of Non-Executive Director Erfana Mahmood's re-appointment • Received the outcome of the Members Council elections • Agreed the updated Audit Committee Terms of Reference • Approved the Updated Scheme of Delegation • Approved the Members Council Declaration of Interests policy

	• Private discussion around the Chairs appraisal • 7 newly-elected governors (3 staff and 4 public) were welcomed to their first meeting following the 2021 elections. • Non-executive director, Erfana Mahmood, was reappointed for another 3 years. • Members' Council agreed an improved approach to governor training and development. • Changes to the Trust's scheme of delegation were approved; and governors approved an updated Members' Council Declaration of Interests Policy. • Presentations were received on current Trust performance and an update on our CQC action plan and inspection annual report unannounced/planned visits. • In a private session, governors discussed the Chair's annual appraisal.
Approved Minutes of previous meeting/s for receiving	Minutes of 29th January 2021 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 6 April 2021
Via MS Teams
(COVID -19)

Present:	Angela Monaghan (AM)	Chair of the Trust
	Charlotte Dyson (CD)	Non-Executive Director (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*)
	Carol Harris (CH)	Director of Operations
In attendance:	Darryl Thompson (DT)	Deputy Director of Nursing and Quality
	Sarah Harrison (SH)	PA to Director of Nursing and Quality (author)
	Nick Phillips (NP)	Head of Estates & Facilities (deputising for Alan Davis)
Apologies:	Sue Barton (SB)	Deputy Director of Strategy and Change
	Yvonne French (YF)	Assistant Director of Legal Services
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Dr Subha Thiyagesh (SThi)	Medical Director

CG/21/31 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting and advised that due to the pandemic, these meetings would continue to be held via Microsoft Teams until further notice. The revised agenda was also acknowledged due to Covid-19 and that due notice had been given for the preparation of the papers. It was noted that the meeting was quorate and would be recorded for note taking purposes. The Committee agreed. The Committee wanted to thank those who had prepared papers given the current pressures.

Tim Breedon (TB) suggested that as Alan Davis (AGD) and Subha Thiyagesh (SThi) were both absent from the meeting, if any major decisions needed to be made, a further discussion could be arranged after the Committee meeting.

CG/21/32 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 2021 or subsequently.

CG/21/33 Minutes of previous meeting held on 9 February 2021 (agenda item 3)

Darryl Thompson (DT) noted an action that referred to a timeline linked to FIRM however this was in relation to the safecare implementation. This will be amended in the action log. Angela Monaghan (AM) also noted at the bottom of page 3 on the notes, an action in

relation to the CQC improvement plan that needs to be included and DT confirmed that this would be picked up today.

Otherwise notes approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the meeting held on 9 February 2021.

CG/21/34 Matters Arising (agenda item 4)

The Committee discussed and noted the completed actions and updated the action log accordingly.

CG/21/05 - Organisational risk register. In relation to Risk ID 1522 and 1530 CD requested an update from EMT discussions on the risk of long-covid and new variants on staff and patients.
TB advised that the executive trio had discussed both items on the action log in relation to the risk and agreed that more clarity was needed around the impact of long-covid before a description can be given to the risk and the same for the variants. TB confirmed that this was logged as an emergent risk andthat a proposal will be developed at the next trio meeting.

AM raised a query in relation to the Integrated Performance Report (IPR) where there was a comment in relation to inpatient service users who tested positive and the number who had recovered there was a discrepancy of around 14 where there was no statement of what had happened to them. AM would like clarity on this. TB explained that this is more likely to be as a result of transfer to another trust or discharge rather than long-covid. DT will obtain the information. TB also confirmed that this information should be included in the IPR.

Action: DT

CG/21/07 – CQC Improvement Plan – Carol Harris (CH) confirmed discussions are taking place with Commissioners in relation to psychological services and that this does not need to be escalated at the moment. CH confirmed that they are looking at an interim solution of using community psychology for enrichment as is done for adult inpatients and also the staffing models as part of the older people's strategy work. CH informed the committee that Chris Lennox was keen to point out that Calderdale starts from a lower base in terms of investment into psychology, but discussions are positive with commissioners in relation to achieving the right staffing models. CH noted that the team are reluctant to change this risk from red until they are confident that the issues have been addressed. An update is already scheduled for the next meeting in June 2021.

CG/21/09 – Waiting List Improvement Plan - Complete

CG/21/18 Serious Incident Quarterly Report Q3 – Action will be amended to note safe care implementation.

CG20/140 CAMHS – To be addressed later in the agenda.

CG/20/103 QIA – Update to June meeting.

CG20/114 Smoking Policy - The Committee would like to keep sight of this and asked for an update to come back. TB and CD will discuss at agenda planning.

Action: SThi / TB / CD

TB will check the QUIT Programme funding action as this is possibly now complete. AM noted that her understanding from Trust Board was that the Trust is included in the programme.

Action:TB

CG/21/35 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance and Clinical Safety Committee (agenda item 5)

TB gave a brief update to the Committee and noted that the risks had already been discussed at Board however there were some specific areas for the Committee to note.

1. Long covid risk is under consideration (as referenced at CG/21/05 above)
2. Vaccination programme – consider the uptake as programme develops.
3. Committee to note new RISK 1568 – Seclusion risk around inability to have seclusion rooms available due to damage.
4. Covid related risk section. TB noted some areas where risk and impact have reduced e.g. PPE, however no ratings will be changed at this point.

AM noted that this is a comprehensive report as always but queried RISK ID 1530, increase in demand for services. AM queried if the Trust have the right measures in place to enable it to see increases in demand across all services and if the right data is available. TB noted that all referral levels are shown in the monthly IPR and CH informed the committee that data can change very quickly. CD requested that this should be discussed later under the IPR agenda item.

Kate Quail (KQ) asked in relation to delays, whether CAMHS funding could pose a risk to recruitment and if this reflected adequately in the risk register. It was agreed to discuss this further at the CAMHS item.

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/21/36 Quality Accounts (agenda item 6)

TB informed the Committee that the Trust is anticipating the same process as last year and that submission will be in December 2021, however formal confirmation is still awaited. The Trust will undertake the same approach as last year with a revised content and aim for September submission to Board.

The Committee NOTED the update of the Quality Account.

CG/21/37 Transformation & Priority Programme Update (agenda item7)

The chair confirmed that this report will be taken as read.

TB advised the Committee that the next phase will focus on recovery and restoration ensuring that the appropriate systems and processes are in place. TB explained that the committee needs to be aware of the impact of any proposals and thus the outcome of the

EQIA and QIA reviews becomes crucial. Future reports should focus upon areas where quality impact raises any concerns.

Action: TB to brief SB

CG/21/38 Care Quality Commission Improvement Plan (agenda item 8)

DT gave a brief update to the Committee.

As the majority of the plan is now complete, the Trust recommendations for outstanding actions going forward are:

- The majority of the improvement plan is formally closed.
- Provision of progress reports on care planning and risk assessment to be provided to CGCS in July, Sept & Nov 2021. Then to be reviewed.
- Suitable psychology provision on our older people's wards – to be overseen by Deputy District Director for inpatients and reported into OMG or EMT.
- QIAT to develop a plan to monitor assurance against the completed key actions to make sure the Trust sustain improvement. This will include performance measures reporting, quality monitoring visits and use of existing quality data / information.

DT went on to inform the committee that the focus is on CQC improvement would be around care planning and risk assessment going forward. There is a new dashboard to inform whether risk assessments have been completed. Local audits are underway in relation to the quality and process of the risk assessments and the task is how this is brought back to the Committee to give assurance.
DT noted a psychology action plan which has been addressed through operational services and queried whether it could be aligned with this piece of work rather than the CQC improvement plan.

AM supported the approach however raised questions in relation to the quality monitoring visits (QMV) and how these would fit into this, both in reflection of the process of the improvement plan and the actions arising out of that. AM noted that we would need to see what arises out of the QMV's and then to reflect on the process. This would help to inform the process going forward and not to miss the QMV aspect whilst undertaking the improvement plans.

DT advised that it is important that the learning from QMV visits and the improvement plan is not reliant on the CQC actions and that the Trust has its own improvement based plan and own improvement initiatives.

TB noted that in the revised work plan for the Committee that there will be a a focus on the Trust's own quality improvement plan which incorporates the CQC improvement plan and ensuring that the two are aligned. The revised workplan proposes a progress update on a section of the quality improvement strategy to every Committee meeting. KQ supported the revised approach.

KQ queried the detail available to support statements in the plan that items have been completed and implemented. DT advised that the QIAT team hold a database of evidence for each action which could be cross referenced. DT noted that where there are concerns around achieving completion, issues would be escalated to committee. CD queried as to whether it would be helpful to reinforce what the governance processes are in place to support this escalation.

Action: DT

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AM noted that an item is not turned blue unless all aspects have been completed and would like assurance on this. TB advised that assurance and evidence is provided via the clinical governance group and then shared with the CQC to ensure alignment.

The Clinical Governance and Clinical Safety Committee NOTED and APPROVED the recommendations regarding the CQC Improvement plan reporting.

CG/21/39 Mental Health Service User Survey (agenda item 9)

TB reminded the Committee that this item was scheduled previously and thus significant amount of time has passed since receipt, however it is important to receive an update. DT informed that the Trust's rating has remained the same. Improvement in 18 out of 27 areas of feedback. The Trust has done well in the areas of service user care and service users.

CD noted that there was a lot of useful information in this report and wanted to understand what is done with this information to improve services.

AM supported this and noted that there were a number of concerns and areas for quality improvement and that we needed to be clear on what the focus areas where and what the priorities are and how we will address them. KQ agreed. DT informed that the Trust is on par with other Trusts.

CD summarised that there was a lot of learning in the report and that we needed to understand what the action plan was in more detail on next steps. CH suggested that it goes back through OMG and then to check with BDUs for their plans for improvement.

Action: CH

TB advised the Committee that Dawn Pearson is also alert to the survey.

KQ would like the next area of focus on carers and ensuring that they are involved.

The Committee NOTED the update.

CG/21/40 Trust Achievements (deferred) (agenda item 10)

CG/21/41 Patient Safety Strategy (agenda item 11)

TB gave a brief update to the Committee and reminded those present that the patient safety strategy is a subset of the overall quality improvement plan. TB highlighted the following:-

1. Patient Safety Manager is now in post and the Trio will have a discussion with the manager in terms of guiding some of the priorities.
2. Work around the suicide prevention strategy.
3. Safe care - defined timeline around early adopting on the unity centre and roll out to forensics.

The Committee noted the huge amount of work and that it is a comprehensive report and a key document in the work of the Committee going forward.

AM wanted to know if the committee had the right level of oversight of hotspot areas in the Trust for example safer staffing. AM was also aware of issues that have not been flagged in

this report so wanted to be clear that the Committee had the right level of assurance. CD noted that she felt the same after a QMV visit around safer staffing and how this impacted on the service. CH noted that safer staffing is on the risk register and that it is an ongoing challenge for the trust.

It was agreed to pick up the issues around safer staffing under agenda item 19

The Committee RECEIVED the report and accepted it as evidence of assurance of the work undertaken.

CG/21/42 Update on Covid-19 Response (agenda item 12)

National Issues / Phase 3 Letter / NHS Providers Briefing

TB informed the Committee there was no further update to the one given at Trust Board in March 2021. It was noted however that although restrictions may have changed for people outside of work, restrictions have not changed within the workplace.

We have been advised that PPE supplies will be provided until March 2022 which indicates the time scales for continued used of PPE.

Focus on the mental health agenda nationally will increase in reporting.

The Committee NOTED the update.

CG/21/43 Workforce Update with response to Covid-19 (agenda item 13)

13.1 Safer Staffing

Will be addressed at the safer staffing item below.

13.2 Outbreak and Testing Management

Updated received and noted.

The Committee NOTED the update.

CG/21/44 Delivery of Clinical Services (agenda item 14)

Update on impact on all clinical areas

Committee received and noted the report

The Committee NOTED the update.

CG/21/45 Patient Safety (agenda item 15)

15.1 Incident Trends

DT highlighted to the Committee the fluctuations in reporting rates and where this was a variation outside of normal range, further analysis has taken place to explore this. Analysis of the data from 2021 shows that higher numbers of self harm incident are predominantly due to a small number of service users across Mental Health inpatient wards and the Trust is supporting people with their behavioral plans. The Trust continues to monitor suicide and incident trends weekly in line with Covid-19. DT reported that there are no emerging trends.

DT advised that the data is currently calculated weekly for suicide and self harm trends and would like to move to monthly reporting - this was agreed.

No further comments from the Committee.

The Committee NOTED the analysis of suicide and self-harm incidents during the Covid-19 pandemic.

15.2 PPE Arrangements
Discussed above.

CG/21/46 Issues arising from Integrated Performance Report, not covered on the agenda (agenda item 16)
The Committee noted the new front sheet summary format. TB asked if there were any further comments following Trust Board on the revised format.

TB reminded Committee that there is to be a revised approach to screening of complaints and setting revised targets for reporting. The revised approach and how it will be reported against will be bought into committee.

Action: TB

TB advised the Committee that the 3 avoidable pressure ulcer incidents had all been investigated carefully and risk assessment training had been discussed with associated staff and District Nurses. The Clinical Quality Board in Barnsley is also comfortable with the approach.

KQ queried whether within the locality part of the IPR there is an opportunity to show improved triangulation between all the sources of data that OMG receive to highlight if a service is struggling.

CH advised that this is in the locality part of the IPR and the challenge is to extract this information. OMG also receives a clinical governance report. The Committee acknowledged the difficulty with this. KQ queried whether this could be covered in FIP.

The Committee noted the improvement of the locality reports and information and that it would be useful for FIP to pick this up in relation to the emerging risks coming to the fore. TB informed that FIP discussed areas for a deep dive and this could be one for consideration. To be discussed with Chris Jones in relation to FIP picking this up.

