Trust Board (performance and monitoring)
Tuesday 28 September 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 July 2021**	Chair	**Paper**	2	To approve
4.	9.05	**Matters arising from previous Trust Board meeting held 27 July 2021 and board action log**	Chair	**Paper**	10	To approve
5.	9.15	**Service User / Staff Member / Carer Story**	Deputy Director of Operations	**Verbal item**	10	To receive
6.	9.25	**Chair's remarks**	Chair	**Verbal item**	3	To receive
7.	9.28	**Chief Executive's report**	Interim Chief Executive	**Paper**	7	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
8.	**9.35**	**Performance reports**				
	9.35	8.1 Integrated performance report Month 5 2021/22 • Community Transformation programme update	Interim Director of Finance & Resources/Director of Nursing, Quality and Professions & /Director of Operations/Director of Strategy	**Paper**	60	To receive
	10.35	*Break*			*5*	
	10.40	8.2 Serious incident report quarter 1 2021/22	Director of Nursing, Quality and Professions	**Paper**	5	To receive
	10.45	8.3 Financial planning arrangements 2021/22 H2	Interim Director of Finance and Resources	**Paper**	5	To receive
	10.50	8.4 Emergency Preparedness Resilience and Response (EPRR) Core Standards	Interim Chief Executive	**Paper**	5	To approve
	10.55	8.5 Reset and Recovery – Demand and Capacity modelling	Director of Provider Development	**Paper**	5	To receive
9.	**11.00**	**Business developments**				

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.00	9.1 Integrated Care System developments white paper update	Director of Strategy	**Paper**	10	To receive
	11.10	9.2 South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Interim Chief Executive/ Director of Strategy	**Paper**	10	To receive
	11.20	9.3 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) - Wakefield Integrated Care Partnership Update	Director of Strategy/Director of Provider Development	**Paper**	10	To receive
	11.30	9.4 Receipt of Partnership Board minutes	Chair	**Paper**	5	To receive
	11.35	*Break*			*10*	
10.	**11.45**	**Strategies and policies**				
	11.45	10.1 Quality Strategy update	Director of Nursing, Quality and Professions	**Paper**	5	To receive
	11.50	10.2 Workforce Strategy Equality Impact Assessment (EIA)	Interim Director of Human Resources	**Paper**	5	To approve
	11.55	10.3 Green Plan EIA	Interim Chief Executive	**Paper**	5	To approve
11.	**12.00**	**Governance matters**				

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	12.00	11.1 Quality Account	Director of Nursing, Quality and Professions	**Paper**	5	To receive
	12.05	11.2 Medical appraisal/revalidation annual report	Medical Director	**Paper**	5	To receive
	12.10	11.3 Patient Experience annual report	Director of Nursing, Quality and Professions	**Paper**	5	To approve
12.	12.15	**Assurance and receipt of minutes from Trust Board Committees and Members' Council** - Clinical Governance & Clinical Safety Committee 14 September 2021 - Finance, Investment & Performance Committee 23 August and 22 September 2021 - Mental Health Act Committee 17 August 2021 - Workforce and Remuneration Committee 21 September 2021 - Members' Council meeting 17 August 2021	Chairs of committees/Members' Council	**Paper**	10	To receive
13.	12.25	**Use of Trust Seal**	Chair	**Paper**	5	To receive
14.	12.30	**Trust Board work programme for 2021/22**	Chair	**Paper**	3	To approve
15.	12.33	**Date of next meeting** The next Trust Board meeting held in public will be held on 26 October 2021.	Chair	**Paper**	2	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
16.	12.35	**Questions from the public**	Chair	**Verbal**	10	To note
	12.45	*Close*				

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

Present:	Angela Monaghan (AM)	Chair
	Chris Jones (CJ)	Deputy Chair / Senior Independent Director
	Mike Ford (MF)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
	Mark Brooks (MB)	Interim Chief Executive
	Tim Breedon (TB)	Director of Nursing and Quality / Deputy Chief Executive
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Dr.Subha Thiyagesh (ST)	Medical Director
Apologies:	Natalie McMillan	Non-Executive Director
	Kate Quail	Non-Executive Director
In attendance:	Carol Harris (CH)	Director of Operations
	Lindsay Jensen (LJ)	Deputy Director of Human Resources and Organisational Development
	Lisa Kelly (LK)	Mental Health Liaison Team Practitioner
	Sean Rayner (SR)	Director of Provider Development
	Darryl Thompson (DT)	Deputy Director of Nursing and Quality
	Julie Williams (JW)	Assistant Director of Corporate Governance, Performance and Risk
	Salma Yasmeen (SY)	Director of Strategy
	Andy Lister (AL)	Company Secretary (author)
Observers:		
	Robert Storr	360 Assurance
	John Laville	Public Governor - Kirklees (Lead Governor)
	Tony Wilkinson	Public Governor - Calderdale

TB/21/64   Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies were noted, 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 introduced attendees Lindsay Jensen, Darryl Thompson, Julie Williams and Robert Storr from 360 Assurance, the Trust's internal auditor, who was attending to observe the public Board meeting.

With **all of us** in mind.

Apologies were received from Natalie McMillan, Kate Quail and Chiara DeBiase, the Insight Programme candidate.

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/21/65   Declarations of interest (agenda item 2)

Name	Declaration
Chair	
Monaghan Angela Chair	Spouse is Associate Consultant with Project Rome. Consultancy projects may include NHS clients.
Non-Executive Directors	
Natalie McMillan Non-Executive Director (appointed 1 May 2021)	Director/owner of McMillan and Associates Ltd Chair of Kyra Women's Project, York

It was RESOLVED to NOTE the changes to the declarations of interest.

TB/21/66   Minutes from previous Trust Board meeting held 29 June 2021 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 29 June 2021 as a true and accurate record.

TB/21/67   Matters arising from previous Trust Board meeting held 29 June 2021 (agenda item 4)

TB/21/52 – This action relates to last month's Board story and mandatory training. AGD reported there is a detailed process for agreeing mandatory training through specialist advisors. AGD explained the governance process and that it concluded with sign off through the Extended Management Team (EMT). To close.

TB/21/55 – The Friends and Family test review. TB reported an update has been included in this month's Integrated Performance Report (IPR). Noted and to close.

TB/21/55 – TB reported the Clinical Governance and Clinical Safety committee will monitor the transition to the FIRM risk assessment and this is included on the Committee agenda setting schedule. Noted and to close.

TB/21/55 – Non-Executive Director (NED) involvement in reset and recovery work. AM noted a discussion with the Non-executive directors (NEDs) still needs to take place. Action to remain open.

TB/21/58b –Serious incidents annual report, MF agreed to have an introductory meeting with Darryl Thompson and follow up outside of the Board meeting. To close.

TB/21/39a – The new Trust Board workplan is in progress. To remain open.

TB/21/25a – The green plan Equality Impact Assessment is complete and is coming to Board in August. To Close.

TB/21/27 – Psychology Commissioning, Sean Rayner (SR) updated this item will be on the Mental Health, Learning Disability and Autism programme board agenda in August and SR will update September Board.

TB/20/74 – The publishing of Public Board meeting recordings on the Trust website. Andy Lister (AL) reported a national consultation on the recording of meetings through the company secretary network has taken place. The current practice of informing all parties the Board meeting is being recorded to support the minutes and is to be deleted once the minutes are approved is recommended to continue at this time. This approach was agreed. To close.

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

TB/21/68   Service User/Staff Member/Carer story (agenda item 5)

AM introduced Lisa Kelly, a Mental Health Liaison Team clinical lead nurse in Calderdale.

Lisa introduced the MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) pathway which is for patients with very serious anorexia nervosa. The pathway involves the Mental Health Liaison team, the medical ward at Huddersfield Royal Infirmary (servicing both Kirklees and Calderdale), and the Eating Disorders Unit in Leeds. These services came together following a review of a number of patient deaths that were considered to have been preventable.

The pathway identifies a number of standards and interventions designed to keep patients safe, to educate clinical medical staff, and get patients access to the correct psychological support.

Lisa used the example of Penny (name changed) who is a 42-year-old woman with anorexia. Penny had never engaged with mental health services previously, but following the isolation experienced during Covid-19 Penny became very ill. This was identified by her GP during a routine check-up.

Penny's Body Mass Index (BMI) was 11. A BMI under 13 requires a patient to be on a medical ward. Penny refused admission to the medical ward and tried to take her own life, but was found by her family, treated, and referred to the MARSIPAN pathway.

On admission, Penny was fed through a tube in her nose, under the best interest criteria of the Mental Health Act. This was emotionally draining for Penny, her family and the staff involved in her care.

Penny improved well through the treatment and necessary interventions, and engaged with psychological support. She has now gone to the specialist Eating Disorder Unit in Leeds. She remains in treatment today and has written a card to Lisa and her Psychiatrist, Dr Rasha:

"You have both played a vital role in transforming my tsunami wave of illness and despair into a tsunami wave of recovery and hope. I am deeply grateful for your professional care, skill and compassion. You both definitely went above and beyond for me. During my stay in hospital poetry has been hugely healing for me and I came across a poem on gratitude which I have written out for you. Heartfelt thanks and warmest wishes."

Lisa explained the poem was about gratitude and explained the context as "if you accept help when you need it, you get a better sense of self".

Carol Harris (CH) thanked Lisa for her story and asked her to tell Board about how the team works with acute trusts and any pressures that arise.

Lisa explained the pandemic had brought pressure as had the lack of available beds. Patients on the MARSIPAN pathway need a medical admission. If there is no bed available on the gastronomic ward (where the pathway is familiar to staff) it can be hard to implement on wards where staff aren't aware of the pathway. Staff throughout Huddersfield Royal Infirmary are now being trained so that they are aware of what is required for patients on the MARSIPAN pathway.

Ongoing training is available to the medical ward and weekly reviews are taking place. Pathway meetings take place and recent patients are discussed and areas of good practice and learning are identified. Contingency planning also takes place in case patients require admission again.

Patients on this pathway are normally very unwell with acute behaviours, and compliance with treatment is low. The psychological impact on staff on the medical ward is a key priority and staff are provided support through clinical supervision and additional support, as required.

ST questioned if there is increasing demand for adult eating disorder patients, noting a considerable increase in the referrals for children and young people.

Lisa reported adult referrals have increased by 80% in last two years and the degree of illness has increased. The number of adults requiring medical admission has quadrupled in the last ten years.

Lisa stated the MARSIPAN pathway has produced clear lines of communication between the Liaison Psychiatry team, the medical ward and the Eating Disorder Unit, and this has been a significant improvement.

MB stated the story clearly illustrated the team's dedication to help others, demonstrating the Trust's values in their work. MB noted the impact of the pathway on staff along with rising demand and asked if the Board can do more to support the staff and the team.

Lisa reported one of the desired goals is to provide one-to-one mental health support for patients during their admission to medical wards but there is some way to go before this can be achieved.

AM thanked Lisa for her story and the work conducted by Lisa and her team and asked to pass on the Board's thanks to Penny for allowing her story to be told today.

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

TB/21/69 Chair's remarks (agenda item 6)
AM made the following comments:
- Tim Breedon (TB) and Sam Young (SYo) are attending their last Board meeting today.

- SYo is leaving after three years as a Non-Executive Director (NED), and has brought a large amount of energy, drive for improvement and skills for transformational change, particularly in relation to digital aspects of Trust work. Sam has brought a rich perspective and often diverse opinion to Board discussions which has been extremely valuable. AM thanked SYo for her contribution to the Trust.

- TB joined the Trust in 2006, became Director of Nursing and Quality in 2013, and more recently has been the Deputy Chief Executive. He has made an enormous contribution to the Trust and has been instrumental in leading the change from the CQC rating of 'Requires improvement' to 'Good'.

- TB is highly regarded throughout the Trust, and across the region, for his improvement work. He has led with calmness and compassion throughout the pandemic and has held safety at the forefront of everything the Trust has done. He is always supportive of new nurses and developing new staff, and is a great leader and role model. AM thanked TB on behalf of the Board for all that he has done.

It was resolved to NOTE the Chair's remarks.

TB/21/70   Chief Executive's report (agenda item 7)
Chief Executive's report
MB highlighted changes that have occurred since the report was written on 19th July:
- MB noted that, in his first month as interim Chief Executive, the key focus has been the increase in prevalence of Covid-19, and the increase in demand across the Trust and other health settings.
- System pressures are coming to the fore, and as a result most organisations and systems have reintroduced their command structures, including the Trust.
- Staff absence has increased due to themselves or family members being symptomatic and test and trace procedures.
- The Health and Care Bill has had its second reading at parliament and should feature in a future Board agenda.
                                                      Action: Andy Lister
- The Trust is part of an anti – racism campaign and has responded to the recent events at the European football championship final.
- A recent report has highlighted the impact of Covid-19 on people with a learning disability. This has drawn the Trust's focus to the heightened risks of the pandemic to those with learning disabilities.
- MB reported TB and SYo would be very much missed by the Board and thanked them for their contributions to the Trust over the years.
- MB noted there is consultation taking place around mental health standards which the Trust will be invited to engage with.
- A further consultation is in progress around the requirements of NHS staff visiting care homes and the need for them to be double vaccinated.
- Further guidance has been received around the new hospitals programme, and mental health trusts are being encouraged to apply for available monies.

AM noted there had been public protests over the weekend and comments made may have been distressing to health and social care staff. AM reported she strongly supports all staff in everything they are doing and wholeheartedly rejects and condemns comments made at the weekend.

A discussion followed about staff feelings to changes in the Board and leadership, and if this has had any impact on morale.

It was noted the retirement of TB and Alan Davis (AGD) had been planned for some time. On reappointment AM had asked for a review after one year and as such appropriate succession planning has taken place.

MB reported he is looking to visit as many services as possible in the forthcoming weeks to offer an executive presence and reassurance about the stability of the organisation. In future weeks and months work will take place to assess any impact on staff morale so the Trust can respond accordingly. Some issues have already been identified in individual teams and these are being addressed.

AGD reported the Trust has a number of insight events planned taking a 360 degree view of recent changes. There is a weekly meeting with staff side. Cherill Watterston, the Workforce Race Equality Standard Organisational Development (WRES OD) lead, is speaking to services as is Estelle Myers the lead Freedom to Speak Up Guardian.

AGD noted the strength of the Executive team and Board and reported the Trust values remain unchanged.

EM made reference to the Health and Care Bill and the need for future scrutiny by the Board and asked if the Covid enquiry and the review of the Mental Capacity Act (MCA) and Mental Health Act (MHA) need to be addressed at Board level.

MB reported a governance process is already in place for the Covid enquiry, and the consultation around the MCA and MHA will go to the MHA Committee first for scrutiny and will then be presented to Board if required.

AM thanked MB for his report.

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

TB/21/71 Risk and Assurance (agenda item 8)
TB/21/71a Board Assurance Framework (BAF) strategic risks (agenda item 8.1)
Julie Williams (JW) highlighted the following updates:
- A significant review of controls, assurances and target dates for actions took place in April 2021
- The Executive Management Team discussed the BAF in July to consider the impact of any changes in circumstances and the impact of these on any Trust strategic risks.
- EMT concluded that assurance levels had been maintained throughout the pandemic. The Trust has demonstrated strong mitigation against its risks as demonstrated in controls and assurances.
- EMT have considered the scoring of the strategic risks and no changes in assurance have been recommended at this time.

Chris Jones (CJ) reflected on papers presented at the Finance Investment and Performance (FIP) Committee and the demand paper that features later on the agenda and queried what circumstances would cause Risk 2.3 (Increased demand for services and acuity of service users exceeds supply and resources available leafing to a negative impact on quality of care) to move to red.

CH reported the Trust is generally managing demand, but it is putting pressure on services and there is significant pressure on staffing.

JW reported an intelligence tool has been developed to look at demand across each of our services and places, and will be critical in assessing demand and whether we are moving from amber to red. Reports regularly go into the Operational Management Group, and there is a working group now in place around waiting lists.

Weekly reports are going into Business Development Units (BDUs) who all have access to data showing their performance against key indicators. JW reported there is still work to do, but the foundations are being put in place to build on this work.

MB noted these are strategic risks, and different services are experiencing different demands, which may not affect all services in the same way. The Board needs to consider what specifically would need to happen for the assurance level to change to red.

Action: Julie Williams

Mike Ford (MF) noted risk 1.4 (Services are not accessible to, nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy). MF reported the gaps in assurance look fairly small, and asked could this move from amber to yellow? Does the Board need to reflect on the changes in leadership in relation to risk 4.2 (Failure to deliver compassionate and diverse leadership and a values-based inclusive culture meaning not everyone in the Trust is able to contribute effectively)?

Action: Julie Williams

MB noted MF's comments on risk 1.4 and stated the Board needs to understand what is within the scope of our control and what requires greater system change. It is at the forefront of the Trust agenda, but we need to work closely with commissioner colleagues, stakeholders and across our integrated care systems (ICSs) and consider what we can influence externally.

Salma Yasmeen (SY) reported each of our places and partners, including both ICSs, is aware of the pressures and demands across the system. Discussions are taking place about joined up responses.

The weekly West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) briefing now includes system pressures and any mutual aid requirements.

Internally, we have the Operational Pressures Escalation Level (OPEL) and the framework we have developed, which will be a good indicator for areas of significant demand that need greater focus through our command structure.

CH referenced risk 2.3 and reported it does not just relate to an increase in demand but also the impact on the quality of care. Current indicators show we are maintaining the quality of care. The measures SY has talked about can be used to monitor this. When considering the move from amber to red, the move should happen when the quality of care is significantly impacted by demand.

JW reported each BDU reports against the OPEL level framework on a weekly basis in Operational Management Group (OMG). Should OPEL levels be seen to be increasing by OMG this could then be escalated to EMT to be considered for escalation to Board.

TB felt that some of the answers to accessibility in Risk 1.4 lie in the Equality and Inclusion action plan that is being monitored by the Equality, Inclusion and Involvement Committee. If some key metrics can be identified within the action plan, progress can be reviewed, and used to determine whether sufficient progress has been made to move from amber to yellow.

CJ noted a presentation that went to FIP committee yesterday from Child and Adolescent Mental Health Services (CAMHS). CJ did not feel it was common practice yet to review access data by protected characteristics. When this becomes common practice, the Trust will make progress on understanding accessibility to services from different groups.

Subha Thiyagesh (ST) reported in addition to TB's comments on risk 1.4 there are work streams in progress through the ICSs regarding accessibility to services. She added that public health teams are looking at the gaps in services. Some services are increasingly provided on a regional basis and so the Trust does not always have an immediate influence as a result.

It was RESOLVED to APPROVE the updates to the Board Assurance Framework and NOTE the discussions and actions raised for 1.4 and 2.3 and review 4.2 in relation to the leadership changes.

TB/21/71b   Corporate / Organisational Risk Register (ORR) (agenda item 8.2)
JW highlighted:

- This is the report for Q1 2021/22
- There are two new risks in relation to speech and language therapy and access to single storey roofs
- Risk 1076 (cash risk) is recommended for closure.

AM asked Board members to note the Trust risk appetite statement is being reviewed in September.

AGD reported the Workforce and Remuneration Committee (WRC) has been reviewing its risks and looking at how they can be consolidated. The updated risks will be presented to the next business and risk Board meeting. This has been approved by EMT.

SYo reported the risks have been reviewed to make them more relevant to the current climate. These will need to be reviewed closely at the next risk Board meeting.

Action: Trust Board

A discussion followed in relation to the new risk concerning access to roofs of single-storey buildings.

CH reported the risk has been escalated to the ORR due to the large blanket restriction across the Trust. The Care Quality Commission (CQC) perspective is that we are removing patient choice.

Patients cannot access garden areas or leave the ward without consulting a member of staff and it is dependent on their risk assessment whether they will be allowed out without staff supervision.

A number of different options are being considered to resolve the problem and a definitive timescale for resolution is being developed.

EM referenced risk 1530 – Covid-19 leads to a significant increase in demand. EM stated the Trust needed to be mindful of "Covid-19 demand" becoming "normal demand" and queried how this could be monitored.

CH reported the learning from Covid-19 is still ongoing. A tool has been developed to look at demand increases on mental health services over time. A request has been made for this to be compared against actual activity to understand how we are responding to that demand.

CH referenced the service demand paper later in today's agenda. CH explained work is ongoing in places looking at how to deliver services differently to address the demand. Conversations with commissioners are taking place to try and tackle these issues.

JW noted in future, where risks are escalated to the ORR, the rationale for escalation will be included in the risk report.

Action: Julie Williams

AM referenced risk 1368 – demand and capacity for CAMHS beds. Commissioners have agreed to additional resources to support young people in the secure estate who are waiting for a bed. Is the problem a lack of resources or is the problem something different, and will the increased resource reduce the risk?

CH reported additional resources had been agreed in the Young Offenders' Institute (YOI). It has not always been a good experience for the service users. Our care team are doing everything they can, but the position is not ideal.

TB stated resources can create capacity but providing the capacity from a workforce perspective can be difficult as there are national shortages. The current position has been escalated to NHS England through our Trust, Leeds Community Healthcare Trust and the governor of Wetherby Young Offenders' Institution because the waiting time for beds is unacceptable.

A discussion followed about the level of movement of risk ratings in the ORR over the last 15 months, and if the Board is comfortable with the level of movement.

MB explained the ORR is regularly reviewed by EMT, Board and board committees and as such is considered a good reflection of our current position. Committee chairs could assist the wider Board by providing a recount of recent discussions at committees and whether the Trust has responded quickly enough to actions identified. Committee chairs can be asked to report back on the level of movement in their committee allocated risks for the next risk Board meeting, to be included in the ORR executive summary.

Action: Julie Williams

SYo reflected on "aged vacancies" where there has been a vacancy for a long time. Long term vacancies in individual roles need looking at in WRC and the associated risks then need escalating into the Board report.

Action: Workforce and Remuneration Committee

AGD noted this links into the workforce strategy and the zero approach to clinical vacancies. Some vacancies are long-term, and we need to consider alternatives. Some of the work will be to consider new roles and new models of care. We need to increase supply and look at new roles which can add to the therapeutic environment.

It was RESOLVED to NOTE the key risks and ratings for the organisation and comments made by the Board, to AGREE to the removal of risk 1076, regarding cash resources, from the organisational risk register, and add Committee Chairs' comments about allocated risks to the cover paper at the next Board meeting.

TB/21/72   Business developments and collaborative partnership working (agenda item 9)

TB/21/72a   Integrated Care System developments – white paper update (agenda item 9.1)
SY asked for the paper to be taken as read and highlighted the following points:
- The Health and Care Bill is expected be at Committee stage by September and there are expected to be a number of changes and amendments before then.
- The Trust has been working closely with both ICSs in all of our places, looking at partnership arrangements and what is required in the future.
- Our involvement in places is important and will be critical in the Trust having a voice through the system at place level and system level.