Action: TB/CH

The Committee RECEIVED and NOTED the update.

CG/21/47 Child and Adolescent Mental Health Services including Wetherby and Adel Beck (agenda item 17)
CH gave a brief update to the Committee and informed that the papers are the reports that are received from the CAMHS improvement board. It was noted that since the reports had been written there have been a number of referrals and the acuity of the referrals to CAMHS has increased, which is in relation to the children going back to school. The acuity had led to an increase in Tier 4 and placements. CH reported to the Committee that a 14 year old had been cared for in a 136 suite and then transferred to an adult ward for 1 night. A 14 year old in Barnsley had also been waiting for a bed for too long. CH noted that there is clearly

an increase in demand but it was not yet clear if this was a one off spike or if the pressure will continue. It was agreed that this needed to be monitored.

Barnsley and Wakefield
There continue to be improvements in the waiting lists but there was an increase in referrals.

Calderdale and Kirklees
Improvement work around ASD and ADHD was continuing and funding could be available - outcome awaited..

CD noted that in terms of the referrals the reports are helpful however they do not give a total picture. CH informed there is a clear document that would address this and is happy to share. AM suggested going back to the previous report that Dave Ramsay provided and that this would be more helpful and clear. The Committee agreed.

Action: CH

AM highlighted the psychology waits which had been mentioned at Trust Board under IPR discussions.

The Committee queried whether the level of risk in the risk register was felt to be right in terms of likelihood and consequence. TB advised that this will be picked up in the next review of risks with the Trio. **Action TB**

TB informed the Committee of a spot survey in relation to under 18's occupying and waiting for CAMHS beds. This is in response to the reduction in Tier 4 beds across the system and concern around impact.

The Committee RECEIVED and NOTED the update.

CG/21/48 Quality Impact Assessment (agenda item 18)

TB informed the Committee of the need to use QIA's in terms of recovery and restoration and once the final programme has been agreed, the approach will be resurrected.

The Committee NOTED the update.

CG/21/49 Safer Staffing (agenda item 19)

DT gave an overview to the Committee and noted a focus on fill rates and staffing levels.

DT noted there is a strong focus on staff wellbeing and safe care has been a way to get a sense of the day to day acuity on the wards. DT noted the variance in the care hours per patient day (CHPPD). DT informed the Committee of the new roles in the Trust.

DT highlighted the vast amount of detail in the report and queried if the detail was helpful in providing assurance and alerting the circumstances to the Committee.

CD informed that the report is helpful in giving assurance around the national requirements but that the impact of staffing levels on individual wards was lost and KQ agreed noting for example the vast amount of reds within the report and what the impact of this was on the ground. DT noted that there is challenge around each scenario and that it is a very live system on an hour by hour basis.

TB reminded the Committee of the benefits of the Safe Care introduction as this shows fill rates against need rather than what was originally set as establishment. TB reported that the ratios are right but are diluting the skill mix to maintain safety is a consistent problem.

AM queried whether it would be helpful to look at certain ward in greater depth for example consider their sick rates; supervision rates; turnover rates; Datix reporting;, would the ward recommend to friends and family; what the ward felt like for staff. Could we do a triangulation exercise?

The Committee also queried whether the threshold was too high as to what is acceptable.

DT noted that the threshold of what we tolerate is lifting and what we are faced with is not always acceptable however this is what the Trust is dealing with at the moment. DT noted the breadth of information that is required to be triangulated. The Committee queried what proportion of newly qualified staff stay within the Trust and whether this is linked to certain wards or circumstances.

CH noted the above comments and acknowledged this was helpful challenge to understand if the levels were right at operational level. It was agreed that this would be discussed at the EMT timeout in May and that more focused work needs to be done.

The Committee noted that triangulation and alignment had been discussed in detail and suggested that the report needs to be more integrated. The Committee agreed that this should be revisited. AM suggested a discussion at Strategic Trust Board after a discussion at EMT.

Action: TB/CH

The Committee NOTED the report and the update provided.

CG/21/50 Freedom to Speak up Guardians Report (agenda item 20)

Nick Phillips (NP) gave a brief from AGD. It was noted that the Whistleblowing report includes Freedom to Speak Up (FTSU). The emphasis nationally has moved from managing whistleblowing to creating a culture where staff feel safe and confident to speak up without suffering a detriment and knowing they will be listened to. On this basis, AGD has been working with Estelle Myers to move the agenda along those lines and that is why it was agreed to change to her job title (Ambassador for Cultural Change and Freedom to Speak up Guardian) to reinforce this approach.

AGD also noted wanting to strengthen the link between the Freedom to Speak up Guardians (FTUGs) work with the Workforce and OD Strategies. On this basis, subject to Committee agreement, it was suggested to take the FTSU Annual Report and Strategy to Workforce and Remuneration Committee in May then to Board in either May/June. Given the link with Bullying and Harassment and Staff Wellbeing, it sits better there.

The Committee agreed that they were happy with this approach however noted that they did not want this to incur any delays.

The Committee noted the update and the actions identified.

CG/21/51 Internal Audit Report (agenda item 21)

Nil

The Committee NOTED the update.

CG/21/52 Review of Health Care Deaths Policy (deferred) (agenda item 22)

CG/21/53 Sub-groups – exception reporting (agenda item 23)

Drug & Therapeutic

Report received and noted.

Safety and Resilience

Safety Services Annual Report

Report received and noted. NP noted a slow and steady improvement from the annual safety report which is positive. Partnership working continues to be well established, the embedding of a robust risk based, including for Covid, audit programme continues and risk assessments will continue to be reviewed following the changes in the use of buildings.

Committee agreed it was an easy to read and detailed report.

CD raised a query in relation to fire training and whether this is now just online. NP confirmed that there is now a combination of online and face to face training and numbers have maintained and are showing an improvement.

The Committee thanked NP and the teams for the support over the year.

Infection Prevention and Control

Report received and noted.

Safeguarding adults and children

Report received and noted.

Reducing Restrictive Physical Interventions Group

Report received and noted. CD noted that this had been discussed at FIP around prone restraints. Numbers are going down but the Trust is an outlier and FIP wanted CGCS to look into this. DT confirmed that this has been looked at and a paper is going to a benchmarking meeting. CGCS to discuss this further after the benchmarking meeting.

Action: DT

Improving Clinical Information Governance Group

Report received and noted.

Physical Health

Report received and noted.

Clinical Ethics Advisory Group

Report received and noted.

CG/21/54 Serious Incidents Update (agenda item 24)

TB updated the Committee on the 2 incidents which were discussed at Board recently.

- SANCUS Report – The revised report has been received which is now under review and discussion with NHSE/I
- Regulation 28 from the Coroner – CQC is named as an interested party to our response which will also be sent to the CQC by the 3rd May. Yvonne French is dealing with the response which will go to TB then EMT.

TB also informed the Committee of a whistleblowing report to the CQC around concerns at the Dales and will update the Committee at the next meeting.

CG/21/55 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 25)

Action - None

Alert and Advise

- **CQC Improvement Plan** - Focus on quality improvement approach going forward with progress reports on care planning and risk assessment into Committee. Monitoring to encompasses a range of measures to ensure triangulation and a sustained and embedded improvement.

- **Safer Staffing** - Assurance received around meeting national safer staffing requirements. Recognition of significant work around staffing and recruitment. Committee wanted a greater understanding of the impact of staffing and mix on individual wards, particularly on the impact on staff.

- **Mental Health User Survey** – Received. Agreed that there were some significant findings and that some priorities for focus needed to be agreed

- **CAHMS** - update on commissioning of C+K services. Increase in demand for services following schools going back noted. Issue around tier 4 services and capacity discussed.

- **FTSUG** - National move to create a culture where staff feel safe to speak up. EM new title Ambassador for Cultural Change and FTSUG.

- **RRPI TAG** - Benchmarking report identifies us an outlier on prone restraint. Review paper being provided into benchmarking group in first instance

Assurance

- **Safety and resilience annual report** - Received. Recognition of significant work achieved and action plan for 2021/2 noted.

CG/21/56 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance and Clinical Safety Committee (agenda item 26)

- Nil

CG/21/57 Work Programme (agenda item 27)

Work programme received and noted that a revision is planned.

Workplan Assurance Session

TB shared the Assurance Session work plan example and informed of the suggestion to have 1 day or 2 half days for an assurance session to consider annual reports thus alleviating pressure on the workplan and affording the opportunity to discuss the items in more detail.

Any comments back to CD and TB.

Action: All

CG/21/58 Date of next meeting (agenda item 28)

The next meeting will be held on 8 June 2021 between 2.00-5.00 pm via MS Teams

Glossary

ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement

NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Equality and Inclusion Committee held on
2 March 2021
Via Microsoft Teams

Present:	Angela Monaghan (AM)	Chair of the Trust (Chair of Committee)
	Tim Breedon (TB)	Director of Nursing and Quality (Lead Director)
	Alan Davis (AD)	Director of Human Resources, Organisational Development and Estates
	Erfana Mahmood (EM)	Non-Executive Director
	Mike Ford (MF)	Non-Executive Director
Apologies	Chris Jones (CJ)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
In attendance	Aboobaker Bhana (ABB)	Equality and Engagement Manager
	Zahida Mallard (ZM)	Equality and Engagement Manager
	Sarah Harrison (SH)	PA to Director of Nursing & Quality (author)
	Dawn Pearson (DP)	Marketing, Communications, Engagement and Inclusion Lead
	Elaine Shelton (ES)	Unison Branch Secretary
	Cherill Watterston (CW)	WRES OD Lead/Specialist Physiotherapist
	Donna Somers (DS)	LGBT+ staff network Chair/Matron
	Darren Dooler (DD)	Governor
	Paul Brown (PB	Disability staff network rep/HR Business Partner
	Charlene Sibanda (CS)	Health & Wellbeing Practitioner (BAME)
	Noma Ndhlovi (NN)	BAME staff network Vice Chair/Ward Manager
	Melissa Harvey (MH)	General Manager
	Manreesh Bains (MB)	BAME staff network Chair/Consultant Clinical Psychologist
	Gillian Cowell (GC)	Carers staff network Chair/Carer Support Worker
	Chris Lennox (CL)	Deputy Director of Operations
	Sue Threadgold (ST)	Deputy Director of Operations
	Lauren Summers (LS)	Marketing, Communication & Engagement Manager
	Lindsey Metcalf (LM)	Business Intelligence Lead
	Debs Teale (DT)	Lead Peer Support Development Coordinator
Apologies Attendees:	Dr Subha Thiyagesh (SThi)	Medical Director
	Claire Hartland (CH)	HR Business Manager

EIC/21/01 Welcome, introductions and apologies (agenda item 1)

The Chair Angela Monaghan (AM) welcomed everyone to the meeting and noted apologies. Full introductions were given to all. It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed. Also, that a recording was taking place for note purposes.

EIC/21/02 Declarations of interest (agenda item 2)
The Committee noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2020 or subsequently.

EIC/21/03 Minutes of previous meeting held on 8 December 2020 (agenda item 3)
Minutes of the previous meeting were agreed as a correct record.

It was RESOLVED to APPROVE the minutes of the meeting held on 8 December 2020.

EIC/21/04 Matters arising and action log (agenda item 4)
Actions from the meeting held on 8 December 2020 were noted and the action log was updated as appropriate.

EIC/20/71 Equality Standards Updates WRES/WDES – Alan Davis (AD) informed the Committee that an update would be taken to the Executive Management Committee on the 4th March and then on to the next Workforce and Remuneration Committee (WRC).

EIC/20/74 report on Commitment to Carers - Aboo Bhanabaker (ABB) confirmed that the commitment to carers is now included within the local induction programme for the Trust. Angela Monaghan (AM) would like a further update on progress in June.

Action: ABB

EIC/20/77 – Barnsley & Wakefield –compare and contrast to the E&I forums B&W and C&K. Good progress on taking the learning of what's working well and not so well from each forum, have made progress re drawing standardised agendas together to ensure key issues and items are shared, and we now have common administrative and chairing processes.

EIC/21/05 Review of Committee related risks and any exception reports as required (agenda item 5)
Tim Breedon (TB) informed the Committee that since the last meeting there have been some updates.

TB highlighted RISK ID 1531 which had been to Trust Board in relation to the description of protected characteristics especially in relation to learning disabilities (LD) and race/ethnicity to ensure a higher profile. This has also been discussed in EMT and at the E&I Sub Committee.

TB also informed the Committee that RISK ID 1536 has also been part of the discussion within the WRC in terms of the impact.

TB went on to inform that there have been no changes to the corporate risk register in terms of any gradings and just noted the updated risk description on RISK ID 1531.

Mike Ford (MF) raised a query in relation to RISK ID 1536 and noted a reference to the review of staff risk assessments January 2021. MF queried whether this had happened and where this would be recorded. TB advised that updates in terms of actions are colour coded so the progress can be noted. AD advised that this review is continuous.

The Committee DISCUSSED and commented on the current Trust-wide corporate/organisational level risks relevant to this Committee and were ASSURED that the current risk levels, although above the Trust risk appetite, given the current environment, are appropriate.

EIC/21/06 Context report – national, regional and local (agenda item 6)
TB advised the Committee that the focus on the inequalities agenda remains high across the system and national level and that there is a growing understanding of the benefits of addressing the inequalities for the person and the broader community.

TB noted a meeting with Calderdale & Huddersfield Foundation Trust (CHFT) and the local work undertaken to understand the numbers and the impact in real terms. The overall position is that it is high profile with a high focus across all levels.

Zahida Mallard (ZM) went on to present on regional and national updates.

Dawn Pearson (DP) then presented on the reform of the Mental Health Act and wanted to raise awareness that this was underway. DP advised that investment would follow the reform which follows on from the 5 year plan.

DP noted that there is a consultation underway at the moment which closes on the 21st April. Work is underway with Julie Carr in the legal department for a joint response and approach.

Anyone interested in supporting the consultation should respond to DP.

Action: All

Erfana Mahmood (EM) advised that the Mental Health Act Committee (MHAC) would be looking at this from a service user perspective and would like a view of equality and inclusion issues particularly for the Committee.

EM also raised a query in relation to ZM's presentation – whether there was a way to coordinate all the work across the system through the ICS. ZM informed that work is being coordinated with York and Leeds and Bradford and Airedale.

The Committee NOTED the update.

EIC/21/07 Service User Feedback (no further update for the March meeting (agenda item 7)

EIC/21/08 Peer Support Worker Update (agenda item 8)
Debs Teale (DT) provided slides to the Committee in relation to peer support workers (PSWs) and talked the Committee through them.

The Committee thanked DT for her presentation on this very important piece of work and noted the crucial role that the PSW plays within the Trust.

MF raised a query in relation to the number of PSWs within the Trust and DT advised that there had been 3 initially, however there were now 15. DT informed the Committee that some areas of the Trust need more focus and more PSWs are needed. It is hoped that the number will rise to around 100 in the next few years. It was noted that PSWs are also covered in part of the action plans later in the agenda.

The Committee thanked DT for the presentation which was very well received.

The Committee NOTED the update.

EIC/21/09 Feedback from Staff Equality Networks

BAME

Manreesh Bains (MB) informed the Committee that the main focus was around vaccine uptake and supporting staff. Q&A sessions had been held in mid February with support from community leaders and more Q&A sessions have been arranged.

MB advised that RACE forward needs to be relaunched or reenergised and a meeting is set up for next week to discuss this. WRES bullying and harassment could also sit under this umbrella.

Bollywood dance classes are being offered to all staff in the Trust to improve positive engagement. Wellbeing check in's are also being provided.

Disability

Paul Brown (PB) advised that since the last Committee he had reached out to the group to query if they still wanted to be members of the network, over 20 had responded and a couple would like to be more actively involved. PB is liaising with Andy Lister (Company Secretary) for support from Board and Exec level in terms of leadership. Following on from this, PB is hoping for more energy and enthusiasm to relaunch the network very soon.

LGBT+

Donna Somers (DS) informed that there had been another members' meeting a month ago and the update was very good however there were only a few in attendance at the meeting. MB suggested that this could be a confidence issue.

Gender neutral toilets – this had been pursued with facilities but the current position is that the Trust needs more communication on these issues. The LGBT+ network has no identified leader in relation to taking forward specific issues and the group is looking to elect someone from within the group.

MB advised that the NHS Confederation are undertaking some research and queried whether the Trust could be involved. DS has shared the links with DP. MB highlighted that confidence needs building within members.

Working Carers

Gillian Cowell (GC) informed the Committee that the focus at the moment is on staff carers being identified and the carer's passport. There is information on the intranet and within the staff marketplace.

A wider network meeting was held last week with 15 staff in attendance. Staff carers shared experiences of how they manage and how the impact of Covid-19 has greatly had an effect.

Carers leave – staff had shared a negative experience and reported that they have had to take annual leave which is being discussed with HR.

EM queried whether the networks are now embedded and that it would be positive to bring the networks together. AM suggested convening one meeting a year to bring networks together. The Committee agreed this is a good idea, as did the networks.

Action: AM

MF queried the disability policy with PB. PB informed that the working draft had been sent to network members for feedback and it had also been to HR and Staff Side. Once it is in a position for a final draft then it will go to the employment policy group for EMT to sign off.

EIC/21/10 Feedback from BDU Forums (agenda item 10)

Calderdale & Kirklees

Chris Lennox (CL) advised that the above Equality & Inclusion forums had recently met and were well attended and had a strong front-line presence. CL informed of a presentation re changes at ICS and CCG level around community transformation and a good discussion had taken place. ABB and Melissa Harvey had a follow-on meeting in relation to embedding and ensuing co-production and participation to include involvement of networks and front line staff.

Overall a valuable meeting.

Barnsley & Wakefield

CL informed that the above Equality & inclusion forum recently met and again was well attended. There was a presentation on equity guardians which was positive and well received. There was also discussion on the Trust's recovery process in terms of Covid and the numbers of studies taking place. Also, the Digital Inclusion Strategy and the possibility of co-production with a service user voice.

Overall a valuable meeting.

Forensics / Specialist

Sue Threadgold (ST) informed that the above forums joined together including Forensics, LD, Creative Minds and Spirit in Mind. The meeting was well attended and lively with 20+ people in attendance. Membership was discussed to make this as wide and open as possible.

Forensic services were involved with RACE Forward and this will continue.

The forum discussed LD and health inequalities, vaccines and how services have adapted. Some changes have been far reaching.

ST informed that all meetings have been planned for the next year and agendas are full with a real range of subject matter.

ST noted that the meeting was very lively and felt reinvigorated.

The Committee felt very encouraged by this.

AM queried how to make best use of all this feedback and will have a discussion with TB regarding this.

Action: AM

Darren Dooler (DD) raised a point in relation to digital inclusion projects in the voluntary sector and whether going forward there would be an option of pooling resources together across the ICS.

TB will address this with Sean Rayner in terms of Wakefield Mental Health Alliance work.

Acton: TB

AM advised that work is ongoing at ICS level and the Trust is about to take the Digital Strategy to Trust Board so there will be an opportunity to discuss this at Board.

The Committee noted the update from the BDU Forums.

EIC/21/11 Inclusive Leadership and Development Update (agenda item 11)

AD gave a brief update to the Committee as follows: -

- The Board is going through the NHS leadership Academy inclusive leadership board development programme as part of the overall building leadership for inclusion initiative. A number of sessions have been undertaken and the Board are committed and well engaged with the programme.

- Launch of the BAME talent pool which has had a really positive start.

- The second phase of the Building for Leadership for inclusion, around development of activity focused on inpatient services, had been placed on hold and talks with Tavistock were being held. Andrew Cribbis is leading on this.

Lauren Summers (LS) raised that she was pleased to hear about all the work going on but queried about the other protected characteristics and what were the Trust's plans in relation to this. AD advised that inclusive leadership is not just about race and is not just focused on one characteristic. AD informed that the Trust will be broadening the talent pools and Andrew Cribbis will be looking at this.

LS asked if there was a time scale and AD confirmed that there wasn't at the moment, however more detail will emerge in the near future.

The Committee NOTED the update.

EIC/21/12 Strategy & Policy (agenda item 12)

No scheduled updates.

EIC/21/13 Covid-19 Vaccination (agenda item 13)

AD informed that the Vaccination programme was going really well and 86% of the workforce have been vaccinated. There was a disparity in the figures of 69% BAME and 89% white. AD advised that a lot of work is taking place around how the Trust encourage colleagues to take up the vaccine. AD noted that it felt a little stuck at the moment however the Trust is looking at approaches and tactics which is very important. There are a lot of natural concerns and questions coming up and the Trust are doing their best to answer all these.

AD reported that the Trust vaccination performance is in line with performance nationally and has had a good uptake.

WRES and Staff Survey

AD gave a brief update to the Committee in relation to the Workforce Race Equality Standard (WRES) and NHS Staff Survey which does include WRES data. The Trust had been named in the report as one of the least best performing Trusts in terms of bullying and harassment for BAME colleagues in terms of service users and carers. AD informed the Committee that RACE forward had been a drive for the Trust and noted that a RACE

forward meeting was planned for next week to address any issues and will be looking at broader characteristics also.

AD noted that there have been some improvements and positive developments around BAME staff seeking support from the Trust.

AD also informed that disabled colleagues are suffering higher levels of bullying and harassment from service users and carers.

AD informed the Committee that the mapping of the actions around the staff survey will be going into EMT on 4th March 2021.

The Staff Survey is embargoed until 11th March 2021.

DD raised a query in relation to volunteers and access to the vaccinations. DD had had a conversation with some volunteers who had advised that their offers of vaccination had been withdrawn. DP informed that a survey had been done to ascertain how many volunteers the Trust had to identify who were operating face to face as there is a strict order for the roll out of the vaccine and face to face and first line staff had to be prioritised. It was noted that there had been some communication breakdown with how the survey was worded. DP advised that work is underway to look at how volunteers can be returned to services safely and Silver Command is looking into this.

AM informed that at the moment the over 50's were now eligible for the vaccine and if spare vaccines are available these can be allocated. TB agreed to find out if volunteers can be added to the "last minute" list for spare vaccines. Local authorities are also an option.

Action: TB

ABB raised a question in the chat in relation to equity guardians and how they are recruited and supported to carry out their roles. AD will address this outside of the meeting due to time pressures.

Action: AD

The Committee NOTED the update.

EIC/21/14 Performance Dashboard development update (agenda item 14)

TB introduced this item and informed the Committee that the dashboard had been paused while IM&T staff were allocated to the vaccination programme but advised that preparatory work had recommenced. The key areas of focus remain as;

1. Managing the uptake of the vaccine across the Trust using live data and insight to target our response appropriately.

2. Understanding access to services and where the Trust is in relation to local population data so the Trust can take the right action.

Lindsey Metcalf (LM) introduced herself as the Business Intelligence lead for the Trust and went on to demonstrate the dashboard for the Committee.

The report showed the vaccination update from various groups / protected characteristics.

LM will share the link to the dashboard with the Committee for access.

Action: LM

LM also showed the Committee the work around urgent actions within the report.

LM informed that work around this is still ongoing.

Committee thanked LM.

AM asked whether there is a non-binary option on gender. LM will take this question away and will advise.

Action: LM

EM noted that this was a really good set of information and informed that the MHA Committee have also been looking at this. EM queried whether this will be shared with MHA Committee and TB advised that Subha Thiyagesh is alert to this and it will be utilised.

DP noted that the vaccination tool is a great addition to ensure targeted comms and this will be equally helpful.

MF queried how the Committee would use the dashboard and TB advised that it would assist if;
1. The Committee is explicit what they would like to be included and be clear about proposed metrics.

2. Once a decision has been reached on the metrics they should come to the Committee with the right narratives. The integrated performance report (IPR) metrics are a good starting point

TB informed that the E&I Sub Committee could look at the broader areas of the dashboard to bring suggestions to the Committee.

Action: TB

The Committee queried the next steps and whether there will be a working dashboard for the next meeting. TB noted that we have to be cautious about what is achievable given capacity and advised that a draft dashboard should be available but it may not be possible to include the analysis and narrative.

The Committee NOTED and COMMENTED on the progress update on the development of the Performance Dashboard.

EIC/21/15 Equality, Involvement, Communication and Membership Strategy Implementation Plan report – Action Plan update (agenda item 15)

AM noted that the action plans will be taken as read.

Trust Board signed off the Equality, Involvement, Communication and Membership Strategy in December 2020 and from that delegated responsibility to the Committee to sign off the action plans. The action plans run for an 18-month period from September 2020. A lot of work has been undertaken to move the agenda along.

Committee agreed to use the plans going forward with a possible highlight review if needed with a formal review in September 2021.

Equality & Inclusion Action Plan

AM noted the earlier point from LS regarding ensuring that all protected characteristics are addressed. DP informed that WRES and WDES are specific requirements that have to be reported on but there is a wider public sector equality duty so work is undertaken at services level through equality impact assessments and making sure the Trust captures good equality data. DP is happy to support networks and increase network representation.

DP made reference to increasing data collection in particular looking at sexual orientation monitoring standard (SOM) making sure this is increased and also additional training and support has been put in place.

DP noted that the action plan is for all protected groups and informed that this is a data and insight driven approach for the involvement element of the action plan.

Involvement Action Plan
DP informed that the above is to have one approach for involving people using existing insight. Testing out of a toolkit to ask questions in a systematic way is also underway. DP informed that meetings with Healthwatch are also continuing.

AM acknowledged and thanked the governors who supported this.

TB noted the massive step forward in terms of involvement in this action plan and putting the two things together was really important. TB added that the insight that was required to ensure that things continue to improve is in a great position and something solid to monitor.

MF queried the section on development opportunities, and the opportunity for BAME staff to access support and learning. MF queried whether this point needs to be more general rather than just related to BAME staff.

MF noted in the action plan report that “everything is in progress” and queried whether more details would be needed on what is progressing well or at risk etc. DP informed that as the action plan progresses issues will be flagged and the exception report would cover this.

A highlight report will be available for the next Committee meeting.

Action: DP

ABB noted the importance of valuing involvement and valuing all the people that help the Trust in this journey and queried how the Trust can reward people and support them. AM also noted this.

AM noted it is important to act on the data and not to just admire the problem.

The Committee support the action plans with the exception report and will review in September.

The Committee COMMENTED and SUPPORTED the Action Plans.

EIC/21/16 Equality Standard updates (WRES, WDES) (agenda item 16)
Deferred

The Committee noted.

EIC/2117 Equality Impact Assessments (EIA) (agenda item 17)
Deferred

The Committee noted.

EIC/21/18 Equality Delivery System (EDS2) (agenda item 18)
Deferred

The Committee noted.

EIC/21/19 Internal Audit Reports (agenda item 19)
Deferred

The Committee noted.

EIC/21/20 Committee Annual Report (agenda item 20)

AM informed the Committee that the report will be taken as read.

Annual Report
AM noted the table on the second page needs to be 2021 and the membership needs amending as Mike Ford is not showing. Also Darren Dooler is not a member, he is an attendee.

The membership section will be revised to reflect the above.

The Commitment to carers work also needs to be included.

Survey /AM
AM thanked the participants of the survey however noted only 3 undertook this.

Terms of Reference
The Committee discussed the title of the Committee and queried the addition of involvement to the title. It was agreed to propose to change the Committee title to "Equality, Inclusion & Involvement Committee".

Work Programme
TB advised that this may need to alter in light of involvement.

Acton: TB/AM

MF noted the WRES and WDES frequency on the work plan and would like these to be discussed in more detail. The Committee agreed that more time does need to be spent on these.

The Committee approved the work programme subject to incorporating the above comments.