AM noted further discussion on this paper and the Bill will take place as it progresses through parliament, considering its impact on the Trust and the Trust's role within systems. An earlier action had been raised to this effect.

It was RESOLVED to NOTE the update on national policy/legislative update and the update on local ICS response to the white paper.

TB/21/72b   South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 9.2)
MB asked to take the paper as read and highlighted the following points:
- The prevalence of Covid-19 demand particularly in acute hospitals is an area of focus.

- Further to the decision that Bassetlaw will no longer be part of this ICS, any implications for the Trust will need to be considered by the Board separately.

Action: Andy Lister

- Most aspects of the development of the ICS are in the design stage currently and progress is expected to increase after the summer.

A query was raised in relation to the QUIT programme, what it means for our staff in Barnsley and if this impacts Trust community staff.

ST reported the QUIT programme is focussed on inpatient admissions and service users in Barnsley, so the work takes place through the South Yorkshire ICS, but the focus is hospital care. The wider aspects of smoking cessation are dealt with in the community.

EM queried the children and young people transformation programme and noted the impact of this could be influential in relation to inequalities. EM noted how different places may have different issues in relation to inequality, and asked how the Trust is ensuring we are raising these correctly?

SY reported the Trust has representation in each place through an alliance specifically for children and young people. Issues identified by place in relation to inequalities will be addressed looking specifically at that place.

It was RESOLVED to NOTE the SYB ICS update and boundary changes and NOTE the MHLDA Alliance and Barnsley Integrated Partnership programme update.

TB/21/72c   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:
- Work on monitoring the ten big ambitions is ongoing. EMT are reviewing the document to assess what areas the Trust is directly contributing to and how it can be shown through the Integrated Performance Report.
- There is an ICS anti-racism campaign, and the Trust is a strong partner in this work.
- We continue to work with partners regarding the Covid-19 response.

SR highlighted section 6:
- The West Yorkshire Adult Secure Lead Provider Collaborative earliest go live date is now 1st October 2021. The final financial offer is still to be received from NHS England (NHSE).
- The Leeds and York Partnership Trust is to develop a West Yorkshire central commissioning hub. Until this is developed, contingencies have been put in place to make sure the adult secure collaborative has sufficient capacity in key areas, particularly in quality monitoring
- A risk has emerged in the short term with the resignation of Dr Berry as clinical lead. Interim arrangements and urgent actions are being taken forward to address this.
- Sarah Ives is the current head of commissioning but won't continue in that role past September. This role will be part of the West Yorkshire Commissioning hub and a replacement is being sought.

AM raised the ongoing discussions around the commissioning hub, noting there are different approaches across the country. The Board needs to have greater understanding of what the new arrangements will look like and what it means for the Trust, and the Trust's role in the West Yorkshire commission hub, particularly as a lead provider.

Action: Sean Rayner

AM thanked SR for a comprehensive update, and noted this would be part of discussions at the Strategic Board in August, looking at our focus in each place.

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 and West Yorkshire Commissioning Hub.

TB/21/72c   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/21/73   Performance reports (agenda item 10)
TB/21/73a   Integrated performance report (IPR) month 11 2020/21 (agenda item 10.1)
TB highlighted the following points:
Covid-19
- Although there have been changes in guidance for the public, guidance and restrictions remain the same for staff at work in healthcare settings and the difference between home and work has to be managed.
- There is new guidance for staff who have had two vaccinations, which will allow staff to come into work under certain conditions, but they will still need to isolate whilst not at work.
- PPE remains in good supply and asymptomatic staff testing continues with results now going into the national system.
- The Trust command structure has been re-established due to the increase in prevalence of Covid-19 and impact on both the wider system and the Trust.
- Given the pressure in the system the likelihood of future mutual aid options will continue to increase.
Quality
- Two consecutive months of low Friends and Family Test (FFT) results have been recorded. Many responses have been received by text, with a lack of free text and detail. A URL link is now being sent out so that responses include more detail and significant work is taking place.
- Under-18 (U18) admissions on adult wards remains an area of concern.
- Wetherby YOI is an area under constant review.
- Pressure remains in the Out of Area (OOA) bed position and acuity is high across the system.
- There are staffing pressures due to the high levels of acuity and activity.
- Significant numbers off staff are absent from work as a result of test and trace, and family member isolation. In previous stages of the pandemic our wards weren't as full as they are now, and this is a change adding to the pressure in the Trust.
- The safer staffing group is reviewing metrics and looking at demand and capacity and the impact on quality.
- There has been a noticeable increase in restraint, which may be linked to acuity. This is being checked by the Reducing Restrictive Practice and Interventions (RRPI) team.
- The risk assessment position, relating to Formulation Informed Risk Management (FIRM) only, is being monitored through Clinical Governance Clinical Safety (CGCS) Committee and progress is to be discussed at the next Committee meeting.
- Self-harm and apparent suicide levels continue to be monitored closely.
- Safeguarding remains a key focus and the Trust maintains strong links into local safeguarding panels.
- The CQC action plan has recently been refreshed.

- In summary, performance metrics are holding up well but there is significant demand and high levels of acuity. We need to maintain vigilance on early warning signs through risk panel, OMG and Trust Board. All these processes have served us well during the pandemic and we need to keep a focus now on emerging risks.

NHSI national Indicators
JW reported performance against national targets remains largely positive.
- There were three U18 admissions to adult wards in June which is a deteriorating position.
- OOA beds usage has decreased from May.

Locality
CH highlighted the following points:

Trust-wide CAMHS (child and adolescent mental health services)
- Waiting numbers for neurodevelopmental diagnostic assessments remain high, but business cases in Calderdale and Kirklees have been approved to address this.
- High number of referrals for children in crisis and with an eating disorder are placing pressure on waiting times.
- Performance against the 18-week target is good but is under pressure and this may not be maintained if current demand continues.

Barnsley General Community Services
- CH reported the sad death of a colleague, Ruth Donoghue. This has had a significant impact on the leadership team, but service provision has been maintained.
- Different ways of managing demand and services that need face to face and direct care input are being reviewed.
- First contact physiotherapy has commenced in the musculoskeletal service, which is joint work with the primary care network and GP practices.
- Supervision remains a challenge, but the leadership team have action plans in place.

Forensics
- Staffing remains a challenge.
- Absence, both in relation to Covid and Non-Covid absence, remains high.
- The psychology service will be fully staffed by October 2021.

Learning Disabilities (LD)
- Referrals rates are 20-30% higher than in 20/21 and are above pre-pandemic levels.
- Medical cover across LD remains a key concern.
- Consultant positions are hard to recruit into in LD.
- Plans are in place to keep the service safe.

Trust-wide Inpatient Services
- Blanket restrictions for access to gardens and courtyards are in place.
- OOA beds have reduced but this remains challenging.
- Wards are experiencing high levels of acuity.

Mental Health Community Services (all areas)
- The impact of Covid-19 prevalence rates for Improving Access to Psychological Therapies (IAPT) has seen a sustained increase in referrals.
- There has been an increase in referrals to Single Points of Access (SPA), which requires increased staffing.
- In Barnsley, some non-recurrent recovery investment money has been obtained to help manage this demand.

AM expressed sincere condolences to Ruth Donoghue's family, friends, and colleagues on behalf of the Trust Board.

A discussion followed about cardiometabolic assessment and treatment figures.

CH reported work is ongoing with the Performance and Information team to make sure the Trust gets accurate data on internal performance in the context of the overall figures, which are subject to external factors outside of the Trust's control.

A query was raised about OOA beds, and a revised plan that had been put in place pre-Covid-19, and if further review is now required.

CH reported the plan has been further reviewed since the pandemic began, the Trust continues to work with partners across the ICS and she explained some of the current challenges. There is a quarterly partnership meeting with commissioners, a monthly steering group and a daily report that monitors discharges and admissions on each ward to identify hotspots.

CJ queried how quality of care is being maintained considering increased demand, increased acuity and staffing fill rates being down. CJ referenced his earlier query in relation to the BAF on quality of care and asked about the impact on staff welfare.

CH reported staffing levels in inpatient wards are a key concern and work continues to maintain staff safety. Isolation due to track and trace has had an impact. Operations has welcomed the new guidance that if staff receive a negative PCR test, they can return to work, but this must be done safely and appropriately.

CJ raised community staffing and noted it is hard to track the impact of the shortfall in community staff in the IPR and asked if this is affecting the quality of care and queried safer staffing in the community teams.

CH reported agency staff have been brought back into community services to improve waiting times.

TB stated the safer staffing work in community teams was paused during Covid-19. Two pieces of work are ongoing, Safecare in the community and a caseload management tool. An update was provided in the recent six-monthly safer staffing report.

TB reported skill mix changes have to be discussed with the CQC as they have to be within framework the CQC provide. The CQC have made some alterations to Trust proposals. This is being managed through the quarterly CQC engagement meetings.

AGD reported one of the reasons we have brought back silver command is because of the workforce pressures and this is being monitored closely.

MB reported the ICS section is being added to the IPR, as per the request from the Board. We are liaising with each ICS to ensure we can populate this section in a meaningful way.

AM suggested using the triple-A process to escalate ICS items for Board discussion.
                                                                    Action: Julie Williams

Priority Programmes, Communications, Engagement and Equality
- SY noted that Priority Programmes' highlights have already been covered.
- Communications continue to support work across the Trust in relation to priority programmes, Covid briefings, vaccination programmes in places, and collaborative work on partnership arrangements in places.

- A substantial amount of work is ongoing in relation to equality and engagement and the increased profile of this agenda has increased the workload. A suite of materials is in progress to support the dissemination of our Equality, Involvement, Communication and Membership Strategy. A presentation on our approach went to the ICS and was well received.
- The Equality Impact Assessment process work continues.
- We are in the early stages of embedding the use of data to address inequalities.

AM asked that highlights from the ICS section and Communications, Engagement and Equality sections are included in the executive summary for the IPR.

Action: Julie Williams

Finance

MB highlighted the following points:
- Financial performance is strong, partly due to the current number of staff vacancies.
- There is a current £1.7m surplus year to date, and this is forecast to achieve £2.3m by the end of H1. This increase has been communicated to the West Yorkshire ICS and NHSE/I.
- Our cash position is healthy.
- Capital is currently in line with plan, and capital expenditure on major projects is being reviewed to ensure the programme remains a key priority and can demonstrate value for money.

Workforce

AGD highlighted:
- Turnover figures are red and represent an annualised figure so are not the yearly rates. These need to be closely monitored over the next couple of months.
- Covid-19 absence figures have decreased. Nearly 40% of staff not attending work because of Covid-19 are working from home.

MB responded to finance queries noting income was lower than plan in the first four months due to timing. The majority of mental health investment standard funding will be realised in the second half of the year. The Trust has followed national guidance in relation to the NHS pay award and it is assumed there will be income received to offset the cost.

An action was raised to identify what roles are included in the category "other" in reference to staffing numbers

Action: Julie Williams

CJ queried priority programmes and digital interaction and the four measures included in the IPR.

MB reported the level of digital interaction differs by service and this will be a focus of recovery and reset work.

CJ noted the Trust needs to set some targets and ambitions for digital interaction in addition to benchmarking against national figures.

AM asked that Non-Executive Directors are involved in the reset and recovery discussions.

Action: Salma Yasmeen

ST reported there needs to be an underlying clinical perspective about contact and what is best for the patient. ST uses all mediums to speak to patients, dependant on need, and this has to be balanced against benchmarking and clinical need.

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

TB/21/73b Focus on report – Service Demand (agenda item 10.2)
AM noted that the purpose of the paper is to set the scene for the strategic board in August.

CH asked to take the report as read and emphasised to the Board that an increase in demand is not always easy to count and measure.

SR noted the mitigation section of the report and suggested there are opportunities as part of community mental health transformation that include the voluntary and community sector. We can look at how we can simplify access to services. There are also opportunities with the Trust's involvement in mental health alliances.

MF noted there is no data about length of stay and questioned whether this is important when looking at demand.

CH reported the Trust benchmarks well against length of stay. This is usually measured on discharge and so the data is only recorded when the patient leaves. The length of time a patient has been in a bed locally is monitored regularly to keep this in view.

AM noted demand needed to be viewed in respect of protected characteristics. Demand is not just about high referrals. Low referrals from some aspects of the community can highlight inequalities and this needs to be monitored too. The report references the demand tool developed by Mike Garnham and AM queried if a further update will be coming to the August Board?

CH agreed to check whether a further update on the demand tool would be available for August Board.

Action: Carol Harris

CJ queried if there was any work taking place across the system around bed capacity or is this purely internal?

CH reported the developing estates strategy covers the work required in the Dales (Halifax) and Priestley Unit (Dewsbury). CH reported when inpatient services are referenced in the report, they include older people's services.

MB noted bed numbers may be considered in individual places but did not think they are being considered across the system. This is something the Board may want to consider. MB will determine how best to access this information.

Action: Mark Brooks

It was RESOLVED to NOTE the information and actions set out in the report and NOTE the actions highlighted through discussion for the Strategy Board in August 2021.

TB/21/74   Governance Matters (agenda item 11)
TB/21/74a   Motion to Amend the Trust Constitution (agenda item 11.1)
AM reported the item has emerged through discussion that took place in the Nominations Committee on 13th July 2021 regarding recruitment of the Chair. Following those discussions, it was agreed a proposal would come to the Board and then to the Members' Council on 17th August 2021.

The proposal is to extend the "Rest of Yorkshire and the Humber" constituency to the area outlined in the paper. If agreed this would mean that the area from which the recruitment of future Non-Executive Directors and Chairs would be extended to the area as described.

The Trust Constitution was reviewed pre-pandemic and a number of amendments were made. Further amendments were then delayed due to Covid-19. Further work has just started on a review of the Constitution as a whole, as recently reported to the Audit Committee.

If agreed by the Board today the proposal to amend the constituency boundary will go to Members' Council for approval on 17th August following a consultation event with the governors on 9th August 2021, where any comments or questions can be raised.

MF queried the pros, cons and current constraints of the constitution and asked what discussion had taken place at Nominations Committee.

AM reported there had been good, detailed discussion at the Nominations Committee. The current western boundaries meant a candidate living just over the border in Lancashire/Manchester would be ruled out.

AM reported other trusts have a "Rest of England" constituency. A candidate's knowledge of the Trust area will feature strongly in the recruitment process as will their understanding of, and connection to, the region and the communities the Trust serves.

AM reported this is an extension of the Trust's current boundary, not the previous boundary. There may be a difference of opinion on the extension of the boundary, and this can be amended if required.

CJ queried if Cumbria and Durham were close enough to the Trust areas to be relevant. Under the proposed update there is potential for all future Non-Executive Directors to recruited from outside the Trust's current area.

SY expanded on comments from CJ and MF in relation to commitment to local communities, especially from Board members. The Trust would not want a whole board from out of the Trust area and there is a need to consider diversity in this process.

AGD reported the world has changed, people work in our area but live nearby and therefore broadening the boundaries feels more inclusive. Nominations Committee have been very keen to look at the right dimensions of who to recruit and the balance across the Trust board and where we might want to recruit from, in addition to the right skills and values.

SY reported the current policy context is about places, people, the system, and the communities it serves and this needs to be reflected in the Trust Board.

ST stated the Trust needs to achieve the right balance between being inclusive and the area the Trust serves.

AM summarised the discussion and asked for the Board to support to the motion going to the Members' Council for a decision.

MB noted Members' Council need to be informed of today's discussion to help inform their decision.

Action: Andy Lister

It was RESOLVED to APPROVE the motion for the extension of our constitutional boundaries as described above to go the Members' Council for a decision on 17th August 2021.

TB/21/74b   Assessment against NHS Constitution (agenda item 11.2)
JW highlighted the change to the NHS Constitution in January 2021:

- From 1 January 2021, the rules had changed regarding UK residents' access to healthcare in the EU, Norway, Iceland, Liechtenstein and Switzerland following the UK's exit from the EU.

AM summarised the paper demonstrates we are meeting the requirements of the NHS Constitution.

MB reported the paper shows how we typically meet the Constitution but also includes the additional work that has taken place during the pandemic.

It was RESOLVED to APPROVE the paper, which demonstrates how the Trust is meeting the requirements of the Constitution.

TB/21/74c   Committee Membership Changes (agenda item 11.3)
AM asked to take the paper as read and highlighted the following points:
- From 11th August James Sabin will be the interim finance director.
- From 2nd August Darryl Thompson will be the new Director of Nursing and Quality.
- Sam Young will leave the Board on 2nd August 2021.
- The new Non-Executive Director will now replace Sam Young on 1st October 2021.

SY noted it had previously been agreed that SR would replace TB on the Charitable Funds Committee not DT as stated in the paper.

Action: Andy Lister

AM noted the Corporate Trustee will cover this change as the Charitable Funds Committee reports into the Corporate Trustee.

AM summarised all committee meetings prior to the new NED taking up office will be quorate, and MF will attend all committees at least once during the year in his role as Audit Committee chair, providing additional attendance. Once the new Non-Executive Director is appointed on 1st October 2021, they will, as chair of the Workforce and Remuneration Committee, become the staff wellbeing lead.

It was RESOLVED to NOTE the proposed change in appointment date for the new Non-Executive Director and APPROVE the proposed changes in Membership for the:
   o **Mental Health Act Committee;**
   o **Equality, Inclusion and Involvement Committee;**
   o **Clinical Governance and Clinical Safety Committee; and**
   o **Finance, Investment and Performance Committee**

TB/21/74d   Quality Account Update (agenda item 11.4)
TB reported the paper summarised the approval process for the quality account and highlighted that a submission date of August has been approved.
There is no decision-making board in August and so today's paper has come to Board to ask for delegated authority for approval to keep to the previously agreed timescale.

Trust Board RESOLVED to NOTE the update provided in this report and to DELEGATE approval of the final QUALITY ACCOUNT to the Chair and Interim Chief Executive.

TB/21/75 Assurance and receipt of minutes from Trust Board Committees (agenda item 12)

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

Audit Committee 13th July 2021 (minutes from 13th April and 18th June 2021)

MF highlighted the following:

- As part of an internal audit report on payroll there was a limited assurance finding on one specific area of anti-fraud control. The recommendations have already been completed and all other aspects received significant assurance.
- The post implementation review of the Shared Business Services system has taken place and the implementation has been very positive with very few recommendations.

Finance, Investment and Performance Committee 26th July 2021 (minutes from 22nd March and 23rd April)

CJ highlighted the following points:

- The Committee is confident the Trust is on target for the financial target for the first half of the financial year (H1).
- Committee risk ratings remained the same.
- Considered the ongoing work on developing new finance arrangements around the ICS.
- Early sight of the new System Oversight Framework and clarity around how the new measures will relate to the trust.
- Received a detailed report on CAMHS pressures, the expectation is our referral to treatment target of eighteen weeks is expected to deteriorate in current circumstances.
- There is a current 8% vacancy factor that is putting pressure in the system.
- The Adult Secure Lead Provider was discussed, on which SR has provided a separate update to the Board.

Workforce and Remuneration Committee 20th July 2021 (minutes 16th March, 28th May, 29th June 2021)

- A discussion took place around Committee allocated risks and consolidation as reported earlier today.
- The Freedom to speak up guardian report was received. This used to report into CGCSC.
- SYo asked for all Board members to be overtly supportive of the freedom to speak up guardians and should complete the training.
- Vaccinations were discussed.
- The workforce strategy was discussed, SYo highlighted the WRC is looking to strengthen its role around culture and driving the great place to work agenda.
- Assurance received around the new Trust position and understanding of the new settlement process from the NHS and also around the Flowers case, regarding overtime payments and holidays position.

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

TB/21/76 Trust Board work programme (agenda item 14)

AM confirmed the Trust Board work programme is in draft form and the format is being worked on currently.

Trust Board RESOLVED to RECEIVE the draft work programme.

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

The next public Trust Board meeting will be held on 28 September 2021.

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

No questions were received from the public.

Signed: **Date:**

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

▢ = completed actions

Actions from 27 July 2021

Min reference	Action	Lead	Timescale	Progress
TB/21/70	The Health and Care Bill has had its second reading at parliament and should feature in a future Board agenda.	Andy Lister	September 2021	Will be considered in the agenda setting process. An ICS update paper is currently a monthly item.
TB/21/71a	MB noted the BAF contained strategic risks, and different services are experiencing different demands, which may not affect all services in the same way. The Board needs to consider what specifically would need to happen for the assurance level to change to red for risk 2.3.	Julie Williams	October 2021	
TB/21/71a	In relation to the BAF the Board asked consideration to the given to risks 1.4, 2.3 and 4.3.

Mike Ford (MF) noted risk 1.4 (Services are not accessible to, nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy). MF reported the gaps in assurance look fairly small, and asked could this move from amber to yellow? Does the Board need to reflect on the changes in leadership in relation to risk 4.2 (Failure to deliver compassionate and diverse leadership and a values-based inclusive culture meaning not everyone in the Trust is able to contribute effectively)? | Julie Williams/Andy Lister | October 2021 | |

With **all of us** in mind.

TB/21/71b	AGD and SYo reported that WRC risks were in the process of being consolidated and the Board needed to scrutinise the next iteration of workforce risks when they return to Board in October	Trust Board	October 2021	
TB/21/71b	When a risk is added to the Organisational Risk Register the front sheet should include the rationale as to why.	Julie Williams	October 2021	
TB/21/71b	Committee chairs to review their allocated risks and consider the level of movement in their risks	Julie Williams	October 2021	
TB/21/71b	SYo reflected on "aged vacancies" where there has been a vacancy for a long time. Long term vacancies in individual roles need looking at in WRC and the associated risks then need escalating into the Board report.	Workforce and Remuneration Committee	November 2021	Further work is required on identifying long term vacant post and will be discussed at the November 2021 WRC.
TB/21/72b	Further to the decision that Bassetlaw will no longer be part of this ICS, any implications for the Trust will need to be considered by the Board separately.	Andy Lister	October 2021	
TB/21/72b	AM raised the ongoing discussions around the commissioning hub, noting there are different approaches across the country. The Board needs to have greater understanding of what the new arrangements will look like and what it means for the Trust, and the Trust's role in the West Yorkshire commission hub, particularly as a lead provider.	Sean Rayner	August 2021	Included in the Strategic Board agenda in August
TB/21/73a	MB noted ICS metrics are being determined to establish what is required. These will be included for information for the Board and not for detailed discussion. AM suggested using the triple AAA process to escalate any concerns for the Board's attention.	James Sabin	September 2021	Noted for future reporting
TB/21/73a	Updates in relation to the ICS metrics, Priority Programmes, Communication, Involvement and Engagement need to be included on the IPR front sheet	James Sabin	September 2021	Noted for future reporting.