The Committee AGREED and COMMENTED on the Annual Report for the Equality & Inclusion Committee.

EIC/21/21 Governance (agenda item 21)
Nothing to be covered.

EIC/21/22 Items to bring to the attention of Trust Board or other Committees (agenda item 22)

For Board:

- Risks assigned to committee reviewed in detail
- Considered report on the work of Peer Support Workers in the Trust
- Received presentation on new performance dashboard
- Approved equality, involvement, communication and membership strategy action plans
- Received verbal feedback from staff equality networks and BDU equality forums
- Approved committee annual report

EIC/21/23 Return to review of risks in light of Committee discussion (agenda item 23)
Nothing additional to add.

EIC/21/24 Work programme (agenda item 24)
The Committee discussed the above and agreed to look at a strategy session and business meeting at the next Committee. AM and TB to look at maximising feedback.

Action: TB and AM

EIC/21/25 Date of next meeting (agenda item 25)
The next meeting will be 15 June 2021.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held Virtually via Microsoft Teams on 9 March 2021

Present:	Dr Subha Thiyagesh	Medical Director (lead Director)
	Kate Quail	Non-Executive Director (Chair)
	Tim Breedon	Director of Nursing and Quality
	Erfana Mahmood	Non-Executive Director
Apologies:	Members	
	Charlotte Dyson	Non-Executive Director
	Salma Yasmeen	Director of Strategy
	Attendees	
	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Andrea Dauris	Head of Safeguarding (Calderdale & Huddersfield NHS FT)
	Terry Hevicon-Nixon	Operations Manager - Working Age Mental Health (Calderdale) – local authority representative
	April Ramsden	AMHP Team Leader (Kirklees) – local authority representative
In attendance:	Clive Barrett	Head of Safeguarding, Mid Yorkshire Hospitals NHS Trust
	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
	Chris Lennox	Deputy Director of Operations
	Gillian Pepper	Head of Safeguarding, Barnsley Hospital NHS FT
	Stephen Robson	Advanced Practitioner (Barnsley) – local authority representative
	Carly Thimm	Mental Health Act / Mental Capacity Act Manager
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative
	Sarah Millar	PA to Medical Director (author)

MHAC/21/01 Welcome, Introductions and Apologies (agenda item 1)

The Chair, Kate Quail (KQ) welcomed everyone to the meeting. The apologies, as above, were noted.

It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

There were no declarations of interest to record.

MHAC/21/02 The Act in Practice (agenda item 2)
MHAC/21/02a Reforming the Mental Health Act (MHA) White Paper (agenda item 2.1)
Presentation from Julie Carr (JC) on reforming the MHA White Paper.

JC set out the key drivers for reforming the MHA, each of the consultation domains and the Trust approach.

Gary Haigh (GH) referred to the specific actions in relation to Tribunals and queried whether there would be any impact on Hospital Manager reviews and appeals. JC advised that it is not clear at this point, particularly as some of the sections appear to be contradictory.

Erfana Mahmood (EM) queried how this work will be prioritised given that there is so much to do and there are other competing demands.

JC advised that a series of consultation groups have been set up in March and queries that have arisen have been sent out to specifically identified groups for a response. There is also some service user engagement work, so they also have chance to provide feedback.

EM queried whether time, money and effort could be saved via ICS and partnership working and KQ reported that the local Mental Health Act Committee (MHAC) chairs have met with a view to try and do something jointly.

JC indicated that once all the data is collated, a response will be drafted and submission is to be made electronically on 21 April. It was noted that the next MHAC meeting is not until May and it was agreed that Committee members would be asked to provide any feedback via e-mail.

Action: Julie Carr

It was agreed that the final response would be agreed by the executive trio, Subha Thiyagesh (ST), Tim Breedon (TB) and Carol Harris (CH) with final sign off by ST as lead director for the Committee.

KQ thanked JC for the presentation and noted the scale of this exercise and positive partnership working.

MHAC/21/03 Legal updates (agenda item 3)
MHAC/21/03a Reforming the MHA White Paper (agenda item 3.1)

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/21/03b Devon Judgement – Lawfulness of remote examination and MHA assessments (agenda item 3.2)
JC reported that on 22 January 2021 the Royal Courts of Justice handed down a judgement regarding the legality of remote Mental Health Act assessments for civil sections. The finding of the court was that the key phrases of ‘personally seen’ and ‘personally examined’ are to be interpreted as requiring face to face, in person contact. Whilst the judgement did not specifically consider renewals of sections or CTO extensions, given the details of the judgement, it was likely that the safety of these would be ‘doubtful’.

Following the judgement, NHSE/I issued legal guidance and SWYPFT began a process of identifying all fundamentally flawed sections. To date, the Trust has identified 3 fundamentally flawed detentions (Section 3), 6 doubtful renewals and 6 doubtful CTO extensions.

All fundamentally flawed sections have been reviewed resulting in the patients either being made informal or a new assessment resulting in detention. All doubtful renewals and CTOs are being reviewed by the Responsible Clinician.

KQ acknowledged that the action taken in response to the judgement had not only provided assurance but had gone further and also dealt with doubtful renewals and extensions. KQ queried whether there was any risk for Committee to consider.

Yvonne French (YF) advised that everyone affected had been written to, made aware of the judgement and situation, issued with an apology and advised to contact their own legal representative for advice which we would always do in the case of a possibly unsafe section. As such, there was the possibility that someone may make a claim against us.

ST added that since the judgement was received, we immediately shared it with AMHP leads and Responsible Clinicians and advised that no further remote assessments were to be done so there was no risk there. All organisations were in the same position as us, so we were not outliers, and it was noted that our assessments had continued to be carried out in person wherever possible with remote assessments only being used in exceptional circumstances.

KQ concluded that the Committee were assured by the briefing and steps taken.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/21/03c Amendment to MHA legislation electronic submission and electronic signatures (agenda item 3.3)

YF referred to an action from the November MHAC (20/43c on action points) to provide an update on security aspects and risks identified with the use of electronic paperwork. YF advised that Carly Thimm (CT) had worked hard to set up secure e-mail accounts and ensure that the new processes were in line with governance arrangements. New statutory MHA forms were in use from 1 February and YF assured Committee that all measures have been taken to mitigate risk and the use of electronic forms would be kept under review.

It was RESOLVED to RECEIVE and NOTE the guidance note.

MHAC/21/04 Local Authority and Acute Trusts (agenda item 4)

The following updates were noted:

Clive Barrett (CB) – Mid Yorkshire Hospitals NHS Trust (MYHT)

- No major issues with the Mental Health Act and have regular catch ups with the Mental Health Act office.
- Some long waits in hospital but not Section 12 doctor related but more to do with inpatient beds.
- Mental Health Champions are being established to raise the profile of mental health in the organisation. Deborah Longmore is identifying people in 22 specialisms to develop mental health awareness in those areas.

- There was an issue last week with patients being brought in intoxicated by police under Section 136. This is being looked into by Marie Gibb, the named nurse for safeguarding in the Trust.
- CB advised that this would be his last MHAC meeting as he was due to retire shortly. KQ thanked CB for all his helpful and insightful input to Committee and wished him well for retirement.

Gillian Pepper (GP) – Barnsley Hospital NHS Foundation Trust (BHNFT)

- Lot of work on a new Mental Health Policy following queries raised from Non-executive Directors.
- Mental Health Strategy in place and strong Mental Health Liaison Team links.
- New raft of training around MHA papers and the Barnsley MHA office are very helpful in ensuring 100% compliance.
- Activity increasing and last night a patient was detained with acute psychosis, deteriorated while waiting for a bed and assaulted a member of staff. A bed has now been found.

Stephen Thomas (STh) – Wakefield Council

Nothing of note from Wakefield.

Stephen Robson (SR) – Barnsley Council

Nothing of note from Barnsley.

Victoria Thersby – Calderdale & Huddersfield NHS FT (CHFT)

YF fed back on behalf of Victoria who had left CHFT:

- Joint working with the Mental Health Act office continues to be positive.
- Extra work on receipt and scrutiny with registered nurses at ward level.
- Requests from nurses on acute wards for more training and not just at matron level.
- AMHP lead had raised an issue in relation to receipt and scrutiny which had been resolved by rolling out training.
- SWYPFT supporting CHFT with White Paper response in relation to Section 5.2 in emergency departments.
- The Service Level Agreement between SWYPFT and CHFT is due for review.

April Ramsden – Kirklees Council

YF also gave feedback from April who was unable to join the meeting:

- Issue raised about the Mental Health Community team who had requested MHA assessments for people with no capacity. This had been raised previously and extra training had been given. JC is looking into this further.
- Delays in A&E with finding psychiatric beds seem to have resolved in the last couple of months.
- AMHPs were being left alone in the evening and during the night, however joined up working with the Intensive Home Based Treatment Team has helped to improve this and there has been positive feedback.

MHAC/21/05 Minutes/Actions (agenda item 5)

MHAC/21/05a Minutes of previous meeting held on the 3 November 2020 (agenda item 5.1)

It was RESOLVED to APPROVE the notes of the meeting held on 3 November 2020 as a true and accurate record of the meeting.

MHAC/21/05b Action points (agenda item 5.2)
The action points were noted and the following items raised:

- MHAC/20/49a – CTO audit – YF referred to the action to consider whether the audit findings should be reviewed under a Quality Improvement (QI) process and advised that YF, JC and CT have all now been trained in the QI cycle. The findings are being changed and tweaked with a QI view and it is proposed that an update is brought to Committee in August 2021.
- MHAC/20/49b – Patient experience of Tribunals survey – JC reported that very few responses had been received from service users and there is a meeting with Dawn Pearson tomorrow to discuss other options. This will be incorporated into the ongoing service user work and will remain a focus for MHAC along with the patient experience toolkit.
- MHAC/20/50a – CQC visits summary report Quarter 2 – this action related to improving services for BAME service users and it was agreed to convene a separate meeting to discuss reducing inequalities across the board.

Action: Subha Thiyagesh

MHAC/21/06 Compliance and Assurance (agenda item 6)
MHAC/21/06a Mental Health Act Committee annual report to Trust Board (agenda item 6.1)
Committee received the draft report and KQ advised that it would be taken to Audit Committee on 13 April 2021 and Trust Board on 27 April 2021.

- Mental Health Act Committee annual report:
  - Sections added on Covid 19, Quality Improvement and the ambition to reduce inequalities, particularly in relation to BAME, LD & Autism and young people on our wards.
  - CH to replace Salma Yasmeen as a Director member of the Committee.
  - Suggestion for the paragraph on advocacy to be updated with the current position (to be picked up at agenda item 8.3).

  EM suggested that the paragraph on Covid 19 could be expanded to say that our services have not been adversely impacted and there had been really positive work to keep things going. KQ will update the draft and submit to Audit Committee.

  Action: Kate Quail
- Mental Health Act Committee self-assessment
  - 5 Committee members had completed the self-assessment.
  - There was one 'no' response to Question 7 – Are Committee members independent of the management team? It was noted that what constitutes independent is open to interpretation and the Directors are not independent of the management team, however the Committee is chaired by a Non-executive Director and there are two further Non-executive Director member colleagues.

- Mental Health Act Committee Terms of Reference
  - One change to membership as already agreed. CH will replace Salma Yasmeen as a Director member and this has been approved by the Chief Executive.

- Mental Health Act Committee Work Programme
  - KQ proposed updating the Work Programme to incorporate the extra responsibilities of the Committee as agreed in the autumn.

  Action: Kate Quail

MHAC/21/06b Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.2)
KQ reported that there were no risks assigned to MHAC by Trust Board and the ones that were pertinent to this Committee had oversight by the Clinical Governance and Clinical Safety Committee (CGCSC).

MHAC/21/06c Mental Health Act Committee risk register (agenda item 6.3)
YF had reviewed and updated the MHAC risk register and it was noted that some of the risks would come to an end in the next couple of months.

A potential risk around inpatient vaccine rollout was raised which involved capacity assessments for service users who lack capacity to consent to being vaccinated. YF continues to be involved in a group that specifically considers capacity to consent for service users.

It was queried whether the Devon Judgement should be added to the risk register in terms of possible claims by service users affected by it. EM suggested that it should be appropriately logged somewhere although, unless there is a real risk that it is going to cause problems and there will be a significant impact, it should not be added to the risk register. It was agreed that ST, YF and TB would ensure that the risk of litigation is appropriately logged in the Trust.

Action: Subha Thiyagesh/Yvonne French/Tim Breedon

MHAC/21/07 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)
MHAC/21/07a Performance report – Monitoring information Trust wide October-December 2020 (agenda item 7.1)
The report was considered and the following noted:

- 47% of all new admissions in Quarter 3 were under the MHA 1983 which represents an increase of 4% over Quarter 3 activity in 2019/20.
- There were 3 admissions under the MHA 1983 of an under 18 to the Trust in Quarter 3.
- In response to Covid restrictions, all Hospital Managers' Hearings during Q3 were held virtually.
- There were 16 appeals made to the Hospital Managers in Quarter 3, with 4 appeals achieving a hearing.
- A total of 12 DoLS applications were made. 3 have been authorised, one was refused, 7 were either discharged or regained capacity prior to assessment and one application is pending an outcome from the Local Authority.
- Quarterly Performance Report detailed greater breakdown and analysis of ethnicity data and made recommendations to improve consistency and data quality. In Quarter 3, 5.7% service users accessing services had no ethnicity data or were recorded as having 'refused to disclose' their ethnicity.
- Activity was steady in relation to external transfers (counted as discharge) and many were to rehab pathways in the private sector.
- A CAMHS patient came into hospital and was then transferred to an appropriate setting for them.
- Hospital Manager appeals activity continues to show a low number of appeals being made.
- There was one inpatient death in Quarter 3 and the cause of death was cardiac arrest.
- Of the 180 Section 136 assessments made in Quarter 3, 87 resulted in admission and 70 of those were informal.