TB/21/73a	MF asked for an action was raised to identify what roles are included in the category "other" in reference to staffing numbers	James Sabin	September 2021	The "other" category includes a wide range of staff not covered in the other headings. This is reflective of the wide range of staff that support the services which we provide. Large WTE group examples include psychologists (287), PAMs (205) ancillary staff and housekeepers (191) and Occupational therapists (169). This is included in the narrative under the table in the pay information section of the report (finance appendix).
TB/21/73a	CJ queried priority programmes and digital interaction and the four measures included in the IPR. MB reported the level of digital interaction differs by service and this will be a focus of recovery and reset work. CJ noted the Trust needs to set some targets and ambitions for digital interaction in addition to benchmarking against national figures. AM asked that Non-Executive Directors are involved in the reset and recovery discussions.	Salma Yasmeen	September 2021	To continue to monitor the use of digital through recovery and reset workstreams and programme. The working effectively workstream has developed a plan to engage staff, governors and the Board - a survey to capture views and feedback is being developed.
TB/21/73b	AM noted the report references the demand tool developed by Mike Garnham and AM queried if a further update will be coming to the August Board? CH agreed to check whether a further update on the demand tool would be available for August Board.	Carol Harris	August 2021.	Included in the Strategic Board agenda in August
TB/21/73b	MB acknowledged in relation to service demand that bed numbers were being considered in individual places but was not sure they were considered across the system. This is something the Board might want to look at. MB will determine how best to access this information.	Mark Brooks	September 2021.	WYHHCP have commissioned Niche to analyse PICU bed numbers across the West Yorkshire system. Once this analysis is complete there is likely to be further work take place to review bed numbers across other service lines.

Min reference	Action	Lead	Timescale	Progress
TB/21/74a	AL to update the Members Council in relation to the Trust Board discussion about the Motion to Amend the Trust Constitution	Andy Lister	August 2021	MC updated the constitutional change was approved at Members Council in August.
TB/21/74c	SY noted it had previously been agreed that SR would replace TB on the Charitable Funds Committee not DT as stated in the paper.	Andy Lister	August 2021	Committee matrix and terms of reference have been updated.

Actions from 29 June 2021

Min reference	Action	Lead	Timescale	Progress
TB/21/55	TB reported that the figures about FIRM were for measuring the movement from the Sainsburys risk assessment to the FIRM risk assessment. The speed at which this is taking place needs looking at. This may be as a result of the pandemic. AM asked for a focus on this at the next CGCS meeting.	Clinical Governance Clinical Safety Committee	September 2021	Included on agenda setting schedule
TB/21/55	To review the use of Statistical Process Charts CJ reported the board development work that introduced SPC's was about improvement and this may not be how the Trust is using them. We may be using them to ensure we don't decline, which is different. AM summarised we need to look at the use of SPC charts through CGCS and FIP and consider how we might use them differently.	Clinical Governance Clinical Safety Committee FIP	September 2021	Included on agenda setting schedule
TB/21/55	AM noted a decline in recruitment of band 5 and above staff from BAME backgrounds. To be discussed at the next Equality, Inclusion and Involvement Committee (EII). This is one the Race Quality Standard measures.	EII Committee	October 2021	EII committee deferred to 30.09.21

TB/21/55	AGD noted the need to be careful with annual staff turnover figures in the IPR as they are annualised. We need to treat the figures with caution in the first two months as they represent the annual figure rather than the monthly figure. It was requested that both the monthly and annual figures should be presented.	Alan Davis	September 2021	To be included in Septembers IPR
TB/21/55	A discussion followed about staff turnover hotspots, how these are being managed and the use of exit interviews. Identified hotspots are adult acute wards and forensics. They are pressurised and stressful working environments. A lot of work has taken place in forensics and inpatient wards are now a priority programme. AGD noted the Workforce and Remuneration Committee is taking place on 20 July 2021 and exit interviews could be reported into that meeting.	WRC Committee	November 2021	Workforce and Remuneration Committee considered a detailed paper on Recruitment and Retention and Staff Absence together with actions. The 6 month Exit Interview data will be included in the Workforce and Remuneration Committee meeting in November 2021.
TB/21/55	AM asked about reset and recovery in the priority programmes and noted it has three work streams, one of which is working effectively. AM asked how NEDs will be involved in the strategic reset and recovery work. AM asked for a discussion outside of the Board meeting.	Salma Yasmeen	September 2021	Involvement approach being developed and Governors and Board members to be included at key points. July Board - to stay open for engagement to take place. Comprehensive update and discussion at strategy board in August. To include regular updates in the IPR under priority programmes section going forward and workstreams to develop engagement and involvement plans.

TB/21/55	SY updated that there is significant transformation funding starting to come through. The community transformation programme has commenced, and the Trust is fully engaged in both ICS's with this work and all of our places. The aim is to join up care between primary care, secondary care and the voluntary sector. SY reported a highlight report could be brought to a future Board meeting.	Salma Yasmeen	October 2021	On the September agenda – highlight report included under the agenda item.
TB/21/56	AM noted the need for hard outcome measures for both integrated care systems to feature in the Trust IPR.	Mark Brooks	September 2021	This has now been integrated into the IPR
TB/21/58b	RW reflected in a pandemic year we should ask questions about differences in reporting. The action plan on page 42 is for the executive and the teams. We should be augmenting section 5 on page 42 to include what the Board might want to do to promote openness around incident reporting. TB noted the content of this report could be used to look at next steps for the Patient Safety Strategy.	Tim Breedon	September 2021	Comments noted and will be addressed in future report
TB/21/58d	In reference to the Premises Assurance Model RW queried if this work could be integrated with PLACE reviews (Patient Led Assessment of Care Environment) and include the voice of service users. AGD noted governors are actively involved in PLACE reviews. RW noted that PLACE reviews don't show that things are good or outstanding and if there is an opportunity to bring two things together it should be taken. AGD noted this could form part of the discussion about the Estates at the strategic Board meeting in August.	Alan Davis	August 2021	Estates Strategy formed part of the Trust Board Strategic development meeting in August.

Min reference	Action	Lead	Timescale	Progress
TB/21/60	MB offered to review the way in which the Trust seal is being used and make sure it is being used appropriately.	Mark Brooks	September 2021	Complete
TB/21/61	Following a number of questions from a member of the public ST gave an overview response during the Board meeting. It was agreed that ST would provide a formal response to all questions.	Subha Thiyagesh	August 2021	ST has provided a full response to all questions asked.

Actions from 27 April 2021

Min reference	Action	Lead	Timescale	Progress
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	September 2021	New Board workplan in progress and draft created with a key that aligns items to strategic objectives.
TB/21/39a	The Board needs to consider if the Workforce strategy is mitigating the strategic workforce risks.	Trust Board	August 2021	Included in the Strategic Board agenda in August
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	August 2021	This was discussed as part of the Trust Board development day looking at a revised Estates Strategy.
TB/21/41a	AM noted today's discussions around a new priority programme to look at acuity.	Salma Yasmeen	August 2021	Included in the Strategic Board agenda in August
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	September 2021	Covid and Non Covid Staff Absence was included in report to Workforce and Remuneration Committee in September 2021
TB/21/42a	Workforce Strategy EIA to be completed, go to WRC on 18th May 2021 and come back to Board for approval.	Alan Davis	September 2021	On the Trust Board agenda for September 2021 following discussion and support at the Workforce and Remuneration Committee

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	To be discussed in Agenda setting for August Board.
TB/21/25a	AM reported we needed a group that drives the green and sustainability 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	Nick Phillips, Head of Estates and Facilities, producing a paper on development of the Sustainability Strategy including resource implications. Sustainability and Estates Strategies to be included in August's Board Development session.
TB/21/25a	AM asked for an EIA to be completed for the Green Plan.	Alan Davis	August 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. EIA to August Board Included in September agenda

Min reference	Action	Lead	Timescale	Progress
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. September Update - The infographic is complete and has been shared with EMT - just making a few final tweaks to the full strategy. It was requested that we change some of the images.
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	September 2021	April Board - Action allocated to Sean Rayner to progress. Discussions are in place and an update to follow. July update - On the agenda for August WYMHLD programme Board, to report into September Public Board Included in September Agenda

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. | Mark Brooks | September 2021 | June Board update - Sean Rayner (SR) reported the Trust is linked into each districts health intelligence cell.

Nat McMillan (NM) noted the need to keep sight on this matter. Action moved to September 2021.

The Trust continues to feed into intelligence data cells across the system. |

Trust Board 28 September 2021
Agenda item 7

Title:	Chief Executive's Report
Paper prepared by:	Interim 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:	Since the previous report to Trust Board the number of daily positive Covid cases has remained relatively high. Across South and West Yorkshire the rate has typically fluctuated at between 300 – 400 per 100,000 of population and there has been an increase in beds occupied by Covid patients, albeit not on the scale experienced in earlier waves of the pandemic. There have been pressures across the system with urgent & emergency care and ambulance services all reporting high demand and intense pressure.
	There has been some effect of the increase in prevalence of Covid in the Trust. We have experienced outbreaks on a small number of our inpatient wards and have typically had 100 – 150 staff absent from work at any one time because of Covid. Coupled with annual leave being taken during the summer period this has led to staffing challenges in a number of services, particularly inpatient wards. The need to comply with social distancing, mask wearing, infection prevention & control and other guidance continues to be communicated and reiterated. Our command structures remain in place to provide oversight, leadership, and grip of our response to the pandemic.
	Nationally Amanda Pritchard has been appointed as the Chief Executive of NHS England. We congratulate Amanda on her appointment and look forward to her leadership. Mark Cubbon has been appointed as Interim Chief Operating Officer, the role previously filled by Amanda.
	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, which is open to all staff.
	Since publication of The Brief:
	• The government has published its **Covid-19 Response: Autumn and Winter Plan**. Plan A is very much based on the continued successful roll out of vaccines and the associated booster programme (see below). The

key determinant of whether plan B needs to be enacted is the pressure on the NHS. Contingency measures in plan B could include mandatory face coverings in some settings, working from home and the use of vaccine passports.

- **Covid booster jabs are now being offered** to anyone over 50, frontline health & social care workers, older adults in residential care homes, people aged 16 – 49 years old with underlying health conditions and adults who share a household with vulnerable people. The doses will be offered at least six months after the second vaccination. In addition, healthy over 12s are also being offered a single Covid jab

- Whilst at the time of writing this report the detailed planning guidance and our own financial settlement for the second half of the year hasn't been circulated the government has announced the **NHS in England will receive an extra £5.4bn over the next six months** to respond to Covid-19 and tackle the backlog caused by the pandemic**. The introduction of a health and social care tax** has also been announced. This will begin as a 1.25 percentage point increase in national insurance from April 2022 and then a separate tax from 2023. It will be paid by both employers and workers.

- **The development of integrated care systems (ICS) continues at pace**. Recruitment processes are in place for chairs and chief executives, with Pearse Butler already announced as the Chair designate for the South Yorkshire ICS. The Trust is fully engaged in the development of ICSs, associated place-based partnerships and provider collaboratives. **NHS England & Improvement has published a range of guidance to support the establishment of ICSs** covering such matters as the design framework, provider collaboratives, functions and governance of integrated care boards, place-based partnerships, partnerships with the voluntary, community and social enterprise sectors and engagement with people and communities. A change in boundaries for some ICSs has been announced including the transfer of Bassetlaw from the South Yorkshire & Bassetlaw ICS to the Nottingham & North Nottinghamshire ICS.

- **A report published by the Northern Health Science Alliance** highlighted that people in the north of England were 17% more likely to die with Covid than the rest of the country, had a 26% higher mortality rate in care homes than the rest of the country, and spent six weeks longer in lockdowns amongst a number of other poorer outcomes, including mental wellbeing, lower wages, and unemployment. This very much focuses the mind on both the need to address inequalities as well as reinforcing the challenges we face with meeting demand. One recommendation in the report is for increased resources for mental health provision in the North.

- **A review commissioned by the Norfolk Safeguarding Adults Board into the deaths of three young adults with learning disabilities** at Jeesal Cawston Park makes for shocking reading. This represents another instance of inappropriate care for people with a learning disability. It is vital we continue to work with our partners to promote and deliver improvements in outcomes for people with a learning disability, as well as

maintaining focus on how we gain assurance of the quality of care in our own service provision.

- **Our flu vaccination programme has commenced** with the first batch of vaccines now received. We have an excellent record of staff take-up of the flu vaccine and our aim is to again promote and achieve a high degree of vaccination

- **Our coronavirus vaccination communication and engagement team were highly commended in the NHS Confederation's recent 'NHS Communicate' awards.** The commendation was for the use of insight and data in developing campaigns, something we very much focused on throughout the Covid vaccination programme.

- Within West Yorkshire a **virtual event is being held in October to provide more information on new and emerging professional roles in mental health and learning disabilities**. This will support development of future workforce models, workforce planning and recruitment & retention

- **We were pleased to participate in World Suicide Prevention Day.** The Trust is a member of the Zero Suicide Alliance, a collaborative of NHS trusts, businesses and individuals who are all committed to suicide prevention. As well as encouraging staff to complete the Zero Suicide Alliance's training we are promoting the West Yorkshire and Harrogate Health and Care Partnership's website dedicated to helping people with suicidal thoughts and those concerned for the mental wellbeing of anyone who lives in West Yorkshire**.**

- **Trust leadership changes** – the next phase of the planned leadership changes in the Trust take effect from October 1st. Tim Breedon is retiring fully from the Trust after supporting the leadership transition period for the last two months as deputy chief executive. Alan Davis, Director of HR, OD and Estates, is also retiring from Trust. Alan has had a long and distinguished career with the NHS and in particular with our Trust. His contribution to the Trust and his unwavering commitment to do the best for our staff and service users has been outstanding. We wish him a happy and healthy retirement. Lindsay Jensen becomes the acting Director of HR and OD and we wish her every success. Mandy Griffin will be joining the Board in October as a non-executive director and we look forward to working with her.

- **The recruitment process for the Trust Chair** is progressing and is expected to be completed during October. The initial long-listing approach has taken place and the assessment and interview panels are scheduled for October 8th and 11th respectively. Formal agreement of the preferred candidate will be made by the full Members' Council in October.

Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

The Brief

26 August 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

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
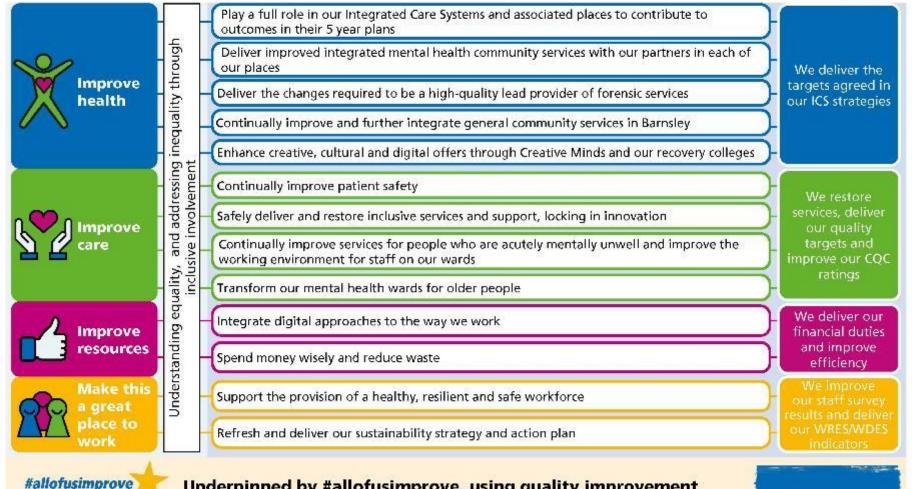
We're working with Barnsley Council to support individuals and families with their self-care this summer. We are providing first aid kits and mental health wellbeing guides to families across Barnsley.

Our priority areas 2021/2022

NHS
South West Yorkshire Partnership
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

We are continuing to work with our partners in each of our places and ICSs to develop our response to the NHS White Paper, building on the local progress we have already made.

The **Health and Care Bill** is currently going through Parliament. The bill is called Integration and innovation: working together to improve health and social care for all. ICSs are currently working with partners on potential operating models and will be engaging with people in each area on how the proposals will work in practise. We will ensure that opportunities to get involved are shared.

A project manager has been appointed by the **West Yorkshire and Harrogate Creativity Hub**, working along with the National Centre for Creative Health. This will build on the work we are a part of that has already taken place to support the impact on health from creativity.

We continue to work with our partners in **Barnsley** on the move to more integrated care. The Borough Health and Care Plan has been signed off, with partners now working on how the plan's objectives will be progressed. It impacts on community mental health and general community services integration.

The ICSs are working with partners in **West Yorkshire and Harrogate** and in **South Yorkshire and Bassetlaw** in response to increased system pressures resulting from the pandemic. This is looking at how primary and secondary care demand can be managed and supported.

The SYB Health and Wellbeing Hub (SYB HWB Hub) is hosting a launch event for staff to find out more about how to access free counselling, self-help and wellbeing webinars.

Our commitment to being an anti-racism organisation

We are proud supporters of the West Yorkshire and Harrogate ICS #RootOut Racism campaign, rolling it out across all of our areas. We also hosted the official Wakefield launch on Monday 23 August, attended by the project group who devised and created the campaign. You can sign up to the campaign on the ICS website to access the resources for your own use. Our Trust is a part of the project group and are committed to ensuring the campaign achieves results.

We also supporting the Barnsley 'No Place for Hate' campaign, which is targeting abuse and harassment in personal interactions and on social media.

NO PLACE FOR HATE

In response to the racism we saw after the Euros last month we issued a public statement reinforcing our aim to be an anti-racism organization. You can read the statement on our website.

Keep an eye out in the Headlines for more information about the campaign and ways the Trust will be tackling racism, including the launch of our own **Race Forward** campaign.

Racism is more than what you see. Let's root it out.

Join the movement.
wyhpartnership.co.uk/rootoutracism

Coronavirus updates

As of 23 August there were **125** members of staff absent or working from home due to coronavirus. There were 136 in the June Brief.

Lockdown restrictions in society may have changed but remember that for us in healthcare restrictions are still in place. So remember to follow all IPC guidance, wear masks and PPE, practice social distancing and work from home if you can.

Keep doing your lateral flow tests and help protect those close to you. Even if you're vaccinated, there's still a chance you can pass COVID-19 on, so you should keep getting tested regularly. From 2 August, the way you submit your lateral flow test results changed and you must now submit your results and order your tests online through the national portal (www.gov.uk/report-covid19-result).

On 16 August, new government guidance came into force around isolating if you're identified as a contact of a person from outside of your household who has tested positive for Covid-19. Please familiarise yourself with this flow chart that explains the steps we all must take within this situation. We must ensure we do whatever we can to keep ourselves and those around us safe.

We are awaiting guidance from the government about the COVID vaccine booster programme. As soon as we hear anything we will let you know.

If you haven't had both doses of your COVID vaccine yet there is still opportunities to do so. It will help keep everyone safe.

With **all of us** in mind.
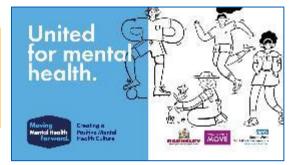
Improving Health
Our performance in July

- **45%** of people completing IAPT treatment and moving into recovery
- **13.7%** of people accessing IAPT are from a BAME community
- **99.3%** of service users with a CPA followed up within 7 days of discharge
- **68%** of inpatients have been screened using the cardio metabolic assessment and treatment tool, **55%** have been screened in our early intervention services
- **83.3%** of learning disability referrals have had a completed assessment, care package and commenced service delivery within 18 weeks
- **94.1%** of people died in a place of their choosing
- **1.9%** delayed transfer of care
- **74.4%** clinical supervision for quarter 1

The **Moving Mental Health Forward** scheme in Barnsley is a partnership between us and the Council, and aims to encourage sport and physical activity settings to be more inclusive and open about mental health; including how to access support where it is needed.

Child and adolescent mental health services (CAMHS) in Wakefield are hosting events to gather views from local young people who use their service so that improvements can be made. More info is on our website.

Improving Care
Our performance in July

- **86** out of area bed days
- **3** young people under 18 admitted onto adult inpatient wards
- **92.2%** waiting list referral to assessment within 4 hours
- **93.3%** waiting list referral to assessment within 2 weeks
- **89.4%** waiting list assessment to treatment within 6 weeks
- **359** average contacts per day in mental health services
- **622** average contacts per day in general community services
- **156** 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; **82% in** our mental health services; and **83.3%** would recommend our CAMHS service.

NHSX is asking mental health clinicians across the country to share their views and experiences of using electronic patient records (EPR) systems, like SystmOne, in their work. Survey closes on Friday 10 September.

In response to increasing demand in A&E departments from children and young people across our areas we produced a simple guide for primary care to help them signpost to the right support. We are also in the process of developing a children and young people focused 'Choose Well for Mental Health' guide, similar to the one for adults we developed last year.

NHS South West Yorkshire Partnership NHS Foundation Trust

Getting support in a mental health crisis or emergency

Important information for children and young people

Improving Care Incidents in July

In July we reported:

- 1,088 incidents – 1,065 rated green (no/low harm)
- 14 rated yellow or amber, it was 25 in June
- 9 rated as red, it was 8 in June
- 2.1% of incidents are recorded as either red, amber or yellow. Down from 3.5% in June.
- We reported **9** deaths (3 awaiting confirmation), **4** suicides, **1** category 4 pressure ulcer, **4** category 3 pressure ulcers, and **13** self-harm incidents.

There were **5** suicides amongst patients with an open referral.

We had **161** restraint interventions in July, down from 170 in June. **88%** of prone restraints were of 3 minutes or less.

We had **56** falls in July, up from 41 last month. All falls are reviewed to identify measures required to prevent reoccurrence.

There were **11 confidentiality breaches** in July, the same as in June.

All of us can reduce the number of patient data or sensitive information breaches at the Trust. Help us protect the people we care for by printing and displaying our new IG campaign posters in your work areas. The posters feature real-life service user stories on how Trust data breaches have impacted their lives.

Think. Check. Share.

Improving resources
Our finances in July

Performance Indicator		Year to Date	Forecast 2021/22
1	Surplus / Deficit	£2.1m	£2.3m
2	Agency Spend	£2.7m	
3	Cash	£61.2m	£52.8m
5	Capital	£0.8m	£9.6m
6	Better Payment Practice Code	95%	

In July a surplus of £0.4m has been reported which is favourable to plan. The forecast position for the first half of the year is currently for a surplus of £2.3m. This will continue to be re-assessed.

Agency expenditure has increased in June and July 2021 with £0.8m spent in July. This is the highest cost incurred in a single month in the last 4 years. The increase is mainly in unregistered nursing staff to support adult acute and forensic inpatient workforce requirements.

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 forecast remains that the full £9.6m capital programme will be utilised in year. A business case for the Bretton Centre development has been drafted and this is currently being assessed. Year to date spend is £0.8m which is £0.1m less than planned.