There was discussion on ethnicity recording and EM referred to the definition of 'BAME' covering a very wide remit. EM advised that Equality and Inclusion Committee had received a really useful presentation from Lindsey Metcalfe about how ethnicity information is held by the Trust and how it can be sliced and diced. EM suggested that it would be useful for MHAC to have sight of that presentation.

It was noted that the Quarter 3 report had drilled down into 'other ethnic groups' although TB raised that any further breakdown could compromise patient confidentiality as individuals may be identified. It was suggested that some of the existing categories may not be appropriate and indeed one related to a religion rather than ethnicity.

The following actions were agreed:

- Review how ethnicity is recorded locally on SystmOne to improve consistency and data quality.
- Consider 're-mapping' some of the ethnic categories currently grouped against the National Code for 'other ethnic groups'.
- Ask care coordinators to review the ethnic category of people currently recorded as 'Ethnic category – 2001 census' or 'Race'.

Chris Lennox (CL) will work with Mike Garnham in relation to categorisation and then develop an operational plan as part of the BDU digital action plans. It was agreed that an update would come to Committee in May although it may not be resolved by then.

Action: Chris Lennox

KQ asked Committee to note the great improvement that had been made in ethnicity recording in recent years (non-recording used to be around 14% and was now down to around 5%). MHAC acknowledged the huge strides that had been made in improving ethnicity recording.

It was RESOLVED to RECEIVE and NOTE the contents of the monitoring report.

MHAC/21/08 CQC compliance actions (agenda item 8)

MHAC/21/08a MHA/MCA Code of Practice oversight group feedback (agenda item 8.1)

YF reported that work had continued in the background while clinical services have been dealing with operational pressures. YF gave an update on the following workstreams:

- Blanket restrictions – Datix reports are reviewed on a monthly basis and clinical services also review any restrictions in their area each month. It was noted that the policy is not due for review until 2022 and it had been suggested that a table top review would be useful given the progress made since the policy was written.

- Seclusion group – It had been agreed to pilot the SystmOne seclusion paperwork on Bronte and Hepworth wards in Newton Lodge. It was hoped that this would start from May and WiFi hubs and laptops are being prepared. YF advised that following the pilot, a review will be undertaken with recommendations for next steps. It was noted that this links with the CQC action plan.

  A review was also being undertaken on the current approach to long term seclusion as the CQC had questioned whether some instances of seclusion should have become segregation. This was part of the Reducing Restrictive Physical Interventions (RRPI) work and it had been suggested that a period of seclusion lasting 4 weeks should be

subject to a formal review with partners to consider whether segregation was more appropriate. Safeguards in relation to the use of segregation were also being strengthened.

YF reported that the Seclusion group had been tasked with reviewing the training programme for junior doctors. For the last rotation in February, YF had done a session with Mathew Cook from the RRPI team. A YouTube video of a patient's experience of segregation was also shared with the junior doctors.

- Section 132 – YF reported a significant improvement with inpatient patient rights and community CTOs. An audit had identified an issue with patient rights renewals not coinciding with outpatient appointments or instances where appointments had been cancelled or moved.

  CH and CL have started a piece of work to review high risk service users in the community with a view to developing some guidance. From a MHAC perspective, they are looking at conditionally discharged patients and CL has commissioned two training sessions for supervisors of those on conditional discharge (28 February and 25 March). YF added that the Mental Health Act office report on conditionally discharged patients each quarter and this is now included in the current performance report to Committee.

CH raised that the risk around seclusion on the organisational risk register currently reports to CGCSC and queried whether it would be better placed with MHAC. It was noted that this relates to difficulties accessing seclusion as some rooms have been damaged and are awaiting repair. It was agreed that the executive trio would review the risk register and make a recommendation.

Action: Tim Breedon/Subha Thiyagesh/Carol Harris

It was RESOLVED to RECEIVE and NOTE the activity.

MHAC/21/08b MHA/MCA/DoLS mandatory training update (agenda item 8.2)
This paper was taken as read with no comments.

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/21/08c Advocacy services (agenda item 8.3)
YF gave an update on advocacy services across the Trust. It was noted that an issue had been raised at the last Committee meeting about advocacy services experiencing difficulties with speaking to service users during the pandemic, either face to face or remotely.

YF advised that CL and Sue Threadgold were leading on this and had set up routine meetings with advocacy managers across the Trust. All wards now have action plans in place and at least three areas have robust arrangements for advocacy contact. Two areas are still experiencing IT issues although these are being resolved locally on a case by case basis. Matrons and practice governance leads are liaising with registered nurses to ensure that they are well engaged with advocacy services.

In response to a query from KQ, it was confirmed that face to face advocacy meetings had re-started in the autumn.

It was agreed to update the annual plan to reflect the current position on advocacy.

Action: Kate Quail/Yvonne French

MHAC/21/09 Audit and Compliance Reports (agenda item 9)

MHAC/21/09a Section 17 leave compliance update (agenda item 9.1)

CT referred to the executive summary of the Section 17 Leave Compliance Report 2020/21 and it was noted that there had been an overall improvement in compliance rates in the Trust following implementation of a new process whereby each leave form is submitted to the local MHA office, reviewed and any appropriate action taken. It was noted that there had been a marked improvement in returns from Forensic services and excellent progress with KPI returns.

KQ thanked the MHA office administration staff for this fantastic achievement and acknowledged the efforts of the Forensic service.

It was RESOLVED to RECEIVE the briefing and to APPROVE a further compliance report for March 2022 Committee.

MHAC/21/10 Care Quality Commission visits (agenda item 10)

MHAC/21/10a Visits and summary reports Quarter 3 (agenda item 10.1)

This update was taken as read with detail being covered in agenda item 10.2. It was agreed to combine these two agenda items for future meetings.

MHAC/21/10b Update on CQC MHA action plans (agenda item 10.2)

JC reported that there had been one CQC Mental Health Act visit during the last Quarter.

Committee noted that the CQC had highlighted care planning as outstanding from previous visits although actions had previously been taken to address this.

JC advised that all actions identified in 2019/20 had been completed. Six actions were now past their due date and it was noted that some of these related to care planning and one referred to the cohort ward in Newton Lodge and delays due to Covid.

EM raised that as such good progress had been made with the Section 17 leave forms, which had been an issue for a while, could something similar be done to tackle the recurring issues with care planning.

CL reported that Tim Mellard, Lead Matron is carrying out spot checks on the wards. It was queried whether this could be done as part of a QI process and JC agreed to look into this. YF advised that Karen Batty is leading on care plans on SystmOne and suggested that JC link with Karen.

Action: Julie Carr

It was RESOLVED to RECEIVE the update and NOTE the progress of the actions following CQC visits.

MHAC/21/11 Independent Hospital Managers (agenda item 11)

MHAC/21/11a Hospital Managers' Forum notes 18 December 2020 (agenda item 11.1)

The Committee received the notes of the Mental Health Act Managers' Forum meeting from 18 December 2020.

GH highlighted the following points:

- The Mental Health Act office administrators continue to go the extra mile to facilitate hearings and overcome problems. GH gave a recent example of a CTO patient being contacted at home and encouraged to join a virtual meeting. The patient did join and was fully engaged.
- Some technical issues continue but are taking less time to resolve.
- There appears to be less patient anxiety and the Hospital Managers can see how well the patients are being supported by staff who are monitoring anxiety levels and taking action where necessary.
- The Hospital Managers really appreciated the goodwill payment of £50 each. GH thanked KQ and ST for their efforts in resolving this.
- The efforts of the Hospital Managers to ensure that service users' rights continued to be upheld during the pandemic had been acknowledged in the MHAC annual report.

GH queried whether hearings would return to face to face from 21 June when the government plans to remove all legal limits on social contact. ST advised that there is a group in the Trust looking at recovery and restoration of all services which includes a period of recovery for our staff. It was agreed that an update would come to the next Committee meeting.

Action: Subha Thiyagesh/Yvonne French

MHAC/21/12 Key Messages to Trust Board and other Committees (agenda item 12)
The key issues to report to Trust Board were agreed as:

- White Paper consultation
- Devon Judgement and our actions following that including discussion in relation to risks
- Ethnicity coding
- Update on Advocacy
- Taking forward the service user experience work, particularly around inequalities

No issues for other Committees were identified.

MHAC/21/13 Work programme (agenda item 13)
The Committee reviewed the work plan.

MHAC/21/14 Any other business
JC raised an item of other business and assured Committee that CT is working to ensure that longer term inpatients are included in the Census we have been asked to complete.

MHAC/21/15 Date and time of next meeting
The next Committee meeting will be held on 11 May 2021 2.00pm to 4.30 pm via Microsoft Teams.

Minutes of the

West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)

held Thursday 22 April 2021, 10.00 – 12.30pm

Virtually by Microsoft Teams

Present:

Cathy Elliott (Chair) (CE) – Chair, Bradford District Care NHS Foundation Trust
Chris Jones (CJ)- Deputy Chair & Senior Independent Director, South West Yorkshire Partnership NHS Foundation Trust
Keir Shillaker (KS)- Programme Director, West Yorkshire and Harrogate Health and Care Partnership
Sara Munro (SM) – Chief Executive Officer, Leeds & York Partnership NHS Foundation Trust
Sean Rayner (SR)- Director of Provider Development, South West Yorkshire Partnership NHS Foundation Trust
Sue Proctor (SP) - Chair, Leeds & York Partnership NHS Foundation Trust
Thea Stein (TS) – Chief Executive Officer, Leeds Community Healthcare NHS Trust
Therese Patten (TP) - Chief Executive Officer, Bradford District Care NHS Foundation Trust

In attendance:

Andy Weir (AW) – Deputy Chief Operating Officer, Leeds & York Partnership NHS Foundation Trust and Senior Reporting Officer, West Yorkshire and Harrogate Health and Care Partnership
Anita Brewin (AB)-Consultant Clinical Psychologist, Bradford District Care NHS Foundation Trust and Clinical Lead, West Yorkshire and Harrogate Health and Care Partnership
Jo Butterfield (JB)- Programme Manager, West Yorkshire and Harrogate Health and Care Partnership
Lucy Rushworth (minutes) (LR) – Project Support Officer, West Yorkshire and Harrogate Health and Care Partnership
Patrick Scott (PS)-Chief Operating Officer and Deputy Chief Executive, Bradford District Care NHS Foundation Trust and Senior Reporting Officer, West Yorkshire and Harrogate Health and Care Partnership
Tom Jackson (TJ)- Senior Reporting Officer, West Yorkshire and Harrogate Health and Care Partnership

Apologies:

Angela Monaghan (AM) – Chair, South West Yorkshire Partnership NHS Foundation Trust
Rob Webster (RW) – Chief Executive Officer, South West Yorkshire Partnership NHS Foundation Trust

Glossary of acronyms in this document can be found on page 5.

Item	Discussion / Actions	By whom
1	**Introductions:** Cathy Elliott (CE) welcomed the group, the apologies and deputies are noted as; Apologies: Angela Monaghan- Chris Jones (CJ) deputised Rob Webster – Sean Rayner (SR) deputised CE Shared that the provider collaborative will be possibly featured as a case study in the NHS Providers national report to profile best practice in provider collaboratives, and a final draft version of the report will be circulated to the Committees in Common (CinC) when available. CE highlighted that Sara Munro (SM) has been appointed a Trustee and Non-Executive Director for the Workforce Development Trust and attendees congratulated her on the appointment. **ACTION** Lucy Rushworth (LR) to circulate the final draft version of the provider collaborative case study or report when shared by NHS Providers, ideally with the post CinC meeting papers. **ACTION 1/04**	**LR**
2	**Declaration of Interests Matrix / Conflict of Interest:** There were no conflicts of interest, or changes to the declaration of interest matrix.	
3a	**Review of Previous Minutes:**	

Item	Discussion / Actions	By whom
	The minutes from the 21st January 2021 were reviewed by the meeting group and were accepted as an accurate record.	
3b	**Actions log and matters arising:** There were no matters arising. The action log was updated with the below: **1/01, Reviewing the Memorandum of Understanding (MoU)** – the meeting between Keir Shillaker (KS) and Paul Hogg has taken place completing this action. **2/01, Reviewing the Memorandum of Understanding (MoU)** – There has been limited capacity to support website presence for stakeholder updates due to current focus on wellbeing hub and suicide prevention micro-sites, however this is in future communication plans. **9/01, ATU** – This action is now complete as covered in today's agenda. **10/01, PMVA**-The Prevention and Management of Violence and Aggression (PMVA) workshop is due to take place 22/04/2021, the meeting group were made aware that the Academic Health Science Network (AHSN) have been asked nationally to prioritise reducing restricted practice, KS has held discussions already held regarding how they can support identification and flow of metrics. and an update on progress with the PMVA project will be provided at the July 2021 CinC meeting. Alert/Advice/Assure (AAA) board reporting was confirmed to be working well for the CinC members and their respective trust Boards.	
4	**Chair's update: ICS Reference Group** A document was circulated in advance outlining the Terms of Reference for the Integrated Care Service (ICS) Reference Group which is made up of some NHS Chairs and leaders of councils on the ICS Partnership Board. The Group will act as an advisory group to the ICS team on the set up of the ICS Statutory Board in line with the Government's White Paper on integrated care. CE and Brodie Clark (BC) are part of this Group and will be linking work between the CinC and into the Reference Group, with CE particularly reflecting the role of the provider collaborative, having been nominated by the NHS Chairs on the CinC. It was suggested for the Strategic meeting session in May this year that there could be a check in on the developments of the ICS to reduce repeated information as well as informal updates to NHS Chairs on CinC. **AGREED** The CinC agreed that CE will check in with CinC NHS Chair members each month for any items to raise at the ICS Reference Group monthly meetings, with updates to be received back in turn at quarterly CinC meetings, as relevant.	
	Governance	
5	**Memorandum of Understanding (MoU)** The MoU was revised collaboratively by Trusts and was reviewed at the January 2021 CinC meeting before going to the respective Trust Boards for approval. NHS Trust Chairs confirmed that their respective Boards have approved the MoU.	