95% 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.

A great place to work
Our performance in July

#allofus
our wellbeing at work

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **4.5%** sickness rate
- **2.3%** of sickness absence is due to stress, anxiety and MSK
- **14.1%** staff turnover
- **71.8%** of staff would recommend the Trust as a place to receive care and treatment (most recent survey)
- **69%** of staff would recommend the Trust as a place to work (most recent survey)

Keep an eye out for information about the **flu vaccine** programme. Clinic information coming soon!

NHS People's 'Pride in the NHS Week' is a new five-day virtual festival dedicated to LGBT+ NHS colleagues, topics, speakers, chats, careers, health and more. The theme for this year is 'Elevate, Educate and Celebrate'. Reserve your space now!

Our staff canteens marked South Asian Heritage Month by serving delicious food from the area. Manreesh Bains, the chair of our BAME staff network, said "Thanks to the network and canteen staff for working together to celebrate some diversity in our day"

Following the announcement that our current Chair, Angela Monaghan, is retiring later this year we are now recruiting for a new Chair. More information on the role can be found here.

We are planning on relaunching our **Excellence awards** early next year and want staff to help us make improvements. If you would like to take part in award focus groups let us know.

Managing risk

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.

This month a new key risk has emerged linked to the coronavirus pandemic, which is having an impact on staffing levels in our operational services.

This has led **Carol Harris, our director of operations, to issue a call to action for all Trust staff.** The call is for anyone who can offer time, support or skill to help the Trust respond to the continued staffing challenges we are facing in our own care system.

Tasks will be allocated to staff who come forward depending on skill and experience for both non-clinical and clinical support to relieve the pressure on teams. If you can offer your services, please contact Amanda directly on **Amanda.dixon@swyt.nhs.uk** or 01924 316020. Clinical staff can also contact the bank office to arrange either bank or overtime shifts.

We continue to do everything we can to mitigate all our risks. This includes supporting staff and enabling everyone to find ways to maintain quality of care while improving services.

With **all of us** in mind.

Leadership changes

Alan Davis, our current director of human resources, organisational development and estates is retiring at the end of September after 39 years of NHS services, 29 years of which have been with the Trust and its predecessor organisations.

In advance of this change we asked Alan to share with us some of the highlights from his time in the Trust:

- Delivery of the estates strategy, particularly modernising inpatient areas and developing the community hubs
- Investment in staff health and wellbeing, including establishing our own occupational health service
- Commitment to staff learning and development despite cost pressures
- Partnership working with Staff Side organisations
- Outcome of the Health and Safety Executive inspection in 2020
- Improvements in cleaning and food standards
- Working with caring and talented colleagues

Alan also shared his thoughts on what makes for what makes a great place to work:
- Kindness and compassion
- Looking out for each other and offering support
- Valuing difference and standing shoulder to shoulder
- Live the values
- Remember we are a guest in the lives of our service user/patient

.

It's been a privilege to work with such dedicated and talented people who make a real difference to the lives of so many people.

Thank You All

With **all of us** in mind.

Take home messages

For us in healthcare workplace restrictions haven't changed. Keep us with the measures that have kept us safe so far.

Safety comes first, always. Make sure you know what to do if you are asked to isolate.

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

If you have been carrying out lateral flow tests then continue to do so. It helps keep our people and places virus free.

If you can help out our clinical services with time, skills or support then let us know.

Take a look at the anti-racism campaigns we are a part of and see how you can get involved.

Share your views on electronic patient records by taking part in NHSX's survey.

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

Title:	Integrated Performance Report
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for August 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 August is in line with developments agreed by the Trust Board, including a 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 was 136 in August, a decrease of 25 (15.5%) from July • No avoidable pressure ulcers were reported in the month • There were 8 information governance breaches reported in August, a reduction from 11 in July • The number of inpatient falls decreased in August (43 compared to 56 in July) **NHSI Indicators** • Performance against national reported targets remains largely positive • Percentage of service users waiting less than 18 weeks remains above the target threshold at 99.7% • Performance against the 6-week wait target for a diagnostic appointment has increased to 100% and is now above target, an improvement from July. • 2 young people under the age of 18 were on an adult ward in June, a total of 41 days • The percentage of individuals completing IAPT treatment who have moved to recovery has fallen below target (43.6% compared to 50% target).

With **all of us** in mind.

- Out of area bed usage increased from July to 165 days (from 86 days)

Locality
- Increased referrals and levels of acuity are being experienced across many service lines
- Staffing levels remain under constant review with absence levels in forensics over 13%.
- Consistent with July, three wards fell below the 90% overall fill rate threshold in August. Significant efforts are underway to address our current staffing pressures.
- In Barnsley, the Covid-19 vaccination of 12-15 year-olds vaccination has commenced
- ASD/ADHD services have seen a significant increase in referrals for assessment
- Implementation of the Specialist Community Forensic Team continues and the team now have service users within the community
- CAMHS referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield, with the % treated within 18 weeks beginning to deteriorate.
- A business case regarding CAMHS neurodevelopmental assessment waiting list initiative has been approved.

Communications, Engagement and Involvement
- Coronavirus updates continue weekly to all staff and governors
- Coronavirus comms has commenced for 12-15 year old vaccination programme in Barnsley
- Attendance at fortnightly flu planning meetings has supported preparation for launching the flu vaccination campaign in September
- Staff engagement has taken place for the equality campaign, and content is in the process of being developed

Priority Programmes
- An updated financial offer has been received for the Adult Secure Provider Collaborative, with final business case going through September governance meetings of all partners prior to planned 1st October 2021 'go live'
- The Trust hosted the launch of the anti-racism movement #WYHRootOutRacism, led by the West Yorkshire and Harrogate Integrated Care System
- Work is underway in each place to review and further develop integrated care partnership arrangements in line with potential implications of NHSE/I proposals

Finance
- A £0.1m surplus was recorded in the month, taking the cumulative position to a surplus of £2.3m. This is £2.3m favourable to our break-even plan.

	- Pay costs increased in August to £17.3m from £16.7, which includes the increased non recurrent costs associated with the bank holiday weekend payment premiums agreed for inpatient areas. - Agency staffing costs were £0.7m in August. This is a reduction from the high value reported in July with a reduction in unregistered nursing. This is correlated with the increase in internal staffing costs in August. - Out of area bed costs were £121k, which is a reduction compared to July. - Capital expenditure of £1.2m has been recorded to date, which is £0.4m less than planned. A business case for the works in the Bretton centre (including en-suite facilities) is on the agenda for a September Board decision. - The cash balance remains positive at £63.3m **Workforce** - Non Covid- 19 sickness is within target at 4.6% in August - Staff turnover increased to 14.6% in August (from 14.1% in July), and remains below target - As of 22nd September, there were 81 staff off work and not working Covid-19 related 85% of staff are double vaccinated **Covid-19 response** - 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 - The Trust Opel level has been increased to Level 3 following recommendation to Gold Command on 26th August 2021 - The Trust flu vaccination programme has commenced and planning for potential Covid booster vaccinations is underway - Silver command structure is currently meeting twice a week, and Gold command weekly - National guidance continues to be monitored, reviewed and adopted - A range of staff wellbeing support offers continue to be available and used
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

**Integrated Performance Report
Strategic Overview**

August 2021

With **all of us** in mind.

Table of Contents

Introduction

Please find the Trust's Integrated Performance Report (IPR) for August 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 August 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. The Trust is also keen to include data related to the West Yorkshire and Harrogate and South Yorkshire and Bassetlaw Partnerships – this is likely to be an iterative process as work is underway within the ICSs to determine how performance against their key objectives will be assessed and reported. Following an internal review of the IPR we are currently looking at which metrics 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.

Improving health

Priority programme	Metrics	Threshold	Jun-21	Jul-21	Aug-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 apparent suicides for patients with an open referral to SWYPFT services		2	5	2			Apparent suicide of those under SWYPFT care at the time of death have been analysed and rates are not outside of normal variation. Figures may be subject to change as we become aware of deaths. In the current month, there is no commonality in reporting teams. Suicide not confirmed by coroner at point of reporting.
	2.Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks) *	55%	Q4 - 74.6% Q1 - 65%	Available beginning of Q3				A weighted average is used given there are different targets in different places
	3.Proportion of people from BAME communities accessing IAPT		14.1%	13.7%	14.3%			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	**80% screened 71% compliant	**68% screened 58% compliant	**65% screened 58% compliant			For current inpatients (as at 22nd Sept) 65% of applicable patients have been screened using the cardio metabolic screening tool and of those 58% have been screened across all 9 domains.

For current patients (as at 22nd September) within early intervention services, 55% of applicable patients on caseload have been screened using the cardio metabolic assessment tool. Of those, 42% 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	**55% screened 41% compliant	**55% screened 41% compliant	**55% screened 42% compliant			
	2. IAPT - proportion of people completing treatment who move to recovery	50%	53.2%	44.8%	43.6%			August data is provisional and will be refreshed in October 2021
	3. % service users on CPA followed up within 7 days of discharge	95%	103/105 =98.1%	139/140 =99.3%	113/114 =99.1%			
	4. % of service users on CPA with a 12 month follow up recorded	95%	95.6%	94.2%	92.5%			
	5. % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 week	90%	93.1%	82.6%	85.9%			Q1 total is 91.5%. July and August data will be finalised at the end of the quarter - further work to be undertaken to finalise the data and it is anticipated that performance will increase.
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. |

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).

Glossary

BAME	Black, Asian and Minority Ethnic
IAPT	Improving access to psychological therapies
CPA	Care programme approach

Below we have set out progress against key milestones for areas of focus for those priority programmes that have taken place throughout August and progress towards milestones set for the next three months. 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

(green)	On Target to deliver within agreed timescales
(yellow)	On Trajectory but concerns on ability/confident to deliver within agreed timescales
(orange)	Off Trajectory and concerns on ability/capacity to deliver within agreed timescales
(red)	Action will not be delivered within agreed timescales
(blue)	Action Complete

Improve health (Salma Yasmeen and Sean Rayner)

Key Milestones		Comments:
1. Creativity & Health: Development of a Creativity & Health digital app with first stage research and development and proof of concept completed by end of September 21. Three creativity courses produced by end of September 21 and testing and evaluation completed by end November 2021.	(green)	**Creativity and Health:** Work to develop a proof-of-concept Creativity app is underway and meetings scheduled with the developer. Testing of initial content has been completed and feedback has been positive. A project manager has been appointed by National centre of creativity and health (NCCH) to work in partnership to analyse health sector investment in creative projects to inform sustainability plans and development of West Yorkshire and Harrogate (WY&H) creativity hubs.
2. Creativity & Health: Partnership working with the National Centre Creativity & Health to map and analyse health sector investment in creative projects to inform sustainability plan by end of November 2021.	(green)	**Active Calderdale:** Work to develop in-house motivational interviewing training with physical activity focus is underway with clinicians however initial timescales to pilot will need to be revised.
3. 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 of August 2021.	(yellow)	**ICS and Partnership developments:** The Trust is part of two advanced integrated care systems (ICSs) and is also part of place-based partnerships and provider collaboratives.
4. Active Calderdale: to hold a partnership event showcasing the work across SWYPFT in integrating physical activity into systems and processes by end of October 2021.	(green)	- We continue to work with partners in West Yorkshire and Harrogate and in South Yorkshire and Bassetlaw in response to increased system pressures resulting from the pandemic. This is looking at how primary and secondary care demand can be managed and supported. - We continue to work with partners to develop our place approach and response to The Health and Care Bill which is currently going through Parliament. - ICSs are currently working with partners on potential operating models and will be engaging with people in each area on how the proposals will work in practice. We will ensure that opportunities to get involved are shared. - We continue to work with our partners in Barnsley on the move to more integrated care. The Borough Health and Care Plan has been signed off, with partners now working on how the plan's objectives will be progressed. It impacts on community mental health and general community services integration.
5. Forensic Lead provider collaborative: Updated financial offer for the provider collaborative received from NHSE w/c 6/9/21. Collaborative business case has been updated as a consequence and is being taken through all partner governing bodies for approval, to be able to 'go live' once approved. Date for practical 'go live' being discussed with NHSE with aim of 1st October.	(yellow)	- The Trust hosted the launch of the anti-racism movement #WYHRootOutRacism, led by the West Yorkshire and Harrogate Integrated Care System (ICS) and West Yorkshire Violence Reduction Unit, at its Fieldhead site in Wakefield. The Trust's Interim CEO and Chair have also formally written a statement that has been shared publicly, emphasising the Trust's commitment as an anti-racism organisation.
6. Community mental health transformation: Recruitment into project/programme lead posts has now taken place and all programme leads are now in post. SWYPFT delivery leads network meeting to be established in next period to facilitate shared learning across our place-based programme leads and operational managers.	(green)	Two organisational development sessions for the executive teams of the 4 Trusts in the West Yorkshire mental health learning disability and autism collaborative in late September & October have been arranged to take forward the functions mapping work, and the wider development of the collaborative.

Improve Care

Priority programme	Metrics	Threshold	Jun-21	Jul-21	Aug-21	Trend	Year end forecast	Notes
Continually improve patient safety	1. Incidents involving moderate or severe harm or death	Trend monitor	31	18	18			
	2. Number of c-diff avoidable cases	0	0	0	0			
	3. Number of pressure ulcers	Trend monitor	37	22	21			
	4. Safer staffing fill rates (%)	90%	118.5%	115.0%	111.2%			
	5. Number of children & young people in adult wards	0	3	3	2			Total of 41 days in August which remains the same as July.
	6. Staff absence due to Covid-19		0	40	29			No of staff still absent from work - Covid-19 positive
	7. Number of nosocomial incidences of Covid-19 in our inpatient units		140	141	141			Cumulative
Provide care as close to home as possible	1. Out of area bed placements (days)		170	86	165			Continued pressure and demand with the number of placements minimised.
Deliver improvements particularly in CAMHS and forensic services	1. Numbers waiting over 4 weeks for assessment (CAMHS)		169	194	221			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)		139	146	161			
	3. Friends & Family test - CAMHS	80%	71.0%	83.3%	66.0%			47 responses in August
	4. Forensics staff sickness	<=5.4%	5.2%	6.6%	5.4%			
	5. Forensics staff turnover		13.2%	11.1%	11.60%			Registered nurses turnover
	6. Race related incidents against staff in forensics		8	3	7			There were a total of 18 race related incidents against staff reported between June and August 2021, occurring in Forensic BDU.
Safely deliver and restore inclusive services locking in innovation	1a. Waiting lists - Referral to assessment within 2 weeks (external referrals)	75%	93.4%	89.4%	96.3%			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%	94.6%	93.3%	95.2%			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%	93.4%	92.2%	96.3%			This mostly relates to IHBT and liaison services
	2a. Average contacts per day - Core mental health		254	226	210			Pre Covid-19 - 240 (October 2019 which is representative of the following 6 months)
	2b. Average contacts per day - intensive home based treatment team		136	133	125			Pre Covid-19 - 154 (October 2019 which is representative of the following 6 months)
	2c. Average contacts per day - Learning disability community		162	156	119			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		585	622	590			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 next month

Glossary

CAMHS	Child and adolescent mental health services
SPA	Single point of access
IHBT	Intensive home based treatment team
PICU	Psychiatric intensive care unit
CCG	Clinical commissioning group

NHS South West Yorkshire Partnership NHS Foundation Trust

Improve care (Carol Harris)

Key Milestones	
1. **Recovery and Reset – Operational recovery and reset:** Undertake 'as is' stocktake of current contact methods used and set 'proxy' measures for the future 'to be' state by end of September 2021.	[green]
2. **Recovery and Reset – Operational recovery and reset:** Gather evidence to shape service user involvement and quality measurements by end of November 2021.	[green]
3. **Recovery and Reset – Operational recovery and reset/Enabling Working Effectively:** Toolkit to support services in recovery and reset inclusively has been codesigned, tested and agreed by end of November 2021	[green]
4. **Recovery and Reset – Enabling Working Effectively:** Ways of working codesigned and tested and framework agreed by end of November 2021.	[green]
5. **Care close to home:** Gatekeeping analysis has been completed and priority activity has now been agreed. As a result the programme is now formally establishing a strand of coordinated work around crisis house support. Focus on discharge solutions is now also being included in the partnership governance. (September 2021)	[green]
6. **Care close to home:** PICU dashboard live (August 2021)	[blue]
7. **Care close to home:** PICU SOP agreed and ready for launch – now September 2021	[green]
8. **Improve Services for people acutely unwell and improve ward environment:** scope and priority strands have been agreed via root cause analysis and driver diagram with some more urgent improvement to support acute inpatient pressures prioritised (July - August 2021)	[blue]
9. **Improve Services for people acutely unwell and improve ward environment:** initial governance is being set up with first formal meeting scheduled for early October. Workstream milestones will then be agreed.	[green]
10. **Older People Inpatient Services Transformation -** Share draft consultation plan and collateral with the CCG and NHSE for comment and assurance – complete July 2021	[blue]
11. **Older People Inpatient Services Transformation -** Start the conversations with and share the consultation plan and collateral with the Overview and Scrutiny Committee. August - September 2021, ongoing.	[green]
12. **Older People Inpatient Services Transformation -** Finalise the outline business case for change, considering resources required, the impact on travel and mitigations, and the equality impact assessment. Agree the business case through appropriate governance structures. (start Q2 2021, complete early Q3), ongoing.	[green]
13. **Older People Inpatient Services Transformation -** Develop collateral required to deliver formal consultation (start Autumn 2021, exact timing TBC)	[green]
14. **CAMHS improvement- Neuro waiting lists (Calderdale and Kirklees:)** Funding for the enhanced service has now been agreed in both Calderdale and Kirklees. The focus for the project has moved onto establishing the new service (initial project plan in place by end August / early September).	[blue]
15. **CAMHS improvement- Neuro waiting lists (Calderdale and Kirklees:)** Princess Royal site ready for new service (early November)	[green]

Comments:

Recovery and Reset: This work is evolving and emergent. Robust governance processes are in place to monitor progress. The initial draft timelines have been amended to reflect the evolving nature of both programmes.

Enabling Working Effectively
 -Utilising the evidence base collated to date, the following areas have commenced cocreation and codesign with a group of services this month:
 •A set of enabling working effectively principles and classifications to help staff and their managers identify their ways of working
 •Work is underway to codesign the organisational strategy and guidance to support staff and managers as part of the recovery and reset toolkit.
 •Services are also involved in the cocreation of the accommodation control framework
 •Services are identifying any improvements required in IT support services provision as part of the IT services review of how they support hybrid and flexible working model for now and the future.
Given the iterative and time-consuming nature of this involvement work, and owing to other organisational pressures, an additional four weeks has been added to the schedule. Estimated completion date is now scheduled for end of November 2021.
 -Amendments to the booking desk and room system have been agreed and finance approved. Work has commenced on undertaking these amendments. This has added an additional 6 weeks to the schedule for when the system will be ready for testing with services. It is now estimated that testing will commence in October 2021.
 -Principles and guidance for meetings to support hybrid working are in development. Work progresses on testing this out with OMG and in service meetings with the group of services identified as testers. Lead times for identifying and procuring supporting IT kit are being taken into consideration.

Operational Recovery and Reset
 -The recovery and reset task and finish group of the programme, made up of membership from Mental Health, Learning Disability and General Community services, provided updates demonstrating significant progress on setting of benchmark proxy measures as part of the work on the road to determining the most appropriate balance of face to face and virtual contacts. Using intelligence and insight, each area has been able to identify the current blend of face to face and non-face to face contact methods used in each service (as is position).
 -With support from P&I there is greater understanding of what the data is telling us pre-covid and the impact of covid19.
 -A second task and finish group is being formed with support from the quality improvement and assurance and performance & information teams to build upon the current work being undertaken in the Trust on the efficacy of non- face to face contacts and clinical models and will further develop the work on the actions from the auditors report, and continue identification of qualitative and quantitative measurements/indicators.
 -Equality and Involvement team members are involved in each task and finish group and formal steering group to help shape the approach to recovery and reset inclusively.
 -The support toolkit for recovery and reset of services is being codesigned and tested out with services. The elements in existence such as clinical support tools are being refreshed, with additional work includes hybrid working guidance, self assessment readiness checklist, and equality and involvement checklist so we can respond to any differential impacts or health inequalities robustly.

Older People Inpatient Services Transformation
Work is now progressing toward the delivery of the outline business case for the proposals and the formal consultation and conversations are ongoing with key external stakeholders to test support for proposals before moving forward.

CAMHS
The focus for the project now is moving onto establishing the new service and the project team has developed a plan for activity over the coming months. Work continues on estates and locating the Kirklees service primarily at the Princess Royal. The aim is to be operational at that site by early November. Calderdale is also planning to use this site to deliver some assessments. Recruitment across the services continues

Inpatient Improvement
Formal governance for the programme is now being established, whilst some urgent priority activity is also being considered to ease some of the immediate pressures. Improvement activity is also being planned that can support easing immediate pressures, such as support to reduce

Glossary	
PICU	Psychiatric intensive care unit
CCG	Clinical commissioning group
NHSE	NHS England

Improve resources

Priority programme	Metrics	Threshold	Jun-21	Jul-21	Aug-21	Trend	Year end	Notes
Spend money wisely and reduce waste	1. Surplus/(deficit) vs target	In line with Plan	£426k	£377k	£118k		£2.3m	H1 forecast is favourable to plan.
	2. Underlying surplus/(deficit)							Not currently calculated due to interim financial arrangements
	3. Cash		£60.8m	£61.2m	£63.3m		£64.6m	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'		4.2%	5.1%	4.2%			
	2a. Percentage of video consultations		2.8%	3.3%	2.2%			Slightly lower than national averages. Both video and telephone contacts have reduced and face to face contacts have increased as services increase the face to face activity.
	2b. Percentage of telephone consultations		35.5%	35.2%	27.5%			
	2c. Percentage of face to face consultations		61.6%	61.5%	70.3%			
	3. Prescribing errors (EPMA) (development required)		Reporting to commence October 2021					Reporting to commence next month for medicine omissions as a proportion of doses due.

Improve resources (Mark Brooks)

Key Milestones		Comments:
1. **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.	(amber)	**Digital dictation:** Business case seeking approval to go out to tender has been prepared and will now be submitted to EMT during September/October 2021 with initial timescales for procurement revised accordingly.
2. **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.	(green)	**Trust Email platform accreditation (NHS Digital dependencies)**: Remains on track but timescales are dependent upon NHS Digital dependencies. The Trust has completed all pre-requisite activities and are awaiting final approval from NHS Digital from which to further issue Trust communications and start NHS mail decommissioning.
3. **IT Services re-procurement:** approach planning prior to procurement – Q1/Q2.	(green)	**IT Services re-procurement:** Trust authority to proceed approved, development of the detailed specification of requirements progressing to support the procurement exercise and remains on track.
4. **Cyber Security:** Annual Survey/Phishing Survey and evaluation of findings – Q2 and implementation of action plan – Q3	(green)	
5. **Digital capital programme 21/22:** detailed programme planning and mobilisation of planned expenditure. A review of HY1 underway and forecast for HY2.	(green)	**Information Sharing:** Development proposal for onboarding Viper360 portal to Yorkshire and Humber care record approved and work underway. Work ongoing to support the establishment of a minimum viable product (MVP) for a Barnsley Shared Care Record by 30 September 2021 – potentially utilising Viper360 together with existing capabilities available within SystmOne and ICE (results reporting) as used by partners across the place. Work ongoing with partners.
6. **Information Sharing:** Yorkshire & Humber Care Record onboarding (utilising Trust clinical portal) – Q1/Q2.	(green)	
7. **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 is established and has been launched across the Trust. Further demonstrations of this reporting tool to be undertaken across the Trust over the next month – August 2021 (ongoing) · Development work taking place for additional CQUIN metrics to support community schemes – schemes on hold and awaiting further information from NHS England regarding whether they will be implemented during 21/22.	(green)	**Digital Inclusion**: Dr Abida Abbas, Trust chief clinical information officer is developing a proposal for a digital inclusion survey for service users and to establish mechanisms for collecting service user digital inclusion/preferences at relevant points of contact to be recorded in SystmOne.
8. **Digital Inclusion:** Technical Feasibility (in collaboration with WY&H ICS).	(green)	**Finance:** Confirmation of initial mental health investment standard (MHIS) monies received. We continue to work with commissioners to secure additional investments and utilise in year slippage. Financial Sustainability Plan: Work to refresh the sustainability plan is underway, roadmap on next steps and proposal for governance arrangements and oversight approved by the operational management group.
9. **Finance:** Confirmation of mental health investment standard (MHIS) monies and other investments by 30.06.21	(green)	

Make SWYPFT a great place to work

Priority programme	Metrics	Threshold	Jun-21	Jul-21	Aug-21	Trend	Year end forecast	Notes
Support the provision of a healthy, resilient & safe workforce	1. Sickness absence	4.5%	4.3%	4.5%	4.6%			Non Covid-19 sickness lower than previous years
	2. Staff turnover - YTD	10%	13.1%	14.1%	14.6%			Slight increase in staff turnover in August. The rolling 12 month rate (Sept 20 to Aug 21) was 11.9%
	2a. Staff Turnover - monthly		0.8%	1.2%	1.4%			
	3a. Clinical supervision	>=80%	75.7%	Due October 2021				Reduced performance reported this quarter
	3b. Appraisal	>=95%	Data currently unavailable					Suspended due to Covid-19
	4. Incidents of violence and aggression against staff	Trend monitor	54	72	62			
	5a. Staff survey - % staff recommending the Trust as a place to receive care and treatment	80%	Most recent survey - 71.8%					Increased from 65.6% in 2019
	5b. Staff survey - % staff recommending the Trust as a place to work	65%	Most recent survey - 69.0%					Increased from 61.5% in 2019
	6. Cases of bullying & harassment		0	0	0			Alternative metric being considered
	7. Absence due to stress & anxiety and MSK		2.3%	2.5%	2.2%			
	8. Relative likelihood of appointment to roles band 5 and above for people from BAME backgrounds		1.34	1.18	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.

Glossary

MSK	Musculoskeletal
GPTW	Great place to work

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Make this a great place to work (Alan Davis)

Key Milestones	
1. Performance Indicators: established for great place to work themes by September 2021 further discussion at WRC on 21 September.	🟩
2. Feeling Safe (Physical and Psychological Safety): Preventing bullying and harassment - Appointment of Civility and Respect Champions Q2 21/22 – training undertaken and role launched in August, ahead of schedule. -Redesigned bullying and harassment policy Q2 21/22 -Panel to review all race related bullying and harassment Q2	🟨🟨
3. Feeling Safe (Physical and Psychological Safety): More staff -Commence ethical international recruitment for nursing Q2 21/22 -Virtual recruitment fairs Q3/4	🟨
4. Supportive Teams (Healthy Teams): Effective and Compassionate Leaders -Start rollout of 'GPTW programme' across Trust Q2 21/22 following successful pilot with senior leaders -Start review & refresh of principles of Trust-wide leadership model (Trios) in Q2	🟩🟩
5. Supportive Teams (Healthy Teams): Quality appraisal and supervision -Streamline appraisal process and develop link to an e-supervision Q2	🟩
6. Keeping Fit and Well (Staff Wellbeing): Enhanced Occupational Health Support Enhanced Occupational Health offer linked to recovery and long covid Q1 21/22	🟨
7. Developing Potential (Investing in the future): Supported personal and professional development plans -Personal development for all staff who have completed appraisal Q2 21/22 -Learning needs analysis linked to personal development plans Q2 21/23	🟩
8. Sustainability: develop Trustwide action plan	🟩

Comments:

Great Place to Work Themes:
Performance indicators for great place to work themes continue to be developed
Working in partnership to review bullying and harassment procedure with an engagement plan being developed to gain insight from staff.
Progress on reviewing the early resolution process has been hampered owing to Covid-19 pandemic restrictions.
Enhanced Occupational Health offer linked to recovery and long covid - a bid has been made for additional funding and is expected to be successfully received before Sept 2021.
Successful supported continuing professional development bid for nursing and allied health professionals (AHP) staff to health education England (HEE) and secured funding.
Window for completion of appraisals has been extended to October owing to pressures resulting from Covid19 pandemic and this will be further reviewed.
BAME talent pool has been established and work continues to develop opportunities, with current members undertaking ILM7 L&M, cognitive behavioural therapy post-graduate and Shadow Board programmes.
Shadow board programme is now recruited to with a cohort of 12 colleagues undertaking the programme between August and December 2021
BAME Fellowship Programme completed for this year with a Fellow now being hosted within our Trust and supporting our community mental health transformation programme in Barnsley. In addition, several Fellows have now undertaken our ILM5 coaching & mentoring programme in a reciprocal arrangement with us providing Peer Supervision Coaching to the ICS Fellowship programme.
international nurse recruitment on track with 25 nurses interviewed in 1st wave. 13 have been sent conditional offers. Estimated first cohort will commence end of October 21. Pastoral package & internal objective structured clinical examination (OSCE) training being implemented.
Workforce Strategic Groups set up and first meetings held in September
Equality data (Workforce disability equality standard (WDES) and workforce race equality standard (WRES) collated) with action plans to the workforce and renumeration committee (WRC) and equality involvement and inclusion committee (EIIC) in September.

Sustainability:
Sustainability action plan is in development and includes the identification of a range of reportable areas.
Work has commenced on producing a monthly report for staff mileage and its carbon impact, awaiting data.

Glossary	
BAME	Black and minority ethnic
GPTW	Great place to work

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 was 136 in August, a decrease of 25 (15.5%) from July
•No avoidable pressure ulcers were reported in the month
•There were 8 information governance breaches reported in August, a reduction from 11 in July
•The number of inpatient falls decreased in August (43 compared to 56 in July)

NHSI Indicators
•Performance against national reported targets remains largely positive
•Percentage of service users waiting less than 18 weeks remains above the target threshold at 99.7%
•Performance against the 6-week wait target for a diagnostic appointment has increased to 100% and is now above target, an improvement from July.
•2 young people under the age of 18 were on an adult ward in June, a total of 41 days
•The percentage of individuals completing IAPT treatment who have moved to recovery has fallen below target (43.6% compared to 50% target).
•Out of area bed usage increased from July to 165 days (from 86 days)

Locality
•Increased referrals and levels of acuity are being experienced across many service lines
•Staffing levels remain under constant review with absence levels in forensics over 13%.
•Consistent with July, three wards fell below the 90% overall fill rate threshold in August. Significant efforts are underway to address our current staffing pressures.
•In Barnsley, the Covid-19 vaccination of 12-15 year-olds vaccination has commenced
•ASD/ADHD services have seen a significant increase in referrals for assessment
•Implementation of the Specialist Community Forensic Team continues and the team now have service users within the community
•CAMHS referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield, with the % treated within 18 weeks beginning to deteriorate.
•A business case regarding CAMHS neurodevelopmental assessment waiting list initiative has been approved.

Communications, Engagement and Involvement
•Coronavirus updates continue weekly to all staff and governors
•Coronavirus comms has commenced for 12-15 year old vaccination programme in Barnsley
•Attendance at fortnightly flu planning meetings has supported preparation for launching the flu vaccination campaign in September
•Staff engagement has taken place for the equality campaign, and content is in the process of being developed

Priority programmes
•An updated financial offer has been received for the Adult Secure Provider Collaborative, with final business case going through September governance meetings of all partners prior to planned 1st October 2021 'go live'
•The Trust hosted the launch of the anti-racism movement #WYHRootOutRacism, led by the West Yorkshire and Harrogate Integrated Care System
•Work is underway in each place to review and further develop integrated care partnership arrangements in line with potential implications of NHSE/I proposals

Finance
•A £0.1m surplus was recorded in the month, taking the cumulative position to a surplus of £2.3m. This is £2.3m favourable to our break-even plan.
•Pay costs increased in August to £17.3m from £16.7, which includes the increased non recurrent costs associated with the bank holiday weekend payment premiums agreed for inpatient areas.
•Agency staffing costs were £0.7m in August. This is a reduction from the high value reported in July with a reduction in unregistered nursing. This is correlated with the increase in internal staffing costs in August.
•Out of area bed costs were £121k, which is a reduction compared to July.
•Capital expenditure of £1.2m has been recorded to date, which is £0.4m less than planned. A business case for the works in the Bretton centre (including en-suite facilities) is on the agenda for a September Board decision

Workforce
- Non Covid- 19 sickness is within target at 4.6% in August
- Staff turnover increased to 14.6% in August (from 14.1% in July), and remains below target
- As of 22nd September, there were 81 staff off work and not working Covid-19 related
- 85% of staff are double vaccinated

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
- The Trust Opel level has been increased to Level 3 following recommendation to Gold Command on 26th August 2021
- The Trust flu vaccination programme has commenced and planning for potential Covid booster vaccinations is underway
- Silver command structure is currently meeting twice a week, and Gold command weekly
- 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 11-May	days stock as at 15-Jun	Approx days stock as at 13-Jul	Approx days stock as at 09-Aug	Approx days stock as at 09-Sep
Surgical masks	42	42	22	50	35
Respirator masks	71	101	105	106	98
Aprons	19	20	19	20	31
Gowns	88	87	88	86	86
Gloves	18	20	19	23	23
Visors	46	33	36	29	28

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	As at 14th July 2021	As at 11th August 2021	As at 15th Sept 2021	Notes
No of service users tested (ward)	174	225	257	278	297	300	302	302	303	304	306	Symptomatic
No of service users tested positive (ward)	60	83	94	115	134	137	139	139	140	147	149	Cumulative
No of service users recovered	60	83	94	115	119	121	123	125	125	125	125	3 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 prevention and control team. August saw 4 wards impacted by outbreaks - Stanley, Appleton and Crofton having staff and patients testing positive and Ward 18 had a number of staff who tested positive.

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. Patients 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 patients 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
  • Outbreaks are an included as an agenda item on Silver
  • Each outbreak has an outbreak management team establish, recorded as a Datix incident.
  • Each outbreak has a specific report and action plan. This is reported through ward management, business delivery unit governance and clinical governance processes.
  • A situation background assessment recommendation is produced from outbreaks, breaches and incidents, and informs areas for improvement.
  • A piece of work is being undertaken to improve admission Covid-19 compliance, and this will include assurance reporting.
  • Inpatient vaccination offer is being actioned and reviewed through the vaccination Bronze group.
  • Hard copies of Covid-19 useful information is being produced for easy access for inpatient wards.
• Identified SWYPFT staff are undertaking lateral flow testing.

Covid-19 response

Lateral flow Testing

NHS England and Improvement ended supply of Lateral Flow Testing (LFT) devices to Trusts on 12th July 2021 and advised that all NHS staff should report their results through the national (NPEX) portal rather than through any local reporting.

Except for a small reserve, all the Trusts remaining LFT stock has now been redistributed. We continue to text staff on the LFT database twice weekly (three times for staff on the Care Home programme). From 2nd August 2021 the link on that text has been to the gov.uk portal. When requested we continue to add new staff to the LFT database and encourage staff to continue lateral flow testing via the coronavirus briefing and occasional text/email reminders highlighting the importance of lateral flow testing and of submitting their results.

Prior to 2nd August 2021, we were typically reporting between 2500 and 3000 test results per week. Since moving to the national systems reporting figures have fallen significantly to around 450 per week. Based on the latest report (week ending 12th September 2021) numbers have increased slightly to 510 per week.

A factor that might be impacting on reporting figures was an issue with the NPEX site and the ability to pick your employing NHS Trust from a configured list. This issue was reported, and we were advised a fix would be implemented mid-September. A check of the site today (24th September) suggests this may be the case, although further reassurance is needed (e.g. checking across different platforms).

We will need to wait at least 2 weeks to determine if there is an improvement in our LFT reporting as a result of this fix being implemented.

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. The Trust has fully engaged with system command structure and other relevant meetings.
• 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 4,560 staff have received their first vaccination (88%) and 4,439 staff have received their second vaccination (85.6%)
• Covid-19 vaccination programme has now closed, with staff offered vaccination routes into the national system. Report provided to the executive manangement team (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 preparedness, resilience and response (EPRR) update including OPEL levels
• Silver command re-established to support ongoing staffing pressures across the trust, with meetings now taking place twice per week.
• Gold command has also reintroduced Thursday morning meetings.
• The Trust OPEL level remains at level 3 due to continuing inpatient staffing pressures.
• Flu vaccination programme is now underway, with 2000+ vaccines currently in the Trust, with further deliveries expected in October
Covid-19 booster jab meetings underway to discuss roll out now confirmation received that the vaccine can be co-administered with the flu vaccine
• West Yorkshire and Humber strategic meetings continue with trends regionally being impact to staffing.

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	Improving Health	Responsive	CH	TBC	63.8%	67.3%	74.0%	73.5%	70.8%	66.6%	N/A
Complaints	% of feedback with staff attitude as an issue 12	Improving Health	Caring	AD	< 20%	16% 7/43	11% 3/27	6% 2/35	19% 7/37	16% 4/25	20% 5/25	1
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	81%	81%	78%	81%	82%	82%	1
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	95%	96%	97%	95%	96%	1
	Number of compliments received	Improving Health	Caring	TB	N/A	31	37	28	22	26	20	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Improving Health	Caring	TB	trend monitor	35	36	26	30	20	18	—
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Improving Health	Caring	TB	trend monitor	4	2	2	2	3	3	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	Improving Health	Caring	TB	0	0	0	0	0	0	0	1
Quality	% Service users on CPA offered a copy of their care plan	Improving Care	Caring	CH	80%	40.4%	40.9%	41.8%	41.5%	41.6%	41.6%	2
	Number of Information Governance breaches 3	Improving Health	Effective	MB	<12	13	7	8	11	11	8	2
	Delayed Transfers of Care 10	Improving Care	Effective	CH	3.5%	1.8%	1.2%	1.1%	1.3%	1.9%	2.9%	1
	Number of records with up to date risk assessment - Inpatient 11	Improving Care	Effective	CH	95%	53.2%	61.6%	68.3%	56.4%	59.1%	60.3%	N/A
	Number of records with up to date risk assessment - Community 11	Improving Care	Effective	CH	95%	57.3%	51.8%	68.9%	67.0%	70.4%	54.7%	N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	1169	1034	1040	1055	1077	1006	—
	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	20	25	18	25	10	14	—
	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	5	6	3	1	1	1	—
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Improving Care	Safety Domain	TB	trend monitor	4	5	3	5	7	3	—
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	116.2%	118.9%	119.8%	118.5%	115.0%	111.2%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	92.9%	94.6%	94.9%	84.7%	88.5%	85.1%	1
	Number of pressure ulcers (attributable) 1	Improving Care	Safety Domain	TB	trend monitor	34	43	32	38	20	21	—
	Number of pressure ulcers (Lapse in Care) 2	Improving Care	Safety Domain	TB	0	2	1	3	1	0	0	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%	79.0%	93.7%	100%	93.8%	88.0%	85.0%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	40	50	39	41	56	43	—
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	179	157	106	170	161	136	—
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	100%	89.3%	90.3%	84.6%	94.1%	87.1%	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 damage

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

4 - Notifiable Safety Incidents are 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 % 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.

12 - 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 August decreased from 161 to 135. Further detail can be seen in the managing violence and aggression section of this report.
• Number of falls (inpatients) – Total number of falls was 43 in August, which is a decrease compared 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 that resulted in a degree of harm of moderate harm, severe harm or patient safety related death tend to fluctuate over time, and data is constantly refreshed within Datix as further information comes to light. This results in changes to the level of harm, severity and categories of incidents amongst other data. We encourage staff to report with an upwards bias initially especially when the outcome is unknown. These are adjusted subsequently. Incident data is regularly analysed to explore any potential higher or lower rates than would be usually expected. Where there are outlying areas, these will be reported on.
• Duty of candour - no breaches in August.
• Percentage of service users on CPA offered a copy of their care plan -
   • Work continues to review the practice and data quality issues relating to care plans.
   • Previously this measure related to 1 specific care plan – the overarching CPA plan, since the introduction of the SystmOne clinical record system it relates to multiple care plans (as above)
   • To achieve that the service is compliant in their reporting that a care plan has been shared, all care plans must be ticked to say that the service user has copies of all care plans. However there are old / inactive care plans on the system that have not been closed. These will be reviewed in line with our review of clinical data quality.
   • There are also data quality issues being explored around how CPA care plan data includes data from teams who would not have people on CPA
   • Operational interrogation of the data on active care plans is that the practice is better than the performance is showing. However, there remains areas for improvement.
• Number of pressure ulcers (avoidable) - there were no incidences of avoidable pressure ulcers to report during August. 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 has 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.
• As the Trusts risk management tool, formulation informed risk management (FIRM) has not yet been in use for twelve months, assurance is provided through existing alternative risk assessments such as Sainsburys or those within medical care plans. The trajectory is 80% completion of FIRM by Q3 and 90% completion by Q4. Responsibility for the quality of FIRM sits within the business delivery unit and will be monitored via audit and exceptions reported into the Clinical Governance Group for escalation to the Clinical Governance, Clinical safety Committee. Training sessions are available between August 2021 and May 2022 for new starters and refreshers.

NHS Improvement - the development of new programmes introduced in the NHS patient safety strategy are continuing with amended timescales. 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. The nine NHS England/Improvement priority areas are being progressed. Details are available here: https://swyt.sharepoint.com/sites/Intranet/Patientsafetystrategy/Pages/NHS-England-updates.aspx

Safety First

Summary of Incidents July 2020 - August 2021

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

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Red (should not be compared with SIs)	6	2	3	6	7	4	6	7	7	4	7	10	
Amber	2	32	25	42	51	28	42	70	53	50	49	44	30
Yellow	19	135	161	167	164	148	242	325	261	314	322	319	319
Green	1114	812	980	936	820	768	667	767	713	672	677	704	649
Total	1141	981	1169	1151	1042	948	957	1169	1034	1040	1055	1077	1006
Percentage of total that are Red/Amber/Yellow *	2.4%	17.2%	16.2%	18.7%	21.3%	19.0%	30.3%	34.4%	31.0%	35.4%	35.8%	34.6%	35.5%

Incident Reporting Update:
Incidents that occur within the Trust will have different levels of impact and severity of outcome. The Trust grades incidents in two ways.
The Degree of Harm is used by all Trusts to grade the actual level of harm to ensure consistency of recording nationally. When staff report incidents, they will complete the Degree of Harm to rate the actual harm caused by the incident. Where this is not yet known, they will rate this as what they expect the harm level to be. It will be reviewed and updated at a later point. This differs from the incident severity (green, yellow, amber, red), which is how we grade incidents locally in the Trust. Incident severity takes into account actual and potential harm caused and the likelihood of reoccurrence (based on the Trust's risk grading matrix).
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).
97% of incidents reported in August 2021 resulted in no harm or low harm or were not under the care of SWYPFT. For 2020/21 this figure was 92% overall. This is based on the degree of actual harm.
Further details about severity and degree of harm can be found in the Incident Reporting and Management Policy.

Initial incident reporting is upwardly biased, and staff are encouraged to report incidents and near misses. Once incidents are reviewed by managers, and further information gathered and outcomes established, incident details such as severity, category and degree of harm can change, therefore figures may differ in each report. Data in this report is refreshed monthly.
Incident reporting levels have been checked and remain within the expected range, any areas with higher or lower rates than normal are explored further.
Reporting of deaths in line with the Learning from Healthcare Deaths policy has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances. As further information is received and decision made about review processes, red deaths may be regraded to green, e.g. when confirmed not related to a patient safety incident.
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://www.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 August 2021

Safety First cont…

Summary of Patient Safety Incidents resulting in moderate or severe harm or death

This section relates to the patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death. Please note this is different to severity as described above.

Initial incident reporting is upwardly biased, and staff are encouraged to report incidents and near misses. Once incidents are reviewed by managers, and further information gathered and outcomes established, incident details such as severity, category and degree of harm can change, therefore figures may differ in each report. This is a constantly changing position within the live Datix system. Incident reporting levels have been checked and remain within the expected range, any areas with higher or lower rates than normal are explored further.

Breakdown of incidents in August 2021:

14 moderate harm incidents:
8 incidents across Barnsley neighbourhood teams - 6 pressure ulcer category 3 incidents and 2 tissue viability incidents
2 inappropriate sexual behaviour (Ward 18)
1 safeguarding adult incident (Poplars)
3 self harm (Nostell ward, Ashdale ward, Core Team South - Kirklees)

1 Severe harm incident:
1 Safeguarding adult (alleged sexual abuse) incident (Ashdale)

3 patient safety related deaths:
2 apparent suicide - community team care - current episode (IHBTT Calderdale & Enhanced Team North 1- Kirklees)
1 apparent suicide - community team care - discharged (IHBTT Calderdale)
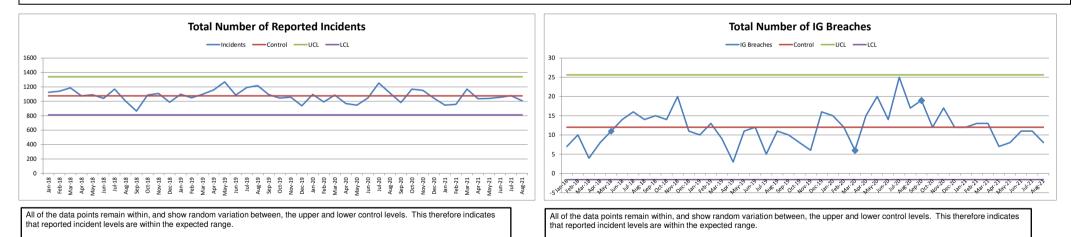
Mortality

The "Structured Judgement Review Exit Survey" for the purposes of quality improvement of the structured judgement review (SJR) training process and support to SJR reviewers has been extended to the end of September 2021. The results will feed in to a review of the SJR reviewer process which is taking place to support the current and future cohort of reviewers.