Item	Discussion / Actions	By whom
	AGREED The CinC have formally agreed to use the MoU going forward. *Thea Stein (TS) entered the meeting at this point.*	
	Problem Solving	
6	**Learning Disability (LD) Challenge – speaking as one voice** The LD Health inequalities challenge has been agreed by System Leadership Executive (SLE), including a workplan which links funding to awareness training for staff, improved data and metrics, raising the profile of people with LD on waiting lists to help Acute Trusts intelligence and working with Local Authorities (LA) to improve employment status & housing availability. Two Non-Executive Directors are helping to raise the profile with this needing to be high on everyone's agenda. There was a discussion between CinC members, including the following points: • the requirement of change to be more significant at the local level with a focus on small things to make the biggest impact. • potentially the ICS being the monitor of the work and helping to share learning for places doing well on this challenge. • a common approach and minimum standards for Health Checks across providers in the ICS. • Need to start in our own trusts and service provision to improve our offers and demonstrate good practice to other providers and ICS partners to in turn influence their practice. • Use of compelling cases when reporting and informing at all levels in the ICS could be a way of maintaining the level of engagement into this work. Going forward, in relation to the metrics required for this work, there are measures available that could be reported at an ICS level, including physical health checks and COVID19 vaccination rates. Over the next 12 months there will be added measures to grow the suite of metrics to potentially have a well sourced ICS level dashboard. It is acknowledged that the LD workforce is under subscribed, particularly for nurses, and this item has been set as a priority strategy within the programme. The LD steering group will continue and be a source of best practice and learning. **ACTIONS** Mairead O'Donnell and K Shillaker to develop a communication plan to support the compelling case for change regarding the Learning Disability Challenge. **ACTION 2/04** Mairead O'Donnell to ensure an exchange of practice and metrics as local providers to benchmark service provision. **ACTION 3/04**	**MO & KS** **MO**
	Assurance	
7	**Focus on: Assessment and Treatment Unit (ATU) transformation plan** The following people joined the meeting for this item: Jo Butterfield (JB), Tom Jackson (TJ), Patrick Scott (PS) and Andy Weir (AW). AW gave an overview of the ATU transformation plan to date.	

Item	Discussion / Actions	By whom
	It was relayed to the CinC that work on the ATU transformation plan had spanned over 3 years, challenged by the pandemic and due to a need to bring all commissioners and providers together, as a first attempt at collective, collaborative, commissioning. The lead provider collaborative framework has proven useful to support this work. There are some areas to develop such as workforce skills mix, consistency in delivery as we begin to work as one unit and year 2 financial flows, but these will not impact on our ability to start the implementation. The ATU working group is committed to move forward and will continue to measure and monitor to ensure working together. It was noted that BDCFT is the lead provider. To summarise the work to date: • Year 1 funding has been agreed, and due to the changes in commissioning year will be worked on and agreed between now and quarter 2 which has the support from Directors of Finance. • Support gained by the Joint Health Overview and Scrutiny Committee • Formal sign off from the Joint Committee of CCGs has been agreed There were questions and comments raised which included occupancy numbers post COVID19, with confidence that the model works within the beds set, and the additional contingency, and this will continue to be monitored. Standardising inpatient areas and working towards a shared culture will highlight inequity in community services which may need further support from the CinC. The working group confirmed they are keeping sight of the aim which is for the ATU system to be the centre of excellence. The CinC thanked all members of the ATU workstream for their work and persistence. **AGREED** The CinC approved the implementation of the ATU reconfiguration. **ACTION** K Shillaker and P Scott to meet and discuss future reporting arrangements into the CinC. **ACTION 4/04**	**KS & PS**
8	**Focus on: Mental Health (MH) & Wellbeing Hub** The following people joined the meeting for this item: Jo Butterfield (JB) and Anita Brewin (AB) to give a presentation of the MH & Wellbeing Hub. They stated that West Yorkshire and Harrogate Health and Care Partnership (WY&HHCP) received funding from NHSE in December 2020 with the expectation to mobilise a wellbeing hub immediately, and further funding will be received throughout 21/22. There is an expectation of quick access for mental health assessment & appropriate support to any staff member, along with creating a wellbeing offer for staff disproportionately impacted by Covid19. The service model was relayed back to the CinC and aims to support all organisations, including Health, social care and Voluntary, Community and Social Enterprise (VCSE) across West Yorkshire and Harrogate (WY&H). The hub was launched on the 6th April 2021 which sees training, coaching, therapy offers and upcoming peer support networks being delivered as part of the delivery plan, along with in house provisions, a website 'microsite' which is available across the partnership and also the utilisation of Schwartz Rounds. The Hub evaluation plan and next steps were also shared. There was a question regarding gaining the maximum exposure for the service and the team	

Item	Discussion / Actions	By whom
	confirmed there are clear plans in place to communicate with people and promote the service, this will include face to face, resource packs, sharing information with managers and building competency on workforce to look out for one and other. Embedding the service for the long term effect was also raised; the funding is currently non recurrent, however the Hub's main aim is to help those impacted by the pandemic – a more robust local psychological offer is required to help with the population and staff need. Peer support was also raised as a key support line for staff and to not underestimate the power of this form of contact, The CinC thanked the team for the quick mobilisation and level of engagement.	
9	**Programme Update** <u>Autism</u> There is systemwide work happening on autism. The pandemic has not allowed full focus, however work has still continued with better understanding using barriers to access, good practice, health and employment. TP shared that BDCFT have a focus week for autism which produced some good learning that can be shared. <u>Children and Young People</u> There are significant pressures existing nationally and regionally particularly for tier 4 inpatient services, with regular meetings to try to manage risks. <u>Governance and Future working</u> The future 'mechanics' of how the programme works is being discussed in line with the Government's White Paper. The work seeks to balance place-based discussions about infrastructure with what is needed across the system and includes VCSE partners as well as statutory services. It was shared that doing this work is challenging given the uncertainty around the ICS, however the aim is to continue to add value at both system and Place. The CinC thanked the thoroughness of the paper which is well balanced. TP added that a Transforming Care Pathway (TCP) funding bid was not sighted in Bradford until very late on, and KS will raise this information back to the TCP Programme. SR shared that a SWYFT Perinatal Mental Health Service (PMHS) peer support worker shared her story at their Trust Board which helped bring the service to life, and the PMHS is also featured in the Programme as a focus point. **ACTION** K Shillaker to raise the TCP late funding information to Bradford with the Transforming Care Programme. **ACTION 5/04**	**KS**
	Horizon Scanning	
10	**Strategic meeting on 17th May 2021** • Future demand modelling • Capital The meeting is an opportunity to discuss demand modelling at each place and comparing capital strategy, and the Directors of Finance (DoF's) will be invited to present at the strategic meeting.	

Item	Discussion / Actions	By whom
	SM would like to share the future provider collaboratives and national guidance at this meeting also.	
	Agreement of Outputs	
11	**The following will be reported at the Boards:** May: • Advise: The LD Health inequalities challenge. • Advise: MHLDA Core Team Structure – Private Board. • Assure: ATU Reconfiguration. • Assure: CE to continue as the Chair of the CinC – as referenced below • Assure: MH Wellbeing Hub mobilised • Assure: Wider programme progress update	
12	**Any Other Business** The rotation of the Chair for the CinC is usually every 12 months, though due to the White Paper implementation and the future of the ICS structure the CinC have agreed for CE to continue as Chair of the CinC until January 2022, linking also with the ICS Reference Group. **AGREED** The CinC Chairs have confirmed for CE to continue as Chair of the CinC until January 2022	
	Date and Time of Next Meeting: 22nd October 2021 10am-12.30pm	

Item	Discussion / Actions	By whom
	Glossary	

ATU	Assessment and Treatment Unit
BDCFT	Bradford District Care Foundation Trust
CQC	Care Quality Commission
CAMHS	Child and Adolescent Mental Health Services
C-In-C	Committees in Common
CCG	Clinical Commissioning Group
DTOC	Delayed Transfers of Care
ICS	Integrated Care System
LD	Learning Disabilities
LCH	Leeds Community Healthcare NHS Trust
LYPFT	Leeds and York Partnership NHS Foundation Trust
MHLDA	Mental Health, Learning Disabilities and Autism
MoU	Memorandum of Understanding
NCM	New Care Model
NED	Non-Executive Director
NHSE/I	National Health Service England / Improvement
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
TCP	Transforming Care Programme
VCH	Voluntary and Community Sector
WY&H	West Yorkshire & Harrogate
WY&H HCP	West Yorkshire & Harrogate Health and Care Partnership
WY&H ICS	West Yorkshire & Harrogate Integrated Care System (internal reference to WY&H HCP)
WYMHSC C-In-C	West Yorkshire Mental Health Services Collaborative Committees in Common

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Members' Council meeting held at 10.00am on 29 January 2021
Meeting Held Virtually by Microsoft Teams

Present:	Angela Monaghan (AM)	Chair
	Marios Adamou (MA)	Staff – Medicine and Pharmacy
	Bill Barkworth (BB)	Public – Barnsley (Deputy Lead Governor)
	Bob Clayden (BC)	Public – Wakefield
	Jackie Craven (JC)	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)
	Cllr Steven Leigh (SL)	Appointed – Calderdale Council
	Ros Lund (RL)	Appointed – Wakefield Council
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Debbie Newton (DN)	Appointed – Mid Yorkshire Hospitals NHS Trust
	Cllr Mussarat Pervaiz (MP)	Appointed – Kirklees Council
	Tom Sheard (TS)	Public – Barnsley
	Phil Shire (PS)	Public – Calderdale
	Jeremy Smith (JS)	Public – Kirklees
	Keith Stuart-Clarke (KSC)	Public – Barnsley
	Debs Teale (DT)	Staff – Nursing support
	Tony Wilkinson (TW)	Public – Calderdale
	Tony Wright (TWr)	Appointed – Staff Side organisations
In attendance:	Tim Breedon (TB)	Director of Nursing & Quality / Deputy Chief Executive
	Mark Brooks (MB)	Director of Finance & Resources
	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Carol Harris (CH)	Director of Operations
	Chris Jones (CJ)	Non-Executive Director
	Mike Ford (MF)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Subha Thiyagesh (ST)	Medical Director
	Sam Young (SYo)	Non-Executive Director
	Laura Arnold (LA)	Secretary to the Chair, Non-Executive Directors and Members' Council
	Andy Lister (AL)	Head of Corporate Governance (Company Secretary) (author)
	Kevin Gelder	Strategic Planning Lead (item 7.5 only)
	Adam Newman	WRM Sustainability Consultants (item 7.5 only)
Apologies:	<u>Members' Council</u>	
	Kate Amaral (KA)	Public – Wakefield
	Paul Batty (PB)	Staff – Social care staff working in integrated teams
	Pauline McCarthy (PMc)	Appointed – Barnsley Council
	Barry Tolchard (BT)	Appointed – University of Huddersfield
	<u>Attendees</u>	
	Sean Rayner (SR)	Director of Provider Development
	Rob Webster (RW)	Chief Executive
	Salma Yasmeen (SY)	Director of Strategy

MC/21/01 Welcome, introductions and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting, apologies were noted as above. The meeting was quorate and could proceed.

AM explained the logistics of how the meeting will be run due to it being conducted virtually through Microsoft Teams. AM noted the meeting is being recorded to assist with minutes but the recording would be destroyed once the minutes are approved. Attendees of the meeting were advised they should not record the meeting unless they have been granted authority by the Trust prior to the meeting taking place.

Item 7.5 relates to sustainability and estates and Kevin Gelder (KG) and Adam Newman (AN) will be joining the meeting for this item only.

Item 8.1 concerns the appointment of a Non-Executive Director. Members of the public and directors will be asked to leave the meeting for this item as it will be held in private.

AM noted today is the last meeting for some governors namely, Lisa Hogarth (LH), Marios Adamou (MA), Adrian Deakin (AD), Paul Batty (PB). AM thanked the governors for their support and contributions during their terms.

AM further noted Charlotte Dyson (CD) is approaching the end of her second term as a Non-Executive Director and this will be her last Members' Council meeting.

Some governors are approaching the end of their first term, Daz Dooler (DDo), Kate Amaral (KA) and Barry Tolchard (BT).

MC/21/02 Declarations of Interests (agenda item 2)

No new declarations for the register of interests were received in advance of the meeting.

AM reported a declaration in relation to items 8.1 and 8.2. AM noted all Executive Directors and Non-Executive Directors (NEDs) will step out for these items and John Laville (JL) will chair.

It was RESOLVED to NOTE the declarations of interest as outlined above.

MC/21/03 Minutes of the previous meeting and the joint Trust Board and Members' Council meetings held on 30 October 2020 (agenda item 3)

It was RESOLVED to AGREE the minutes of the Members' Council meeting and the joint Trust Board and Members' Council meeting held on 30 October 2020 as a true and accurate record.

MC/21/04 Matters arising from the previous meeting held on 30 October 2020 and action log (agenda item 4)

AM noted actions highlighted in blue are considered complete unless any issues are raised in today's meeting.

MC/20/36 – Tim Breedon (TB) confirmed licences for the Institute for Healthcare Improvement programme are now available for governors. To close.

MC/20/38a – TB confirmed the work described in the action is included in the Equality, Involvement, Communication and Membership strategy. Strategy actions are to be reviewed at the next Equality and Inclusion Committee meeting. DDo represents governors on this Committee. To close.

MC/20/25 – AM noted the Constitution update has been deferred to April 2021.

MC/20/27i – Carol Irving (CI) reported she has been working with Lauren Melling around wording of discharge letter. TB has had sight of the new letter and reported this was in its final stage and ready for sign off next week. TB noted CI's input had been very helpful. TB stated he would keep CI updated. TB noted there is to be a change in the way Trust letters are signed off to improve letters in the future. The Members' Council Quality Group (MCQG) have an action to monitor progress.