Further SJR training sessions for new reviewers are planned for late September and early October 2021.

The learning from healthcare death policy is due for review January 2022 but an extension until March 2023 has been requested so that any updates as a result of the new Patient Safety Incident Response Framework can be included.

The next regional mortality meeting is taking place on 14 October 2021. Agenda items include Covid-19 and learning from deaths, the experience of feedback of SJR findings to relatives and learning from SJR.

Total Number of Reported Incidents

Total Number of IG Breaches

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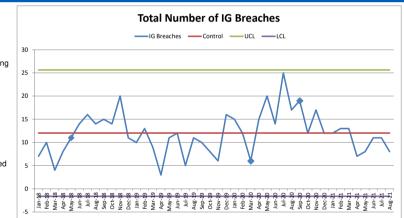
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience.
Click here for further details of the examples http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx
The Quality Improvement Toolkit is available here: http://nww.swyt.nhs.uk/quality-improvement-toolkit/Pages/default.aspx

https://swyt.sharepoint.com/sites/Intranet/learning-from-experiences/Pages/Learning-library.aspx

SBAR recognising the need for specialist assessment - addiction to prescribed medications final.docx

SBAR lethal means and online access final.docx

SBAR EPMA discontinuation

Sharing learning from Covid 19 29.06.21 possible transmission

SBAR - specimen collection from urinary catheters

SBAR learning Choking

SBAR learning Covid 19 restraints

Bluelight alerts

Bluelight alert 49 - 7 July 2021 - Risk of choking

Bluelight alert 48 - 9 June 2021 - Use of end-suite toilet seat as ligature

Bluelight alert 47 - 17 May 2021- Risks from nylon string, lace or cord

Patient Safety Alerts

Patient safety alerts received - August 2021
Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing Patient Safety Alerts. Once received into the Trust, Patient Safety Alerts are sent to identified Trust clinical leads for reviewing safety alerts for a decision regarding whether it is applicable to the Trust or not, and if so, if it should be circulated. All alerts are entered on to Datix. If the alert is applicable to the Trust, the alert is circulated to Trio's who then cascade to ward/team level managers via Datix. Responses are collated via Datix and Trio's enter a final response for the service. Responses are monitored by the Patient Safety Support Team and reminders are sent via Datix to Trio's to ensure the Trust meet the deadlines set. Information is reported into the Medical Device and Safety Alert group on a monthly basis.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2021/007/PHE	Potent synthetic opioids implicated in increase in drug overdoses	18/08/2021	Yes - circulated for action	20/08/2021	20/08/2021

Safer Staffing Inpatients

August has proved to be a particularly challenging time for staffing issues. This has been because of the high annual leave usage during school holidays (which is an annual issue despite the best planning approach of the teams), an increase in sickness, the continued vacancy factor as well as a sustained increase in acuity and Covid related issues. The Trust has formed several task and finish groups to report into the operational management group looking at staffing issues including recruitment and retention, workforce planning and flexible staffing. During the August bank holiday, the Trust had to pragmatically respond to an increase of staffing pressures by authorizing a time-limited premium to these shifts which resulted in covering more vacant shifts through bank and overtime. This is one of the measures that will be looked at in the task and finish groups.
The ongoing situation continues to impact on the pressure on the community services with business continuity plans and escalation plans being utilized more frequently. Throughout September and October, we expect an increase in newly qualified registrants coming into the teams which should positively impact on the registered fill rate and vacancy factor, albeit bringing a different set of pressures for the wards in ensuring that learning opportunities and preceptorship time are afforded.
International recruitment continues to gather pace and we have offered 20 posts in the first tranche of interviewing and the interviews are ongoing. We are hosting our first virtual recruitment fair at the end of September, which we are hoping will help fill some of our more difficult to recruit posts, with our centralized recruitment process ongoing. We continue to explore the collaborative bank to increase our resources and we have increased the recruitment campaign onto bank.
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 is left alone because of an emergency, i.e. sickness or clinical incidents, are looked at and assurances have been given around what support was in place for that incident.
Consistent with July, three wards fell below the 90% overall fill rate threshold, which were Enfield Down (which is going through a reconfiguration so has supported other areas), Stroke Rehab and Priestley. Forensic and Barnsley BDUs continue to experience increased pressure through vacancies, sickness and staff being off clinical areas for various reasons. Of the 31 inpatient areas, 21 (67.2%), an increase of one ward on the previous month, achieved 100% or more. Indeed, of those 21 wards, 10 (a decrease of three on the previous month) achieved greater than 120% fill rate. The main reason for this being cited as acuity, observation, and external escorts.
Although safe and effective staffing remains a priority in all our teams, and there has been a system wide increase on all inpatient areas, the focus for the flexible staffing resources has remained Ward 18 within the Priestley Unit in Kirklees, The Oakwell mental health Unit with Kendray Hospital in Barnsley and Newton Lodge within 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. However, with the added pressures of track and trace, as well as other reasons cited above, they remain a priority for support.

Registered Nurses Days
Overall registered fill rates have decreased by 1.3% to 78.0% in August compared with the previous month.

Registered Nurses Nights
Overall registered fill rates have decreased by 5.6% in August to 92.1% compared with the previous month.

Overall Registered Rate: 85.05% (reduced by 3.45% on the previous month)

Overall Fill Rate: 111.2% (reduced by 3.8% on the previous month)

Unfilled shifts
An unfilled shift is a shift that has been requested of the bank office, flexible staffing, and could not be covered by bank staff, agency or Over Time. Although not exclusive, there are two main reasons for the creation of these shifts, and they are:
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 of the Service Users within our services including levels of observation and safety concerns.

Safer Staffing Inpatients cont…

Unfilled Shifts				Filled Shifts
Categories	No. Of Shifts	Total Hours	Unfill Percentage	
Registered		5,891.67	41.02% (+0.35%)	774 (+11)
Unregistered	598 (-130)	6,692.83	15.34% (-1.89%)	3,203 (-164)
Grand Total	1254 (-112)	12,584.50	22.63% (+7.34 %)	

Total pay costs September 20 - August 21

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. These figures also allows us to monitor an increase on the flexible staffing resource and look at what appropriate resources are required from the trust bank flexible staffing resource.   There was an overall increase, £41,022, on spend on inpatient staffing, see table above, for the month of August 2021. This included an increase of bank and overtime spend of £141,580 and £20,622 respectively whilst agency spend decreased by £114,052.

Information Governance

8 personal data breaches were reported during August, continuing the trend of lower numbers being reported during the current financial year than at any time during the previous financial year.

7 involved information being disclosed in error, which continues to be the highest report category. Incidents reported during August involved such breaches as intranet forms containing personal data being saved to the intranet, post and email being sent to the wrong address, wrong patient's data being sent to a third party and a staff member's mobile number being given to a service user without permission. One incident involving lost paperwork was reported as a completed assessment form was found in an empty meeting room.

IG campaign materials continue to be shared via The Headlines (the trust communications) and further work will be undertaken to share best practice from teams who have made improvements after reporting high numbers of breaches during the last financial year.

The Trust did not report any incidents to the Information Commissioner's Office (ICO) during August and no new complaint about the Trust were made to them.

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.

Total Number of IG Breaches

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.

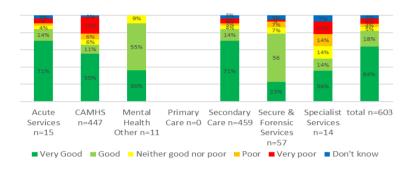**Patient Experience**

Friends and family test shows
• 96% would recommend community services.
• 82% would recommend mental health services
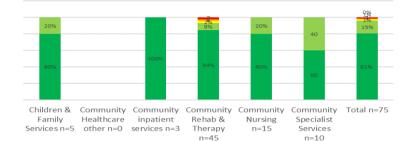
Mental Health Services

Mental Health **82%/ n=603**

Community Services

Community **96%/ n=78**

•83% (681) of respondents felt that their experience of services had been very good or good across Trust services.
•96% (n=78) of respondents felt that their experience had been very good or good across community services.
•82% (n=603) of respondents felt that their experience had been very good or good across mental health services.
•The text messaging service provided 72% (490/681) of responses for August.
•A review of the negative feedback highlighted the following:
•We received 64 negative feedback (poor or very poor)
Breakdown by BDU:
∙ Barnsley MH – 10
∙ Calderdale & Kirklees – 26
∙ Forensics 5
∙ Specialist Services – 16
∙ Wakefield – 7
•56 of the 64 negative feedback was received by text message
•51 of the 56 negative feedback received by text had provided no comments.
•6 of the 13 negative comments provided useful comments. There themes were:
•Staff
•Patient Care
•Clinical Treatment
•There were no other themes or trends identified for those response of either 'neither good nor poor' and 'don't know'
•Services are receiving automated monthly reporting for them to review.
•The text messaging system is being reviewed to encourage respondents to give better quality, qualitative feedback.
•We continue to work to identify the best method of collection for services.

	Top three positive themes	Top three negative themes
Barnsley community service	1. Staff 2. Access & waiting times 3. Admission & discharge	1. Staff
Mental Health Service	1. Staff 2. Access & waiting times 3. Admission & discharge	1. Staff 2. Patient Care 3. Clinical Treatment
Trust wide	1. Staff 2. Access & waiting times 3. Admission & discharge	1. Staff 2. Patient Care 3. Clinical Treatment

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. Safeguarding Care Certificate training aligned to standard and intercollegiate document. West Yorkshire Quality Mark for Domestic abuse training delivered to a clinical team in response to serious incident recommendations.
Safeguarding adult and Children training packages have been developed for Barnsley Hospice and the local MPs, this will delivered buy the safeguarding team.
All members of the team have attended training sessions to ensure that their practice, the training material, and advice provided is up to date and relevant. The Safeguarding team have attended: Safeguarding Young babies & Infant's Masterclass Working group and risk escalation conference.
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.
In response to an service level investigation a meeting has been established by the Matrons and quality leads, to ensure there is a quarterly meeting with specialist advisors. This was attended by the safeguarding team and was considered to be beneficial in terms of sharing updates, learning and good practice.
Safeguarding Children's Nurse Advisor was successful at interview and will take up the post of Named Nurse Safeguarding Children on October 18th, Safeguarding Nurse Advisor post advertised on NHS jobs.
Safeguarding team attended a manager learning event for a Safeguarding adult review in Calderdale.
Safeguarding team completion of Safeguarding Annual report and developed a PowerPoint presentation for the assurance day, this was well received.

Infection Prevention Control (IPC)

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

Surveillance: There has been zero cases of E.coli 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 –92%

Policies and procedures are up to date.

Complaints

There were 25 new formal complaints in August 2021. Of these 6 have a timescales start date and 18 are awaiting consent/questions. We have closed 1 due to no contact/consent.
20% of new formal complaints (n=5) have staff attitude as a primary subject.
20 compliments were received
Customer services closed 7 new formal complaints in August 2021 plus 1 reopened complaint. Of the 7 formal complaints, only 1 achieved the 40 working day target (14% - note this is a local target). Issues with meeting the 40 day local target relate to:
•Clinical capacity to allocate complaints investigations
•Complexity in complaints – complaints over many services and departments which are protracted and multifaceted
•Delays in sign off process

Reducing Restrictive Physical Intervention (RRPI)

There were 136 reported incidents of reducing restrictive physical interventions used in August 2021, this is a decrease of 25 (15.5%) incidents since July 2021 which stood at 161 incidents.

Of the different restraint positions used in the 136 incidents, standing position was used most often 83 (61%) followed by seated at 33 (24%).

Prone restraint was reported 13 (9.5% of total restraints) times in August 2021, this is a decrease of 12 (52 %) from last month.

All reported prone restraints were directly linked to seclusion (12) or medication (1) events.

Incidents where prone descent immediately turned into a supine position were recorded at 8 (5.8%). This is a separate entity to prone restraint.

Wakefield recorded 7 prone restraints; learning disabilities reported 2 prone restraints, all other BDUs reported 1 restraint each in this period.

The Trust target of 90% of prone restraints lasting under 3 minutes and the importance of striving to maintain this is strongly emphasised. In August the percentage of prone restraints lasting under 3 minutes was 85% which is a reduction of 3%. It must be noted that there were fewer prone restraints and less prolonged restraints than previous reporting which appears to give a negative slant on figures.

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.
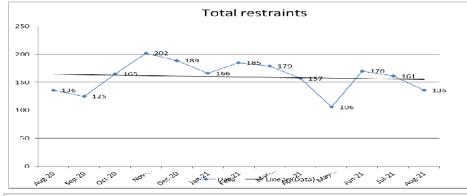
The use of seclusion has reduced to 49 which is a reduction of 3 (5.7%). The psychiatric intensive care unit at Wakefield and the assessment and treatment unit at Fieldhead have experienced a high number of incidents and seclusion due to a range of complex and challenging needs expressed by service users.

The RRPI team continue to provide face to face training in line with current IPC guidance. Although Covid-19 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).
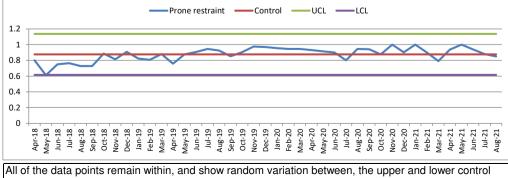
The refresher courses were re-introduced in May this year with update periods extended by 12 months from March 2020. Supplementary to this we commenced a period of workplace competency assessments from April 2021.

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.

Total restraints

Restraints under 3 minutes

% of Prone Restraint with Duration of 3 Minutes or Less

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.

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.
The NHS System Oversight Framework for 2021/22 replaces the NHS Oversight Framework for 2019/20, which brought together arrangements for provider and CCG oversight in a single document. A single set of oversight metrics, applicable to ICSs, CCGs and trusts, will be used to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners.
These metrics align to the five national themes of the System Oversight Framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. There are potentially 41 indicators that are applicable to the Trust in the 21/22 framework. It is anticipated that the majority of these metrics will be taken from existing data flows and sources that are already in operation. The systems oversight guidance refers to the use of in year monthly or quarterly collections – it is not entirely clear which collections this relates to, SWYPFT will try to clarify this, to ensure local systems are in place to monitor performance and a further update will be included in next month's report. A detailed report is being taken to the Finance, Investment and Performance Committee.

NHS Improvement - Oversight Framework Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Data quality rating 8	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	98.7%	99.2%	99.9%	100%	99.9%	100%	100%	100%	99.7%	99.7%		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	43.8%	56.8%	97.8%	100%	97.8%	98.7%	100%	100%	94.1%	100.0%		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	96.1%	98.7%	99.4%	99.7%	99.1%	100%	100%	99.1%	100%	98.9%		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	300/302 =99.3%	301/302 =99.7%	277/281 =98.6%	278/284 =97.9%	98/101 =97.0%	93/96 =96.8%	82/83 =98.8%	103/105 =98.1%	139/140 =99.3%	113/114 =99.1%		
Data Quality Maturity Index 4	Improving Health	Responsive	CH	95%	98.7%	98.8%	98.8%	99.0%	98.3%	99.1%	99.1%	98.7%	98.2%	98.4%		
Out of area bed days 5	Improving Care	Responsive	CH		737	316	251	374	82	122	204	170	86	165		
IAPT - proportion of people completing treatment who move to recovery 1	Improving Health	Responsive	CH	50%	52.7%	56.3%	53.4%	55.3%	53.7%	57.0%	55.6%	53.2%	44.8%	43.6%		
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	CH	75%	92.8%	96.5%	98.8%	98.7%	98.7%	99.1%	98.6%	98.5%	98.1%	98.9%		
IAPT - Treatment within 18 weeks of referral 1	Improving Health	Responsive	CH	95%	99.1%	99.9%	99.9%	99.9%	100%	100%	100%	99.8%	100%	100%		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	60%	87.0%	94.4%	91.5%	90.5%	91.9%	87.0%	89.7%	96.8%	89.2%	78.6%		
% clients in settled accommodation	Improving Health	Responsive	CH	60%	91.1%	91.7%	92.1%	92.4%	92.2%	92.3%	92.4%	92.5%	92.5%	92.5%	⚠️	
% clients in employment 6	Improving Health	Responsive	CH	10%	12.6%	12.5%	12.5%	12.8%	12.6%	12.7%	12.9%	12.8%	13.1%	13.1%	⚠️	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-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	34	10	70	47	6	25	22	40	41	41		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	TBC	6	2	13	7	3	3	3	3	3	2		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	Trend Monitor	205	210	189	217	189		217		Due October 2021			
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	CH	Trend Monitor	13.7%	18.1%	19.0%	19.8%	19.0%		19.8%					

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-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%	99.8%	99.5%	99.4%	99.1%	98.9%	98.9%	99.6%	98.4%	97.1%	97.1%		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	99%	99.9%	99.9%	99.9%	99.9%	99.9%	100.0%	99.9%	99.9%	98.1%	98.1%		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	98.4%	98.0%	98.1%	98.2%	98.1%	98.3%	98.3%	98.2%	99.9%	99.9%		

* 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 99.7%
- The percentage of service users seen for a diagnostic appointment within 6 weeks has increased up to 100% and is now above target.
- During August 2021, there were 2 service users aged under 18 years placed in an adult inpatient ward for a total of 41 days. This is a slight improvement on last month in terms of numbers of service users though the amount of bed days remains high and a concerning position. 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- 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 proportion of people completing treatment who move to recovery has fallen below the 50% target at 44.8% for July and a provisional figure of 43.6% for August. This has been caused by a dip in performance in Barnsley BDU following an opt in exercise where some clients contacted the service after their referral had been closed. There is also a high DNA rate in the Barnsley service (21.5% in August) which is impacting on the recovery figure.
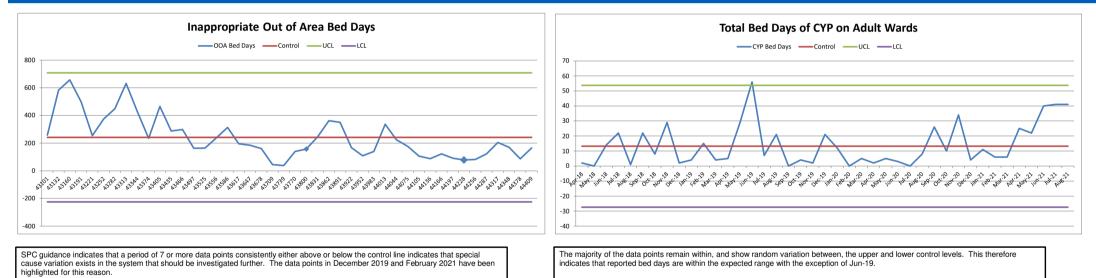
Data quality:
An additional column has been added to the above table to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

For the month of August the following data quality issues have been identified in the reporting:
- The reporting for employment and accommodation for August shows 17.7% of records have an unknown or missing employment and/or accommodation status, this is a slight decrease from July which showed 18% 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

Inappropriate Out of Area Bed Days

SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data points in December 2019 and February 2021 have been highlighted for this reason.

Total Bed Days of CYP on Adult Wards

The majority of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported bed days are within the expected range with the exception of Jun-19.

System wide monitoring

Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Since 2018, they have been deepening the relationship in many areas between the NHS, local councils and other important strategic partners such as the voluntary, community and social enterprise sector. They have developed better and more convenient services, invested in keeping people healthy and out of hospital and set shared priorities for the future.

The Trust sits within two ICS footprints, West Yorkshire and Harrogate and South Yorkshire and Bassetlaw.

This section of the report outlines the metrics that are in place across both ICS footprints along with system performance.

West Yorkshire and Harrogate Partnership

The Partnership finalised and published its five year strategy in March 2020. This document included 10 'big ambitions' – 10 measures that reflect what is important to the Partnership, and by which progress will be measured. These 10 items are:

1 - Increase the years of life that people live in good health in West Yorkshire and Harrogate compared to the rest of England. We will reduce the gap in life expectancy by 5% (six months of life for men and 5 months of life for women) between the people living in the most deprived communities compared with the least deprived communities by 2024.

2 - We will achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024 (approx 220,000 people). In doing this, we will focus on early support for children and young people.

3 - We will address the health inequality gap for children living in households with the lowest incomes. This will be central for our approach to improving outcomes for 2024. This will include halting the trend in childhood obesity, including those living in poverty.

4 - By 2024 we will have increased our early diagnosis rates for cancer, ensuring at least 1000 more people will have the chance of curative treatment.

5 - We will reduce suicide by 10% across West Yorkshire and Harrogate 2020/21 and achieve a 75% reduction in targeted areas by 2022.

6 - We will achieve at least 10% reduction in anti-microbial resistance infections by 2024, by for example reducing antibiotic use by 15%

7 - We will achieve a 50% reduction in still births, neonatal deaths, brain injuries and a reduction in maternity morbidity and mortality by 2025.

8 - We will have a more diverse leadership that better reflects the broad range of talent in West Yorkshire and Harrogate, helping to ensure that the poor experiences in the workplace that are particularly high for black, Asian and minority ethnic (BAME) staff will become a thing of the past.

9 - We will aspire to become a global leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system.

10 - We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole.
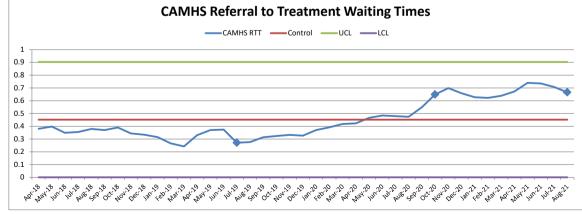
The Partnership have recently outlined an approach to measurement and quantification and it is anticipated that this will be finalised in September 2021. A further update as to progress will be provided in the IPR produced in October.

South Yorkshire & Bassetlaw Partnership

The Trust will work with the partnership to gather relevant information and update this section of the report in October 2021.

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:

Barnsley community Mental Health

Strengths
• Strong mental health partnerships are in place in the local system. A Strategy is being developed for consultation in September 2021. There is also a strong interface with the ICS.
• Service resilience has been maintained. Contacts continue to be delivered by telephone/video link where practicable with face to face support offered as necessary.
• Improving access to psychological therapies (IAPT) waiting list initiative has commenced, with focus on evidence based group interventions.
• A proposal has been developed for Intensive Home- Based Treatment (IHBT) to staff/deliver 136 suite and triage functions out of hours in Barnsley. Planned implementation date 1st October 2021.

Areas of focus
• Increased referrals and acuity have been seen– with associated increase in caseloads across core, enhanced and IHBT.
• Difficulties in maintaining ward staffing levels leading to a 'pull' on IHBT and other community staff.
• Non-recurrent recovery investment made available by CCG. Plans approved to support caseload pressure in the Single Point of Access (SPA) and core/enhanced teams.
• Focus on staff wellbeing/resilience has been maintained

CAMHS

Strengths
• Business continuity plans have to date been effective.
• Waiting numbers/times from referral to treatment are being maintained in Barnsley.
• Business case regarding neurodevelopmental assessment waiting list initiative approved for Calderdale and Kirklees. This creates additional capacity in CAMHS on a recurrent basis and enables short-term utilisation of two independent providers.

Areas of focus
• Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have continued to increase. We are moving to implementation of business cases.
• Referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield. The medium term trajectory is unclear. % treated within 18 weeks beginning to deteriorate.
• 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.
• There are staffing capacity issues across the eating disorder pathway, and proactive discussion with CCG's regarding additional investment.
• There is a focus on maintaining staffing levels in Wetherby Young Offenders Institution and Adel Beck.
• Focus on staff wellbeing/resilience has been maintained

CAMHS Referral to Treatment Waiting Times

The data point in July 2019 has been highlighted as the neurodevelopmental teams have been excluded from this point onwards.
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further.
The data point in August 2021 has been highlighted for this reason.

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

Barnsley general community services

Key Issues
• Neighbourhood nursing are experiencing significant pressures in terms of increased activity and acuity of patients in addition to workforce challenges due to consistent delivery in the context of sustained OPEL 3 level
• The Urban House Health Integration Team (HIT) service is nurse-led and currently has only one Nurse Prescriber in the team. A Nurse Prescriber post was offered to relieve the operational issues this causes, and was due to commence in post in October but has rescinded acceptance of the role.
• The Covid-19 12–15-year-old vaccination programme is due to commence 13th September 2021. The Children's Vaccination and Immunisation Team is currently developing delivery plans and partner organisations have offered to support wherever possible. The service will expect challenges delivering the flu programme within accepted timescales due to capacity issues.

Strengths
• The Musculoskeletal (MSK) Service have appointed an Exercise Instructor and funding is in place for a second exercise instructor for 12 months, which will improve skill mix within team and assist with patient flow. The team have an adaptable work force, committed to improving patient experience.
• Excellent partnership working is in place with the Primary Care Network to set up and deliver First Contact Practitioner MSK Physiotherapy service
• Partnership working to ensure appropriate patient flow and support people's care at home continues

Challenges
• Social care capacity continues to impact on patient flow
• Challenges are expected in the delivery of the Covid 12–15-year-old vaccination programme.
• There are ongoing staffing challenges to ensure safe staffing rotas are filled across all core services including our rehab units

Areas of Focus
• Staff Health and well-being is a key area of focus
• There is continued focus on partnership working
• Delivery of Covid- 19 12–15-year-old vaccination programme

Forensic business delivery unit and Learning Disability services:

Forensic BDU
Key Issues
• OPEL Level has been upgraded to Level 3, due to staffing pressures
• Absence levels (due to Covid and non-Covid reasons) are at just over 13%.
• Recruitment of registered nurses remains a focus, supported by a bespoke recruitment and retention plan. The Forensic services will hopefully be the first services across the Trust to welcome international nurses.
• Work on the Adult Secure Provider Collaborative continues, with a proposed go live date of 1st October 2021.
• Occupancy levels in Newhaven and Newton Lodge are below target. Plans are in place to re-assess out of area patients with a view to repatriate wherever clinically appropriate and possible.
• The Specialist Community Forensic Team (SCFT) now have service users within the community and the team are covering 8am-8pm 7 days a week.
• All targets are being met re national timescales. Nationally, pressures are being seen around access to male low secure beds and female beds (both medium and low secure).
• Staff supervision levels are 63% in medium secure, 83% in low secure and 77% in Newhaven and there is work ongoing to ensure they reach target.
• Staff well-being remains a focus, with the service utilising recent NHS survey results to modify plans.
• All mandatory training which is below expected targets is the focus of attention across the service and recovery trajectories are in place.
Fire safety training across the BDU is 85% and work is ongoing to achieve the internal target of 95%

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 continued:

Learning Disability Services
Key Issues
• OPEL Level remains at Level 2 for community and Level 3 for the Assessment and Treatment Unit (Horizon)
• Supervision levels have fallen and are 64% currently
• Medical cover across all Learning Disability Services is critical. Short term plans are in place, and service managers are liaising closely with the Medical Director.

Community Learning Disability Teams:
• Sickness absence remains higher than usual but is largely incidental and under control. Long-term sickness is all being managed, and we are hopeful that sickness absence will stabilise through Q3.
• Vacancies in psychiatry and psychology posts across all our community teams are proving difficult to fill and we are seeing the impact through increased caseloads and increased waiting times for some pathways (e.g. autism diagnosis). As part of a workforce plan we have engaged locum medical staff and redeployed staff where possible which should ease the immediate pressures.
• There is increased pressure on Speech and Language Therapy provision both from within learning disability services and the wider Trust. This is compounded by recent staff turnover and difficulties in recruitment of specialist staff.
• Face-to-face activity is increasing across all our community teams (currently around 65%) and we are aiming to increase this further to around 85% by end of Q4.

Inpatients (ATU):
• Current occupancy is 4 of 6 commissioned beds (66%) which is typical for the unit.
• Need for high levels of observation and support for the current admissions is requiring high staffing levels (approx. 2:1 staffing) which is proving difficult to source.
• Recently there have been significant challenges finding registered nurses to cover shifts which has proven challenging and impacted on wellbeing of nursing workforce. We are seeing an impact through heightened workforce related stress and subsequent sickness absence which compounds the issue.
• From 1st October 2021 the Horizon Assessment and Treatment Unit (ATU) will join with Bradford District Care Foundation Trust (BDCFT) in providing a regional collaborative ATU service for West Yorkshire and Barnsley. Formally the number of commissioned ATU beds provided by SWYPFT will increase from 6 to 8. We are not anticipating a significant increase in demand following this change as we have been effectively providing this service since the Leeds unit closed in June 2020.
• Sickness levels on the unit remain high and recruitment to vacancies is slow. There is a national under-supply of qualified nurses and the position re psychology input (currently vacant) is awaiting a decision by the new ATU collaborative. Additional temporary occupational therapy and therapy assistant posts are being recruited to help with immediate pressures.
• Medical input is currently being provided part-time by a trust consultant on an interim basis whilst the service works to a longer term solution. Medical staffing balance between SWYPFT and BDCFT is currently being reviewed by medical directors.

ASD/ ADHD service
• The Service is operating fully but has seen a short- term spike in sickness.
• Supervision is currently 62% but the service expects this will improve at the end of Q2.
• There has been a 23% surge in referrals for assessment the service has received support re admin support to process all referrals in a timely manner.
• The service has a list of new business opportunities/ developments to explore further.
• Performance metrics remain good.

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

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Trustwide Acute Inpatients:
• Acute wards continue to see high levels of acuity and service user distress, with further challenges in managing isolated and cohorted patients. Senior leadership from matrons and general managers remains in place across 7 days.
• The work to maintain patient flow continues, with the use of out of area beds being kept to a minimum.
• Work with partners across the ICS continues. Partners are using out of area beds to address bed demand.
• The difficulties have been recently compounded by staff absences and difficulties sourcing bank and agency staff, leading to staffing shortages across the wards, plus further Covid outbreaks.
• An action plan is in place to address improvement required across the service in relation to concordance with fire lecture attendance. This is detailed and specific to each ward led by the matrons and general manager, and actively reviewed in service line meetings and business delivery unit (BDU) governance meetings. The current position shows significant improvement in performance across all but two wards, with an overall rate of 84.42%. Where further support to improve is needed plans are in place to deliver.
• Intensive work to reduce ward sizes, maintain safety and well-being of staff and service users and encourage recruitment and retention is underway. Immediate actions have included:
   - incentivisation of shifts over the August bank holiday period which resulted in supporting people to work and meet service demands
   - use of out of area placements on a planned basis to release pressure, with the support of commissioners
   - a task and finish approach reporting through the command structure to review options to temporarily reduce ward sizes
   - the use of the staffing establishment differently if required
   - building identified challenges and priorities into the workforce strategy and planning work.

Community:
• Work continues in front line services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home. This includes providing robust gate-keeping, trauma informed care and effective intensive home treatment.
• 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.
• Work is underway to better understand and report our balance of face to face and virtual interventions as part of our total offer.
• We are optimising our use of space across Trust sites so that group work and more face to face therapies can be delivered, and are currently reviewing space utilisation in each building to optimise clinical capacity.
• Demand into the Single Point of Access (SPA) continues to increase either in line with, or above, predicted demand, leading to significant pressure in the service and necessitating the use of additional staff and sessions for assessment slots. SPA is prioritising risk screening of 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.
• We continue to work in collaboration with our places to implement the community mental health transformation. A concern is new roles within primary care networks could draw experienced staff from our resources but not release a commensurate level of demand.
• The wellbeing and support of staff is at the forefront of the BDU's aims, including ensuring clinical supervision takes place each month. Quality and Governance Leads in each place are working with teams to enable this in terms of quality access and prioritisation.

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

• 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, booster and 12-15 year olds (Barnsley).
• Communication on Trust leadership changes, both internally and to partners
• Continued promotion of adult 'Choose Well for Mental Health' guide; internally, on social media channels and with partners, alongside award submissions. Children and Young People focused 'Choose Well' in development.
• Staff wellbeing initiatives promoted
• Design and print of materials continuing for services and corporate functions
• Awareness days and weeks supported on social media and in internal communication channels.
• Information governance campaign supported
• Nhs.net removal and Trust email accreditation comms
• Forensic improvement programme – support provided to the Bretton Centre improvement programme (including intranet and web content and letters to local residents)
• Equality campaign in development – staff engagement carried out, content being developed.
• Flu– Attended fortnightly flu planning meetings in preparation for launching 2021/22 vaccination campaign in Sept
• Promotion of civility and respect/equity guardians and FTSU work
• Prepared comms for NHS staff survey
• Developed trauma and adversity resilience programme communication plan
• Developed menopause matters communication plan
• Ongoing support for QI programme
• Supported the virtual recruitment fair
• Support provided to EyUp Charity e.g. Annual Report and case studies, Creative Minds e.g. Moving Mental Health Forward promotion and development of new comms toolkit, Spirit in Mind e.g. promotion of events and Mental Health Museum e.g. organised Mark's visit
• New intranet development project – new Sharepoint launched. Currently working on bug fixes and content updates.
• Working to launch Calderdale IAPT website for September launch (a reskin of the Kirklees IAPT site)
• New video suite of Recovery Skills Training modules created with the Barnsley Core Mental Health Team – launch in September
• New Facebook group launched for Kirklees CAMHS, which has been created in conjunction with the mental health support workers with input from parents
• Barnsley IAPT promotion in various publications across town including Barnsley Football Club
• Website and intranet development work for new Equality and inclusion content
• CAMHS; created and launched crisis and emergency campaign upon request from acute hospital partners, promoted feedback events at Wakefield CAMHS and developed new service materials
• Media enquiries; co-ordinated and issued responses
• Promotion of West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICS' initiatives and campaigns.

Overall Financial Performance 2021/22

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2021/22	Narrative
1	**Surplus / Deficit**	£2.2m	£2.3m (H1 21/22)	In August a surplus of £0.1m has been reported which is favourable to plan. The forecast position for the first half of the year remains a surplus of £2.3m.
2	**Agency Spend**	£3.4m		Agency expenditure in August was £0.7m. This is a reduction from the high value reported in July with a reduction in unregistered nursing. This is correlated with the increase in internal staffing costs in August.
3	**Cash**	£63.3m	£64.6m	Cash in the bank continues to be positive and is forecast to remain so. This continues to be closely monitored to ensure that the cash position is appropriately maximised.
5	**Capital**	£1.2m	£9.6m	The forecast remains that the full £9.6m capital programme will be utilised in year. A business case for the Bretton Centre development has been drafted and this is currently being assessed. Year to date spend is £1.2m which is £0.4m less than planned. No major risks to delivery of plan being flagged at present.
6	**Better Payment Practice Code**	96%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 96% 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	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.0%	4.0%	3.9%	4.0%	4.3%	4.3%	4.5%	4.6%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.0%	4.0%	3.9%	4.0%	4.3%	4.3%	4.5%	4.6%
Staff Turnover (registered nurses)	Improving Resources	Well Led	AD	10%	10.0%	10.0%	10.3%	15.6%	14.7%	13.1%	14.1%	14.6%
Gross Vacancies	Improving Resources	Well Led	AD	-	Reporting Commenced April 2021			10.8%	5.5%	7.9%	7.3%	6.6%
Net Vacancies	Improving Resources	Well Led	AD	-				2.9%	0.6%	3.2%	4.0%	2.2%
Aggression Management	Improving Care	Well Led	AD	>=80%	84.1%	84.1%	82.3%	80.7%	79.95%	85.1%	85.4%	84.7%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80%	85.2%	84.5%	81.7%	78.8%	77.7%	76.27%	75.91%	74.60%
Clinical Risk	Improving Care	Well Led	AD	>=80%	93.3%	93.1%	93.5%	94.6%	94.9%	94.7%	94.6%	93.9%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	95.5%	95.6%	95.5%	95.6%	95.5%	95.2%	95.0%	94.7%
Fire Safety	Improving Care	Well Led	AD	>=80%	86.9%	87.6%	86.2%	85.9%	84.3%	84.6%	83.3%	83.2%
Food Safety	Improving Care	Well Led	AD	>=80%	74.8%	75.9%	75.3%	76.3%	77.2%	79.60%	80.0%	81.3%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	95.0%	94.7%	94.3%	94.0%	94.2%	92.7%	91.8%	90.7%
Information Governance	Improving Care	Well Led	AD	>=95%	97.5%	97.8%	97.9%	96.6%	95.7%	94.67%	93.18%	92.20%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	95.0%	95.1%	94.9%	95.1%	95.7%	96.3%	96.7%	96.8%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80%	94.6%	93.9%	91.0%	90.8%	88.9%	87.7%	87.6%	87.4%
Mental Health Act	Improving Care	Well Led	AD	>=80%	91.3%	90.5%	85.0%	85.1%	82.0%	80.7%	81.9%	81.7%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%		81.3%		74.4%			Due Oct 21	
Prevent	Improving Care	Well Led	AD	>=80%	95.6%	95.6%	95.6%	95.6%	95.3%	95.4%	95.4%	95.4%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	94.0%	94.2%	94.0%	94.7%	94.7%	94.7%	93.8%	93.6%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	93.1%	93.6%	93.5%	93.3%	93.3%	93.1%	92.5%	92.2%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	No longer used							
Bank Cost	Improving Resources	Well Led	AD	-	£946k	£682k	£1,120k	£803k	£911k	£795k	£822k	£1001k
Agency Cost	Improving Resources	Effective	AD	-	£587k	£562k	£760k	£583k	£560k	£794k	£834k	£705k
Overtime Costs	Improving Resources	Effective	AD	-	Data unavailable at the time of producing this report							
Additional Hours Costs	Improving Resources	Effective	AD	-								
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-								
Vacancies (Non-Medical) (WTE)	Improving Resources	Well Led	AD	-								
Business Miles	Improving Resources	Effective	AD	-								

Health & Safety

	Objective	CQC Domain	Owner	Threshold								
Number of RIDDOR incidents(reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-		7			4		Due October 2021	

Covid-19

KPI / Additional Metrics to Highlight Response to and Impact of Covid-19	Target	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	As at 23rd July 2021	As at 20th August 2021	As at 22nd Sep 2021	Trend	Notes
No of staff off sick - Covid-19 not working 7		**159**	**91**	**89**	**33**	**15**	**32**	**95**	**106**	**81**		
Shielding		48	42	50	1	0	0	1	1	1		
Symptomatic		64	29	19	16	2	8	33	57	43		
House hold symptoms		19	4	10	5	3	6	28	7	18		
OH Advised Isolation		0	1	1	1	0	0	4	1	0		
Test & Trace Isolation		0	0	0	0	0	0	0	0	0		
Other Covid-19 related		28	15	9	10	10	18	29	40	1		
No of staff working from home - Covid-19 related 8		**84**	**78**	**88**	**16**	**8**	**21**	**66**	**27**	**42**		
Shielding		49	54	74	8	0	0	1	2	2		
Symptomatic		9	4	3	2	2	3	15	8	18		
House hold symptoms		6	10	4	1	3	8	28	10	16		
OH Advised Isolation	N/A	4	2	2	1	1	0	0	0	0		
Test & Trace Isolation		0	0	0	0	0	0	0	0	0		
Other Covid-19 related		16	8	5	4	2	10	22	7	2		
Number of staff tested 9		3241	3353	3386	3386	3386	3386	3386	3390	3619		Cumulative
No of staff tested positive for Covid-19 10		545	598	610	610	610	610	610	807	929		Cumulative
No of staff returned to work (including those who were working from home)		2381/2608 =91.3%	2588/2758 =93.8%	2605/2780 =93.7%	2775/2823 =98.3%	2813/2836 =99.2%	2828/2882 =98.1%	2888/3054 =94.6%	3125/3258 =95.9%	3254/3296 =98.7%		
No of staff returned to work (not working only) 13		1533/1695 =90.4%	1723/1834 =93.9%	1726/1846 =93.5%	1858/1895 =98.0%	1885/1905 =99.0%	1890/1928 =98.0%	1913/2034 =94.1%	2051/2166 =94.7%	2168/2264 = 95.7%		
No of staff still absent from work who were Covid-19 positive 12		43	22	13	13	0	0	0	40	29		
Additional number of staff enabled to work from home		1175	1306	1369	1281	1271	1223	1350	1359	1394		Cumulative

| Calls to occupational health healthline | | 2274 | 2451 | 2565 | 2655 | 2713 | 2798 | 2911 | 3007 | 3105 | | 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
• Assessing the impact of updates self-isolation guidance for some NHS Staff

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.
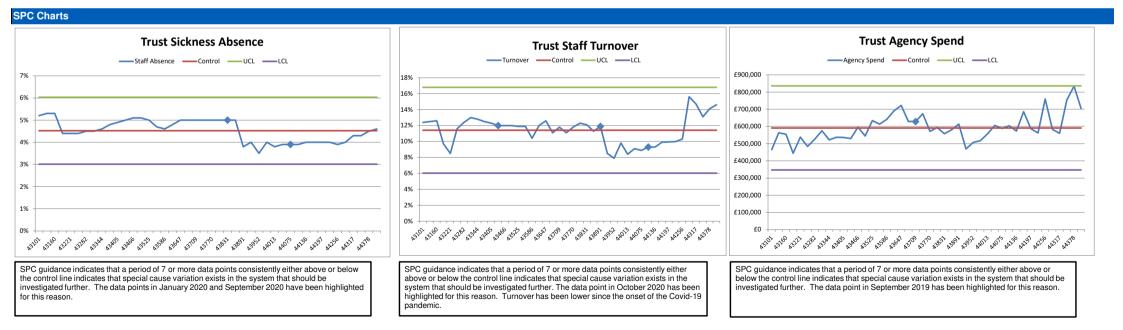
Workforce Issues
• As at 22nd September, 81 staff off work Covid-19 related, not working which compares to 106 one month earlier. A further 42 were working from home.
• 3619 staff tested for Covid-19 as at 22nd September 2021.
• 929 staff have tested positive for Covid-19.
• Staff turnover increased to 14.6% in August a detailed workforce planning report was considered by the workforce and renumeration committee on 21 st September which gave a deep dive into the turnover figures.

SPC Charts

Trust Sickness Absence
Staff Absence — Control — UCL — LCL

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

Trust Staff Turnover
Turnover — Control — UCL — LCL

SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in October 2020 has been highlighted for this reason. Turnover has been lower since the onset of the Covid-19 pandemic.

Trust Agency Spend
Agency Spend — Control — UCL — LCL

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

Sickness reporting

As at 22nd September, the Trust has 124 staff absent or working from home due to Covid-19. This makes up 2.3% of the workforce. Of those absent, 49.1% are symptomatic and 26.6% have household symptoms. The business delivery unit (BDU) with the biggest impact is Adult ADHD/ASD with 6.7% 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 9.3 days in August.
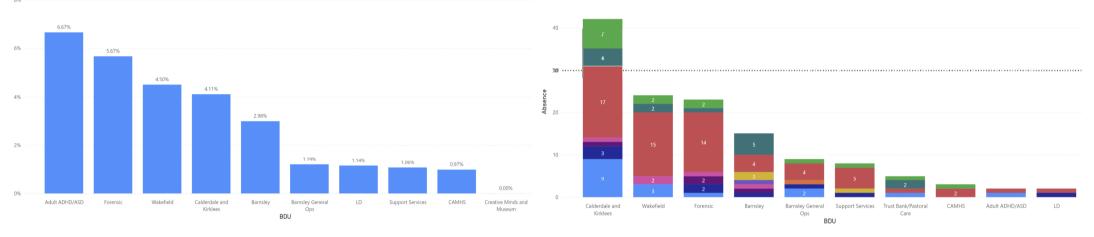
Sick/Absent % by BDU/Service/Cost Centre (excludes Trust Bank/Pastoral Care)

Absence by BDU and Reason for absence

Reason for absence ● Household sympt... ● Long COVID ● OH advised isola... ● Other COVID rel... ● Positive lateral fl... ● Quarantining ... ● Shielding (hi... ● Symptomatic ... ● Test & Trace I... ● Test & Trace

Guardians of Safe Working - Quarterly report Q1 (April-June 2021)

Impact of the Pandemic
The Covid-19 pandemic has had wide-ranging effects. Whilst we are now starting to see more gaps due to infections and self-isolation, the impact on the rotas, for doctors in training, has been much reduced over the period covered by this report. Gaps for Q1 2021 were down nearly 65% compared with the same quarter in 2020 and were lower than all but one quarter since figures have been collected. This quarter still saw one doctor having to self-isolate, and others advised by Occupational Health to come off the rota but the numbers affected were smaller. The Medical Directorate Business Manager, the Postgraduate Medical Education Lead, the AMD for Medical Education, the Guardian of Safe Working and the college tutors continue to meet frequently to coordinate the Trust's support of trainees. Trainers have been asked to meet with their new trainees in August to review how the pandemic has affected their training and ensure that any steps needed are taken to ensure that any deficits in training are addressed.

Distribution of Trainee Doctors within the Trust
Recruitment to core training posts in Psychiatry has been much better recently with reports of 3 applicants per place for this August. This coupled with the amalgamation of core training schemes across W. Yorkshire from August 2020 should see consistently improved recruitment in Calderdale and Kirklees. We currently have one GPVTS trainee vacancy in Barnsley and are anticipating some Foundation doctor vacancies in Wakefield from August.