LH asked why it had taken so long to resolve this matter. TB acknowledged it had taken longer than it should and a new clinical record keeping group will now monitor correspondence. TB confirmed service users are now included in the new process. To close.

AM asked for a new action to review the way the Trust writes notes and communications to service users, families and carers. Letters and communication need to reflect the Trust values of compassion and care. Debs Teale (DT) raised a concern about access to health records following bereavement and the jargon used. AM asked TB to take this into the MCQG also. TB reported these issues were all part of the new Equality, Involvement, Communication and Membership strategy and would feed into MCQG.

Action: Tim Breedon

Joint TB/MC-1 – Bob Clayden (BC) reported he had not been contacted until the day before yesterday and the action is out of date. BC reported the action had now moved on. AM reported she would follow up the item with Sean Rayner (SR).

Action: Angela Monaghan

MC/21/05 Chair's report – to include feedback from the Trust board meeting held on 26 January 2021 (agenda item 5)

AM's report outlined activity of Chair and NEDs since last meeting and AM noted the following key items from the Trust Board meeting held on 26 January 2021:

- The Trust Board Business and Risk meeting took place on 26 January 2021.
- The new Board Assurance Framework (BAF) was approved.
- The Organisational Risk Register (ORR) was reviewed.
- Assurance for Infection, prevention and Control in relation to the Covid-19 was received.
- Assurance in relation to the Ockenden Review (concerning maternity services) was received.
- Reports providing updates for the West Yorkshire and South Yorkshire business developments including Integrated Care Systems (ICSs) were received.
- The Integrated Performance Report (IPR) was received in addition to updates from Trust Board Committees.
- An updated Scheme of Delegation was approved.
- In the private meeting the Chief Executive's dual role was reviewed.
- Commercially confidential business development updates including the Adult Secure Lead Provider Collaborative and integrated care developments in Barnsley were received.
- Progress for the Mental Health, Learning Disability and Autism Alliance development in South Yorkshire and Bassetlaw was received.
- A verbal update in relation to Serious Incidents was received
- A planning update was also received.

Adam Jhugroo (AJ) asked about staff vaccinations and take up from ethnically diverse populations. London statistics suggested update may be less among Black African, Black Caribbean and Filipino communities.

TB reported early data is being analysed to identify groups where uptake may be lower. The vaccination is being offered equally across all staff. Staff are being utilised across the vaccination hubs to represent diverse communities. TB reported targeted work is taking place to encourage people to have the vaccine.

Mark Brooks (MB) reported 4194 vaccinations had been administered as of this morning and a further 100 staff were booked in to be vaccinated today.

AM reported the Trust communications team was working to “myth bust” and provide staff with factual evidence to enable informed decisions to be take about the vaccine. It is an individual decision for staff members ultimately as to whether they have the vaccine or not.

Tony Wright (TWr) asked if there had been any concerns raised in respect of the Chief Executive’s dual role in the private board meeting.

AM reported the Board had reviewed the position from the Trust’s perspective, the West Yorkshire ICS perspective and Rob Webster’s (RW) personal perspective. RW had given a summary of this position and then left the Board meeting for the other Board members to consider the arrangements. The Board are satisfied the current arrangements are working but this will be subject of further review as integrated care systems evolve.

Tony Wilkinson (TW) asked about Red, Amber, Green ratings (RAG) and the context of how they are used. TW asked if Red meant it would receive a higher priority.

AM explained the use of RAG ratings in relation to the BAF, ORR and performance reports and that each document would contain a key that explained the meaning of the different ratings in relation to each specific document.

JL asked about the Trust response to the ICS arrangements and if any delays were expected. TB reported further clarity is to be received in the next two weeks around expected timescales.

Phil Shire (PS) reported there is a useful article from the Kings Fund explaining the context of the ICS developments and he would send this to the corporate governance team for circulation.

BC provided feedback from the West Yorkshire and Humber cancer alliance in relation to RW’s dual role, stating that RW’s leadership in the ICS has helped to get a more patient centred approach.

Councillor Pervaiz (MP) reported she lives in an ethnic minority area and the community is being encouraged to listen to healthcare staff and not to listen to social media. MP is involved in circulating videos to promote the vaccine. MP’s father has had the vaccine and is fine. This has been circulated in the local community in Dewsbury and has worked to good effect. AM asked if the video could be shared with the Trust it would be very helpful for communications use.

Action: Laura Arnold

It was RESOLVED to NOTE the Chair’s report.

MC/21/06 Chief Executive’s update (agenda item 6)

TB reported updates on the following key points in the absence of RW:

- TB noted the significant change in the prevalence of Covid-19 since the last meeting and the pressure this has brought to Trust staff over the Christmas period. TB praised the very positive response of Trust staff over Christmas.
- Prevalence of the virus remains high.
- Services are stable, face to face contact continues where necessary.
- Two vaccination hubs are now operational at Fieldhead (Wakefield) and Kendray (Barnsley).
- Staff self-testing continues with lateral flow tests.
- The Trust is maintaining focus on emergency arrangements with colleagues to support vaccine response.
- Flu vaccinations have concluded with good uptake, the EU exit is complete leaving the focus on the Covid-19 response.

- Staff wellbeing remains a key priority.
- Focus on inequalities work continues within the Trust for both staff and service users.
- The Trust is managing well in difficult and challenging times keeping safety at the forefront of our minds.

AM noted the work of staff and volunteers throughout the Trust and thanked them for their phenomenal efforts.

LH queried the accuracy of lateral flow testing.

TB reported accuracy was about 60-70% accurate. If a positive test is identified a further polymerase chain reaction (PCR) test takes places to confirm the outcome. It is acknowledged that lateral flow test is not as accurate as PCR but works well as an early indicator.

DT has been a volunteer at the vaccine hub, feedback has been fantastic, describing the experience as smooth, easy and pleasant. The team are responding incredibly well to changes.

Councillor Lee (SL) queried lateral flow testing and problems with false negatives.

TB responded to state there was little evidence to suggest this was the case.

Dylan Degman (DDe) stated lateral flow testing is done twice a week to reduce likelihood of false negatives.

It was RESOLVED to NOTE the Deputy Chief Executive's update.

MC/21/07 Members' Council Business Items (agenda item 7)

MC/21/07a Governor Engagement Feedback (agenda item 7.1)

AM introduced the item and asked for the paper to be taken as read:

- JL reported virtual governor meetings by district have now been set up and are working well. These have been aligned with the Members' Council Coordination Group (MCCG).
- Dawn Pearson (DP) and the communications team have produced a draft document about community involvement. The document has been reviewed by governors in virtual meetings and JL will summarise a response to DP.
- JL contacted Platform 1 yesterday – a men's mental health group in Kirklees. JL will now receive monthly updates from this group.
- The intention will be to mirror this work in other areas, with other groups, and feed information back into the Trust.
- The governor elections are ongoing, and applications are being encouraged where appropriate.

It was RESOLVED to NOTE the governor engagement feedback.

MC/21/07b Assurance from Members' Council groups and Nominations Committee (agenda item 7.2)

AM gave an overview of each of the groups that sit under Members' Council, MCCG, MCQG and Nominations Committee.

AM asked to take paper as read.

AM reported NHS Providers is a national body which represents all NHS Trusts across the country. As part of their work they provide support for governors and have a Governor Advisory Committee.

The Trust received information about a vacancy for this committee at the end of last year and was brought to the meeting on 14 December 2020. Due to a timing issue we were not able to

communicate this to governors, but this is now on the work plan and will be highlighted in time for next year. As a result, the Trust did not put anyone forward.

Nominations have closed and voting will start soon and close on 26 March 2021. The recommendation is for MCCG to make the decision on behalf of Members' Council. We get one vote as an organisation.

It was RESOLVED to AGREE that the Members' Council Co-ordination Group makes the vote for the NHS Providers Governor Advisory Committee on behalf of the Members' Council at the meeting on 8 March 2021.

JL will be coordinating a meeting soon to look at Members' Council development plan and welcomes input from all governors.

BC asked for candidates for the NHS Providers vote to be shared well before the MCCG meeting.

Action: Laura Arnold

AM reported encouragement for a governor to co-chair the MCQG had been taking place for some time. PS has stepped forward to take up this role and TB and PS will be meeting next week to look at how this will work.

It was RESOLVED to AGREE that Phil Shire will become co-chair of the Members' Council Quality Group.

AM reported TWr had self nominated for the vacancy on MCCG and as the only nominee he is now an appointed governor on that group.

AM clarified there were no further points of note or queries for this item.

It was RESOLVED to RECEIVE the assurance from Members' Council groups and Nominations Committee

MC/21/07c Update on Members Council Elections (agenda item 7.3)

In addition to the paper Andy Lister (AL) highlighted the following:

- Adverts have gone out in the Yorkshire Post for public governors.
- Two adverts a week are being posted on Trust social media.
- E-mail and postal information have been sent out to members in the constituencies where there are vacancies.
- DP and the communications team are proactively encouraging applications from diverse networks.
- For staff vacancies, direct communications are being sent into the relevant staff groups.
- Adverts have been placed in "The Brief".
- "Headlines" are advertising every week and a further notice has been placed on the electronic payslips message board.
- As of this morning there are four verified public nominations.
- One verified staff nomination.
- This month has seen eight new members join the Trust.

BC reported he had received some comments from members who perceived the information to be about voting and not nominations. AL agreed to look at the election material to make sure it is clear.

Action: Andy Lister

It was RESOLVED to RECEIVE the update on the Members' Council elections 2021.

MC/21/07d Trust Performance Update (agenda item 7.4)

AM noted the slides had been sent to governors for their review.

Chris Jones (CJ) introduced the item and gave apologies for the late circulation of the document but thanked MB, TB and Alan Davis (AGD) for their work in keeping the Board updated in relation to performance during the pandemic.

CJ highlighted the following points in relation to national metrics:

- The single oversight framework is the criteria by which the regulators judge the performance of the Trust. The Trust has been in band 2 for most of the year which demonstrates a good performance in terms of quality and finance.
- Children in adult inpatient wards is monitored closely by the Trust, this is always taken as the "least worst" option.
- Inappropriate "Out of Area" (OOA) bed days continues to be a challenge for the Trust and is closely monitored and managed.
- There has been a steady increase in compliments received which is positive in the current climate.
- Safer staffing fill rates are consistently over 100% aggregate.
- Patient safety incident numbers are in the acceptable range.
- Confidentiality breaches continue despite considerable work in this area.
- Child and adolescent mental health services (CAMHS) referral to treatment waiting times continue to improve.

CD introduced the following sections:

Quality

- Service users are tested for Covid-19 on admission and then tested every third and seventh day. If positive, we have a good system to manage outbreaks.
- There has been good uptake for calls to the Occupational Health (OH) line.
- There are increasing numbers of staff being able to work from home.

Covid-19 response

- Staff lateral flow testing we have had a good level of response and monitoring.
- In care homes we have an enhanced support offer in Barnsley.
- Personal protective equipment (PPE) supply is in good order.

Patient Experience

- Friends and Family test – despite pressure, staff continue to give high quality level of service with 98% of respondents stating they would recommend community health services and 90% would recommend our mental health services.
- Experience with the trust rated as good or very good is 91%. This is reviewed in further depth in the Clinical Governance and Clinical Safety Committee (CGCS) by area, looking at themes and learning opportunities.
- Text messages for service user opinion have resumed very recently following the response to the pandemic.

Safer Staffing

- The Christmas period was very difficult, the staff fill rate is shown at 115%. This is due to the acuity in inpatient areas. It is important to get the right mix of staff. The average fill rate for registered nurses is just above 90%, an increase from last month.
- Community safer staffing is under review and a report will be going into CGCS soon.

Incident Reporting

- Total number of incidents is around 1000 per month. This shows incidents are still getting reported, which is positive, given the pressure on staff.
- Moderate and serious incidents which have increased. All serious incidents investigations are completed a via Root Cause Analysis process and a weekly risk scan takes place looking at themes.

- Incidents with moderate harm has seen an increase whereas serious incidents have remained at expected levels.
- Self harm has increased, and this is being discussed at CGCS and is being reviewed.

Single oversight framework

- The Trust is at Level 2 which is graded as "targeted support", but we are performing above target against most of our national indicators.

AGD highlighted the following:

Workforce metrics

- Non Covid-19 sickness is at lowest level for years, 1% lower than last year.
- Stress and anxiety is up in the staff group – enhanced support is available for staff.
- Staff illness and Covid-19 absence is at 8.37% but this is still lower than April 2020.
- Highest ever uptake of Flu vaccinations, we were joint first Trust in the country.
- The impact of flu has been negligible this year due to high uptake of the vaccine and handwashing and extra measures.
- Mandatory training statistics remain at a good level. Where face to face training is required, staff safety is a priority with Covid-19 measures in place.
- Staff turnover is lower than in previous years at just under 10%
- Corona virus and its disproportionate impact – we now have a BAME (Black, Asian, and Minority, Ethnic) wellbeing practitioner funded through the NHS charities programme.
- Vaccine take up from the BAME community and colleagues. Our aim is to vaccinate 100% of staff but there is lower uptake in certain groups.

CJ highlighted the following points:

Finance

- The Trust is currently performing with a surplus against the plan of a £2m deficit.
- Significant cash balances are present, but this is due to being paid one month in advance and will unwind by the end of the financial year.
- Capital expenditure is a little behind but optimistic about spending £5m.
- MB and team continue to work hard with the better payment requirements.

Performance

- For the first half of the year the Trust was required to break even.
- The deficit of £2.1m was expected but is now reduced to as recruitment hasn't taken place and out of area beds has been less costly than anticipated.
- The Trust is spending more than last year due to pay uplifts and investments and costs of Covid-19.
- Cost pressure remain due to staffing pressures in inpatient services due to high levels of acuity and demand but there is confidence we can achieve the planned deficit.

TB confirmed following a query that reusable PPE was not an option currently due to the risk of transmission. AM noted sustainability was on today's agenda.

CD confirmed the CAMHS friends and family test results were not as good as they previously have been but there were plans in place as to what could be done in this area. AM confirmed the CAMHS Friends and Family test figures could be added for the next meeting.

Action: Tim Breedon / Mark Brooks

Jackie Craven (JC) asked for an update in relation to CAMHS.

Carol Harris (CH) reported there have been significant improvements in waiting times in Barnsley and Wakefield. CAMHS pressure remains in treatment waits for Autistic Spectrum Condition and Attention Deficit Hyperactivity Disorder especially in Kirklees and Calderdale. Detailed CAMHS reports go into CGCS Committee.

LH reported she has been impressed by Trust response to protecting staff. As a member of the BAME community LH feels very safe at work. LH asked AGD if it has been established why staff are feeling anxious and stressed.

AGD reported stress and anxiety has gone up. When reviewed in detail it has reduced in qualified nursing staff but increased in estates and support workers and some of the administration staff. Prior to the pandemic, the pressure was in inpatient areas due to violence and aggression against staff. Inpatient areas have been a focus. The Trust has a good reactive level of support for staff, it is now looking to be more proactive.

AGD reported violence and aggression should not be tolerated but we need to deal with it more effectively. Staffing levels have been a pressure area and there are lots of factors to consider.

JL thanked CJ and CD for presenting the data and their detailed knowledge of the figures. JL asked if the Trust analysed the causes of OH referrals for improvements. JL queried the OOA bed metrics against CJ's comments.

AGD reported the reason for absence and OH referrals were analysed.

MB reported three years ago all NHS organisations had to identify an approach to eliminate the use of OOA beds over three years. In our national metrics that is what we report against, a reducing target of use of beds each year. Internally we recognise that isn't possible and we have set a financial budget that recognises we perform better against our internal target.

SL asked to be sent a copy of the satisfaction survey forms. The danger with surveys is they don't necessarily ask the right questions patients may wish to answer.

Action: Laura Arnold

DDe reported work was ongoing with surveys with DP her team and the right questions will be asked going forward.

AM clarified that the Friends and Family test was only one source of service user and carer feedback and believed the questions are nationally mandated. There is more than one measure to get feedback.

AGD informed governors that the Trust aims to vaccinate 100% of its staff but Covid-19 vaccinations are not mandatory but an option for staff.

PS asked whether the vaccine prevents transmission. If this is the case shouldn't it be mandated.

AM said there has been significant debate about this but there is no significant evidence that the vaccine prevents transmission. At the moment it is there to stop the individual catching it. Mandating the vaccine would have to be a national decision.

SL believed patients have a reasonable expectation that staff have been vaccinated.

DDe reported even if staff have had the vaccine, current information states a person can still carry and spread the virus. DDe reported everyone has a part to play in protecting everyone else.

It was RESOLVED to RECEIVE the update in relation to Trust Performance.

MC/21/07e Focus On – Estates and Sustainability (agenda item 7.5)

AM introduced the item and Kevin Gelder (KG) highlighted the following points:

- The Trust operates from a large and varied estate.
- There are 60 sites, 18 are Trust owned and 42 are held under a lease or a licence.
- Other informal arrangements exist such as GP premises, other NHS trusts, schools and council buildings.

- The bulk of the cost of leased estate is for the inpatient wards in Dewsbury and Halifax and comprehensive local investment finance trust (LIFT) estate in Barnsley with several community health centres.
- KG summarised the previous strategy and reported the Trust had delivered against this strategy since 2012.
- 20 properties across all areas have been disposed of in recent years bringing capital funds of £20m to the Trust.
- 20 lease properties have been vacated, further rationalising the estate.
- Investment has been made to develop our community hubs in Halifax, Pontefract, Wakefield and Barnsley.
- We continue to improve and enhance existing estate.
- From an inpatient perspective the completion of the Unity Centre at Fieldhead marked the completion of the previous estate strategy.
- A new strategic plan for 2020 – 2030 was scheduled to go to Trust Board last year but this was delayed due to the pandemic.
- In its place, there is an interim whilst the Trust deals with the pandemic for the next ten to twelve months.
- The new ten year strategy will then be completed and will look at the estates impact of older people's services transformation, the potential replacement of the Dales (Halifax) and Priestley Units (Dewsbury), the Kirklees estate requirement, in particular a North Kirklees hub, and proposals for South Kirklees where the Folly Hall lease terminates in 2025.
- In addition, it will look at proposals for the Barnsley community estate
- The strategy will also consider the impact of changing work styles partly brought about by the pandemic.
- Last year we completed the sale of Ossett health centre and the Sycamores unit which brought a capital receipt of £900k. We also disposed of the last plot of non-operational land at Southmore Hospital which raised £115k.
- In 2021 Mount Vernon hospital is scheduled to complete in the next few weeks. The Keresforth centre is also for sale this year.
- The Barnsley estates accounts for 36 of the 60 properties and is far more varied than other areas of the Trust.
- The Trust intends re-invest the proceeds of both sales in Barnsley. The receipts are likely to be received in 2021 and 2022. The Trust continues to invest in the Barnsley estate and IT infrastructure.
- Investment has been focussed on service user experience and building maintenance.
- Currently improvements are being made at the podiatry unit on the Kendray estate and plans are being finalised for improvements to the older people's inpatient ward, also at Kendray.
- Plans are also in place for improvements at Mapplewell health centre.
- The Trust has committed funds for solar panels and electric vehicle charging points at Fieldhead and Kendray.
- The capital programme needs to align with the capital allocations within the integrated care system. It is anticipated this will bring access to strategic capital from central sources.
- The operation of a large estate has an impact on the environment. The Trust has a duty to consider how it addresses the climate emergency through the use and running of its estate.

AM clarified some queries from KG's presentation in the MS Teams chat, and KG clarified that valuations were carried out by external chartered surveyors.

LH queried why it has taken so long to sell the Mount Vernon site and reported staff who had vacated both Mount Vernon and Keresforth felt the moving process had been chaotic. LH asked for it to be noted that it had caused stress for staff and service users are losing services in certain areas.

KG clarified the property was marketed subject to planning and it is the planning process that has created the delay. KG reported that a lot of planning goes into moving services but noted LH's comments.

AM explained that issues around estates came into the board directly.

KG clarified in relation to the Dales and the Priestley unit, they are not purpose built for the services they provide; therefore, they are under review to ensure the best possible service provision. Any emerging options will be subject to consultation with local communities and the host NHS Trusts.

Tom Sheard (TS) asked about the disposal of surplus estate in Barnsley in 2021.

AGD reported whatever is received through capital investment is reinvested in estate and IT infrastructure. AGD stated we have invested in excess of what has been received in capital receipts in recent years. Having the right estate is essential to providing good services. The money from Mt Vernon and Keresforth will be reinvested.

TS felt aspects of the paper were misleading.

AM suggested given the number of queries it may be prudent to hold a separate meeting to cover questions on estates and sustainability.

Action: Angela Monaghan

AN from WRM consultants gave a power point presentation on sustainability which had been shared prior to the meeting. AN covered WRM as an organisation and explained sustainability in the context of the NHS and why it is important and relevant.

SL reported some carbon reducing techniques for buildings can affect the health of the occupants and asked if this would be considered.

It was RESOLVED to RECEIVE the update in relation to Estates and Sustainability

MC/21/07f Members' Council Biennial Evaluation Update (agenda item 7.6)

AM summarised the process that was taking place in relation to the Members' Council Biennial Evaluation. The external auditor was to present the findings to governors and there would be the opportunity for governors to reflect on the findings of the survey with actions then being considered by the MCCG. AL agreed to communicate the process to governors.

Action: Andy Lister

MC/21/08 Trust Board Appointments (agenda item 8)

MC/21/08a Appointment of Non-Executive Director (agenda item 8.1)

AM asked for all directors to leave the meeting, except AGD and CD who were supporting JL in the business items. AM confirmed the meeting was private before handing the chair to JL.

JL confirmed the recruitment of a new Non-Executive director is a tried and tested process.

JL briefly summarised the process and the dates over which the process had taken place. JL summarised Natalie McMillan's background and feedback from her recruitment process.

It was resolved to APPROVE the appointment of Natalie McMillan as a Non-Executive Director for a period of three years from 1 May 2021.

MC/21/08b Chairs Appraisal 2021 – process (agenda item 8.2)

CD reported:

- The process will follow as it has done on previous occasions and starts with governor views but may differ slightly from previous years due to Covid-19.
- CJ will lead the process and will conduct interviews with Lead Governor, Chief Executive, all Executive directors.

- Questionnaires will be sent to stakeholders
- Process will start in May 2021 and is line with NHS England / Improvement (NHSE/I) process.
- Once feedbacker received CJ will discuss with AM and then bring the outcome back to the Members' Council.
- The corporate governance team is looking at ways to conduct the interactive session.

JL noted this was CD's last Members' Council meeting and thanked her for support in the time she had been here.

It was RESOLVED to agree the process for the Chairs appraisal.

AM re-joined the meeting.

MC/21/09 Closing remarks, work programme, and future meeting dates (agenda item 10)

No other business items were raised.

AM reported the next meeting is the 11 May 2021.

The work programme will go to the MCCG.

BC reported he was disappointed meetings cannot take place on different days of the week.

It was RESOLVED to NOTE the work programme for 2020/21.

LH thanked everyone for their support during her time as a governor

JC thanked CD for all her help during her time as lead governor and everyone else who had supported her during this time.

JL hoped the meeting isn't deemed to be a failure as all items hadn't been fully covered. JL reported it has been a successful meeting due to governors showing a great deal of interest in items being presented.

AM gave governors reassurance around the new estates strategy that it didn't come into effect for another two years and no big decisions will be taken without consultation. We will be finalising the sustainability strategy in March 2021.

TWr asked about continuing the estates discussion through a closed WhatsApp group. AM asked if JL would like to pick this up with governors.

Action: John Laville

AM said thank you to all governors who were leaving, and to all those standing for election.

Signed: **Date: 11 May 2021**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 June 2021
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 March 2021.
Recommendation:	**Trust Board is asked to NOTE that the Trust Seal has not been used since the last report on 30 March 2021.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2021-22

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item previously deferred due to Covid-19

Note that some items may be verbal

SO	Agenda item / issue	27 Apr	25 May	29 June	27 July	24 Aug	28 Sept	26 Oct	30 Nov	21 Dec	25 Jan	22 Feb	29 Mar
	Standing items												
	Declarations of interest	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
	Minutes of previous meeting	✘		✘	✘		✘	✘	✘		✘		✘
	Chair and Chief Executive's report	✘		✘	✘		✘	✘	✘		✘		✘
	Business developments	✘		✘	✘		✘	✘	✘		✘		✘
	ICS developments	✘		✘	✘		✘	✘	✘		✘		✘
	Integrated performance report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
	Serious Incidents (private session) - verbal	✘		✘	✘		✘	✘	✘		✘		✘
	Assurance from Trust Board committees and Members Council	✘		✘	✘		✘	✘	✘		✘		✘
	Receipt of minutes of partnership boards	✘		✘	✘		✘	✘	✘		✘		✘

With **all of us** in mind.

Questions from the public (to receive in writing during Covid-19 pandemic)	✘		✘	✘		✘	✘	✘		✘		✘
Quarterly items												
Corporate / organisational risk register	✘			✘			✘			✘		
Board assurance framework	✘			✘			✘			✘		
Serious incidents quarterly report	✘		✘			✘		✘				✘
Use of Trust Seal			✘			✘		✘				✘
Half yearly items												
Safer staffing report	✘						✘					
Digital strategy (including IMT) update							✘					
Estates strategy update				✘						✘		
Annual items												
Strategic overview of business and associated risks									✘			
Investment appraisal framework (private session)							✘					
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 working hours	✘											
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘											
Review of Risk Appetite Statement							✘					
Health and safety annual report			✘									

	Patient Experience annual report			✘			✘						
	Serious incidents annual report			✘									
	Equality and diversity annual report							✘					
	Medical appraisal / revalidation annual report				✘								
	Sustainability annual report						✘						
	Workforce Equality Standards						✘						
	Assessment against NHS Constitution				✘				✘				
	Data Security and Protection toolkit	✘										✘	
	Strategic objectives												✘
	Trust Board annual work programme			✘								✘ (draft)	✘
	Operational plan										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
	Five year plan (for review in November 2023)												
	Strategic Board (headings to be considered)												
	Board Development		✘			✘				✘		✘	
	Covid-19 Reflections												
	Horizon Scanning												
	Policies and strategies												
	Constitution (including Standing Orders) and Scheme of Delegation *(January 2020) (deferred to June 2021)*						✘						
	Customer Services policy *(May 2021)*			✘									
	Estates strategy *(July 2022) (in draft prior to sign off) (private)*												✘
	Learning from Healthcare Deaths Policy (January 2022)										✘		

Sustainability strategy *(June 2020)*			✘										
Organisational Development Strategy *(June 2020)*				✘									
Procurement Strategy (June 2021)			✘										
Workforce strategy *(March 2020)*	✘												
Quality strategy *(September 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 (deferred to await ICS development changes) (Scheme of Delegation may need to come back in 2021/22 for further update)
- Equality, Involvement, Communication and Membership Strategy (October 2023)
- Customer Services Policy *(next due for review in June 2020, extended to October 2020 now due May 2021)*
- Digital Strategy *(next due for review in March 2024)*
- Estates Strategy *(next due for review in July 2022)*
- Learning from Healthcare Deaths Policy *(next due for review in January 2022)*
- Organisational Development Strategy *(next due for review in June 2020)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) (amendment version June 2021) *(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 2024)*
- Workforce Strategy *(next due for review in March 2023 (if approved at Board March 2020))*