Exception Reports (ERs - with regard to working hours)
There have been few ERs completed in the Trust since the introduction of the new contract and only one during this period. This was completed by a core trainee in Wakefield and related to a combination of high acuity and covering for colleague absence. Time off in lieu (TOIL) was agreed. The trainee was happy with the outcome of the exception report.

Fines
There have been none within this reporting period.

Guardians of Safe Working cont...

Work schedule reviews
There were no reviews required.

Rota gaps and cover arrangements
The tables below detail rota gaps by area and how these have been covered. Kirklees had the highest proportion of gaps this quarter, mainly due to maternity leave. Other common issues leading to gaps include vacancies, sickness and lLess Than Full-Time (LTFT) trainees in full-time training placements. The costs that were directly attributable to Covid-19, where trainees where shielding or self-isolating, are shown separately. The medical bank has been working well with rota coordinators and the trainees themselves working hard to ensure that all the vacant slots on first tier rotas were filled by the Trust bank. Following the large increase in gaps at the start of the pandemic, trainees were offered higher rates of pay to cover some hard-to-fill shifts.

Gaps by rota April/May/June '21

Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	20 (11%)	20 (100%)	0	0	0
Calderdale 1st	19 (10%)	19 (100%)	0	0	0
Kirklees 1st	13 (14%)	13 (100%)	0	0	0
Wakefield 1st	7 (4%)	7 (100%)	0	0	0
Total 1st	59(9%)	59 (100%)	0	0	0
Wakefield 2nd	52 (57%)	0	0	52 (100%)	0

Costs of Rota Cover April/May/June '21

1st On-Call Rotas	Shifts (Hours) Covered by Medical Bank	Cost of Medical Bank Shifts	Cost directly attributed to COVID-19	Agency Hours (Costs)
Barnsley	18 (184)	£6,440	£0	0
Calderdale	19 (160.75)	£5,526.25	£0	0
Kirklees	13 (240)	£8,400	£0	0
Wakefield	7 (69.75)	£3,138.75	£191.25	0
Total	59 (654.5)	£23,505	£191.25	0

Issues and Actions
Recruitment
Core Training, GP and Foundation Schemes have been better recruited. The main current concern is poor recruitment to Higher Training, especially to the Old Age and to a lesser degree the General Adult Higher Training Schemes. This is the major factor affecting the Wakefield 2nd On-Call Rota.

Junior Doctors' Forum (JDF)
This continues to meet quarterly, offering a forum for trainees to raise concerns about their working lives and to consider options to improve the training experience. The JDF continues to meet by Microsoft Teams. The last was poorly attended after administrative issues meant trainees were not all invited and this has been addressed for future meetings. Issues discussed included rotas, completion of exception reports and understandably also trainees' experience related to COVID-19. There were also brief updates on topics discussed previously such as Seclusion reviews and an audit is being completed in this area and preliminary data suggests that policy changes have reduced the workload for trainees. Where concerns do not relate directly to the contract, issues are raised with the relevant Clinical Lead or the AMD for Postgraduate Medical Education.

Education and support
The Guardian will continue to work closely with the AMD for Postgraduate Medical Education to improve trainees experience and to support clinical supervisors. The Guardian will continue to encourage trainees to use Exception Reporting, both at induction sessions and through the Junior Doctors' Forum. The trust will support the BMA's campaign in August to increase trainees' use of exception reporting.

Publication Summary

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

A&E attendances and emergency admissions: July 2021

Diagnostic waiting times and activity: June 2021

Mental health services monthly statistics: performance May, provisional June 2021

Out of area placements in mental health services: May 2021

Provisional monthly Hospital Episode Statistics for admitted patient care, outpatient and accident and emergency data: April 2021 to June 2021

Psychological therapies: reports on the use of IAPT services, England - May 2021 final including a report on the IAPT Employment Advisors Pilot

Community services statistics: May 2021

NHS sickness absence rates: April 2021, provisional statistics

NHS workforce statistics: May 2021 (including selected provisional statistics for June 2021)

Diagnostic waiting times and activity: July 2021

Mental health services monthly statistics performance: June 2021, provisional July 2021

Out of area placements in mental health services: June 2021

Provisional monthly hospital episode statistics for admitted patient care, outpatients and accident and emergency data: April 2021 to July 2021

Psychological therapies: reports on the use of IAPT services, England June 2021, final including reports on the IAPT pilots and Q1 data 2021-22

Finance Report

**Month 5
(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)**	£2.2m	£2.3m (H1 21/22)	In August a surplus of £0.1m has been reported which is favourable to plan. The forecast position for the first half of the year remains a surplus of £2.3m.
2	**Agency Spend**	£3.4m		Agency expenditure in August was £0.7m. This is a reduction from the high value reported in July with a reduction in unregistered nursing. This is correlated with the increase in internal staffing costs in August.
3	**Cash**	£63.3m	£64.6m	Cash in the bank continues to be positive and is forecast to remain so. This continues to be closely monitored to ensure that the cash position is appropriately maximised.
4	**Capital**	£1.2m	£9.6m	The forecast remains that the full £9.6m capital programme will be utilised in year. A business case for the Bretton Centre development has been drafted and this is currently being assessed. Year to date spend is £1.2m which is £0.4m less than planned. No major risks to delivery of plan being flagged at present.
5	**Better Payment Practice Code**	96%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 96% 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

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
				21,468	21,057	(411)	Clinical Revenue	105,853	102,857	(2,995)	127,101	123,702	(3,399)
				21,468	**21,057**	**(411)**	**Total Clinical Revenue**	**105,853**	**102,857**	**(2,995)**	**127,101**	**123,702**	**(3,399)**
				1,036	1,360	323	Other Operating Revenue	5,393	6,347	953	6,440	7,606	1,165
				22,505	**22,417**	**(87)**	**Total Revenue**	**111,246**	**109,204**	**(2,042)**	**133,542**	**131,308**	**(2,234)**
4,812	4,494	(318)	6.6%	(17,865)	(17,273)	592	Pay Costs	(88,268)	(83,836)	4,432	(106,001)	(100,777)	5,225
				(3,888)	(4,246)	(358)	Non Pay Costs	(19,233)	(19,305)	(72)	(23,050)	(23,619)	(570)
4,812	4,494	(318)	6.6%	**(21,753)**	**(21,519)**	**234**	**Total Operating Expenses**	**(107,501)**	**(103,141)**	**4,360**	**(129,051)**	**(124,396)**	**4,655**
4,812	4,494	(318)	6.6%	751	898	147	**EBITDA**	3,745	6,063	2,318	4,491	6,912	2,421
				(537)	(568)	(31)	Depreciation	(2,683)	(2,772)	(88)	(3,220)	(3,340)	(120)
				(212)	(212)	(0)	PDC Paid	(1,059)	(1,060)	(1)	(1,271)	(1,272)	(1)
				0	0	0	Interest Received	0	0	0	0	0	0
4,812	4,494	(318)	6.6%	**3**	**118**	**115**	**Surplus / (Deficit)**	**3**	**2,231**	**2,229**	**0**	**2,300**	**2,300**
				0	0	0	Gain / (loss) on disposal	0	1,137	1,137	0	1,137	1,137
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,812	4,494	(318)	6.6%	**3**	**118**	**115**	**Surplus / (Deficit)**	**3**	**3,368**	**3,365**	**0**	**3,437**	**3,436**

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. The forecast has been assessed and a surplus of £2.3m, excluding exceptional items, is reported. Development of the H2, and longer term plan, continues with a focus on recurrent and non recurrent run rates.

Trust Monthly I & E Profile

Trust Cumulative I & E Profile

Income & Expenditure Position 2021 / 22

For the period April to August 2021 a surplus of £2.2m has been reported. There is an increase in expenditure in August 2021.

For April to September 2021 the Trust has an operational plan to deliver a breakeven position. It is based on estimated expenditure run rates and updated funding available. This includes non recurrent funding allocated through the Integrated Care System (ICS). Actual and forecast spend continue to be reviewed monthly with the current position reflected in a revised forecast position. This has been discussed with the relevant ICS contacts.

Income

The vast majority of income continues to be received as a singular block payment from each commissioner. These are based upon national funding principles and includes 2020 / 21 and 2021 /22 Mental Health Investment Standard (MHIS) and system recovery (SR) funding.

Mobilisation of these services, including recruitment where appropriate, is being undertaken. Any variation in spend is being monitored to ensure that all funding can be utilised to support mental health services and overall system recovery.

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

Pay

Pay spend increased in August 2021 to £17.3m from £16.7m. This includes the payment of one off premiums to support continued safe staffing levels, higher bank usage and additional substantive staff to support investment. Further analysis has been included in the pay information section 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 9.9% of overall pay expenditure which is the same ratio as last month. The headlines are covered within the pay analysis section.

Non Pay

Non pay expenditure continues to have specific areas of variability. These are subject to 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 and consistent across the Trust.

Heading	Description	Apr-21 £k	May-21 £k	Jun-21 £k	Jul-21 £k	Aug-21 £k	Sep-21 £k	Total £k
Staffing - backfill	Additional staff costs to support Trust workforce response. Includes acting up and backfill arrangements	22	51	37	38	145		293
Staffing - vaccination	Additional staff costs to support vaccination programme (including overtime)	33	62	19	11	26		151
Staffing - Isolation	Isolation, shielding and backfill for covid absence	56	15	31	32	41		175
Staffing - premium	Additional exceptional payments agreed to ensure safe staffing levels over key periods	0	0	0	0	158		158
Total – Pay		**110**	**128**	**87**	**81**	**370**	**0**	**776**
Lateral Flow Testing	Distribution of kits to staff	7	2	12	8	2		31
Laundry & Scrubs	Purchase of scrubs for staff and associated laundry costs	2	1	1	0	1		5
IT	Purchase of equipment and agile working enabling costs (VPN)	0	35	3	0	0		38
OOA Placements	Out of area bed placements required to covid issues	0	6	12	0	77		95
Staffing - security	External security costs to support vaccination	0	0	8	0	0		8
Misc / other	Other general non pay not captured in the headings above	0	15	8	6	17		46
Total – Non Pay		**8**	**59**	**44**	**14**	**97**	**0**	**222**
Total costs		**119**	**187**	**131**	**95**	**467**	**0**	**998**
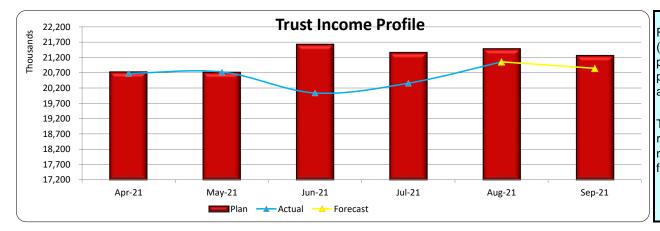
2.1	Income Information

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, and other 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 from those organisations.

Guidance confirming the arrangements for October 2021 to March 2022 is yet to be issued but is expected late September 2021.

Income source	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	14,558	15,120	15,237	15,497							91,120	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	2,493	2,550	2,488							14,948	28,281
Local Authority	404	490	402	385	458	416							2,555	5,025
Partnerships	657	636	654	547	939	646							4,080	7,514
Top Up / ERF	0	0	169	85	21	0							275	5,458
Other	41	50	46	(9)	116	61							304	4,815
Total	20,679	20,725	20,039	20,358	21,057	20,845	0	0	0	0	0	0	123,702	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	

Trust Income Profile

Plan — Actual — Forecast

Funding continues to be agreed with commissioners for both recurrent (Mental Health Investment Standard) and non-recurrent (system recovery) programmes. Income, and expenditure, are included in line with expected profiles and will be increasing over the course of the year as additional staff are in place.

The month 5 position includes funding from all NHS commissioners with recruitment ongoing into newly funded posts. This continues to be monitored internally with proposals being developed to ensure that all funding is utilised to support mental health and system recovery.
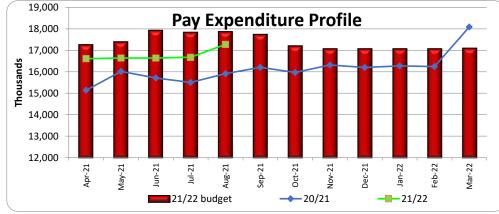
2.2		Pay Information	

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.

Staff type	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	15,089	15,019	15,567								76,070
Bank & Locum	803	911	795	822	1,001								4,331
Agency	583	560	754	834	705								3,436
Total	16,610	16,641	16,637	16,675	17,273	0	0	0	0	0	0	0	83,836
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

	Apr-21	May-21	Jun-21	Jul-21	Aug-21								Total
Bank as %	4.8%	5.5%	4.8%	4.9%	5.8%								5.2%
Agency as %	3.5%	3.4%	4.5%	5.0%	4.1%								4.1%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,104	4,078	4,051	4,068	4,074								4,075
Bank & Locum	255	263	218	224	283								249
Agency	107	115	128	155	138								128
Total	4,465	4,456	4,398	4,447	4,494	0	0	0	0	0	0	0	4,452
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

Pay Expenditure Profile

Legend: 21/22 budget, 20/21, 21/22

The position, and forecast, continues to exclude 2021/22 national pay awards. These will be paid in September 2021 and funding is expected to fully cover these increased costs. These will be backdated to 1st April 2021.

Costs have increased in August 2021. £165k relates to additional exceptional payments agreed to support staffing levels over the August bank holiday. In making such payment additional staffing was secured.

Other contributing factors for the increase in costs were additional substantive staffing and additional bank and locum costs. Absence due to covid-19 reasons will have had an influence on this higher than normal level of spend and staff utilised.

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 £k	Substantive £k	Bank / Locum £k	Agency £k	Total £k	Variance £k
Medical	10,758	9,839	268	1,342	11,449	691
Nursing Registered	34,352	25,230	1,419	443	27,092	(7,260)
Nursing Unregistered	10,625	8,644	2,173	1,233	12,050	1,425
Other	24,005	20,309	190	403	20,902	(3,103)
Corporate Admin	6,969	6,493	117	15	6,625	(344)
BDU Admin	5,751	5,554	164	0	5,718	(33)
Vacancy Factor	(4,191)				0	4,191
Total	**88,268**	**76,070**	**4,331**	**3,436**	**83,836**	**(4,432)**

WTE In month Budget v Actual - by staff group

Staff Group	Budget WTE	Substantive WTE	Bank / Locum WTE	Agency WTE	Total WTE	Variance WTE
Medical	229	194	1	18	213	(16)
Nursing Registered	1,484	1,225	77	17	1,319	(165)
Nursing Unregistered	880	706	176	87	969	89
Other	1,380	1,196	9	15	1,220	(159)
Corporate Admin	353	333	8	1	342	(11)
BDU Admin	487	419	12	0	431	(56)
Total	**4,812**	**4,074**	**283**	**138**	**4,494**	**(318)**

By staff group the key elements to highlight are:

Although there continues to be a monthly underspend there was an increase overall of 26 WTE in the registered nurse category compared to last month. This is mainly in the bank sub heading. Unregistered nursing utilisation also increased in month with 89 WTE more than funded reported.

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

The other category includes a wide range of staff not covered in the other headings. This is reflective of the wide range of staff that support the services which we provide. Large WTE group examples include psychologists, PAMs, ancillary staff and housekeepers and Occupational therapists.

The financial plan includes a value relating to expected staff vacancies and posts not back filled. This value, shown separately 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. Vacancies, higher than this assumed level, contribute to the overall pay underspend position.

Year to date Budget v Actual - by service

	Budget £k	Substantive £k	Bank / Locum £k	Agency £k	Total £k	Variance £k
MH Community	38,065	32,236	857	1,660	34,752	(3,312)
Inpatient	19,509	16,418	2,863	1,586	20,867	1,357
BDU Support	5,327	3,135	184	9	3,329	(1,998)
Community	12,124	10,192	178	58	10,428	(1,696)
Corporate	17,435	14,088	249	124	14,461	(2,974)
Vacancy Factor	(4,191)				0	4,191
Total	**88,268**	**76,070**	**4,331**	**3,436**	**83,836**	**(4,432)**

In month Budget v Actual - by service

	Budget WTE	Substantive WTE	Bank / Locum WTE	Agency WTE	Total WTE	Variance WTE
MH Community	1,878	1,596	40	26	1,662	(216)
Inpatient	1,124	957	204	94	1,255	132
BDU Support	357	213	12	0	225	(132)
Community	757	645	12	4	661	(96)
Corporate	696	663	15	14	691	(5)
Vacancy Factor					0	
Total	**4,812**	**4,074**	**283**	**138**	**4,494**	**(318)**

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.

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

Agency spend is £705k in August.

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.
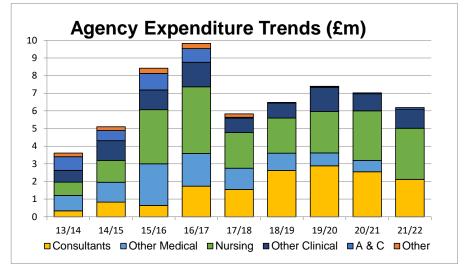
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.
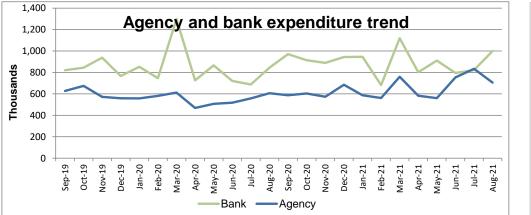
NHS E & I introduced a set of rules in April 2016 to support trusts to reduce agency spend and move towards a sustainable model of temporary staffing. Part of this support has been through the introduction of agency spend caps and suggested maximum pay rates.
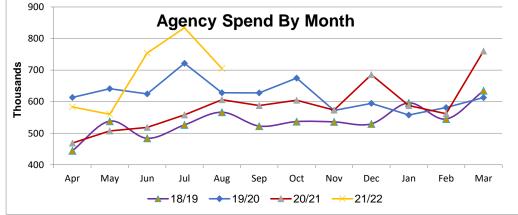
Due to covid 19 there is currently no agency cap for 2021/22 (although a value of £7.7m has been indicated), however controls remain the same. The Trust continue to submit the same detailed agency information to NHSI on a weekly basis. This information monitors both the volume of agency shifts utilised 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.

Spend has reduced in August from the peak experienced in July with the main reductions in unregistered nursing (£103k) and other clinical staff (£43k). There continues to be a correlation between bank and agency usage with agency reducing when more internal bank staff are available.

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

Agency Expenditure Trends (£m)

Agency and bank expenditure trend

Agency Spend By Month
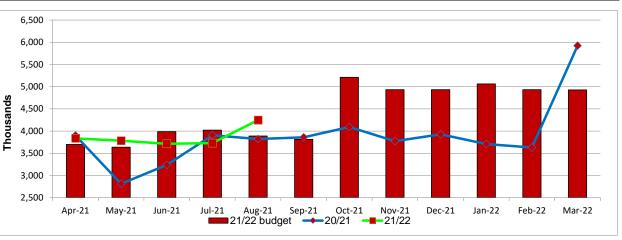
2.3	Non Pay Expenditure

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.

Non pay spend	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	3,712	3,729	4,246								19,305
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	1,548	1,370	(178)
Establishment	3,158	3,375	217
Lease & Property Rental	3,191	3,319	128
Premises (inc. rates)	2,444	2,596	152
Purchase of Healthcare	2,787	2,828	41
Travel & vehicles	1,765	1,693	(72)
Supplies & Services	3,014	2,491	(523)
Training & Education	289	259	(30)
Clinical Negligence & Insurance	363	537	173
Other non pay	673	837	163
Total	19,233	19,305	72
Total Excl OOA and Drugs	14,898	15,106	208

Key Messages

There has been an increase in non pay expenditure in August compared to the first four months of the year which had a relatively flat run rate. This has been the case across most business delivery units (BDU's). In terms of the categorisation highlighted above the main movement is in purchase of healthcare, travel and other.

The purchase of healthcare is considered seperately on page 12. Travel relates to costs associated with the Trusts lease car contracts rather than reimbursement of traditional mileage claims (which continue to remain low).

Supplies and services, such as consumable products and food provisions, continue to be less than planned. Elements of this are also timing related with additional spend forecast later in the 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 provide 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
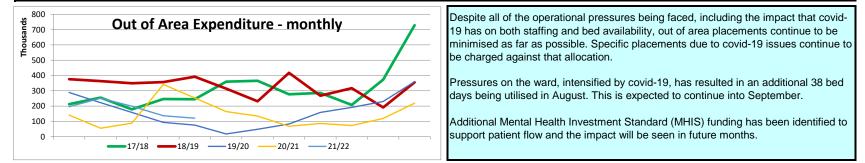
On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Wherever possible service users are placed within the Trust geographical footprint.

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

Heading	Budget Year to date £k	Actual Year to date £k	Variance £k
Locked Rehab	951	1,117	165
Out of Area			
Acute	522	65	(457)
PICU	316	65	(251)
Other Services	998	1,582	584
Total	**2,787**	**2,828**	**41**

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	199	137	121								903

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	316	223	261								1,334

Bed Day Information 2021 / 2022 (by category)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
PICU	203	236	233	176	188								1,036
Acute	18	77	83	47	73								298
Total	221	313	316	223	261	0	0	0	0	0	0	0	1,334

Out of Area Expenditure - monthly (17/18, 18/19, 19/20, 20/21, 21/22)

Despite all of the operational pressures being faced, including the impact that covid-19 has on both staffing and bed availability, out of area placements continue to be minimised as far as possible. Specific placements due to covid-19 issues continue to be charged against that allocation.

Pressures on the ward, intensified by covid-19, has resulted in an additional 38 bed days being utilised in August. This is expected to continue into September.

Additional Mental Health Investment Standard (MHIS) funding has been identified to support patient flow and the impact will be seen in future months.

Balance Sheet / Statement of Financial Position (SOFP)	2020 / 2021 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	104,978	101,917	Pg 14
Current Assets			
Inventories & Work in Progress	173	173	
NHS Trade Receivables (Debtors)	1,173	422	1
Non NHS Trade Receivables (Debtors)	1,828	1,642	1
Prepayments	2,867	3,890	2
Accrued Income	3,090	4,669	3
Cash and Cash Equivalents	56,648	63,276	Pg 16
Total Current Assets	**65,781**	**74,071**	
Current Liabilities			
Trade Payables (Creditors)	(1,182)	(1,984)	4
Capital Payables (Creditors)	(585)	(630)	
Tax, NI, Pension Payables, PDC	(5,920)	(6,908)	
Accruals	(24,112)	(23,757)	5
Deferred Income	(3,981)	(5,320)	6
Total Current Liabilities	**(35,779)**	**(38,600)**	
Net Current Assets/Liabilities	**30,001**	**35,472**	
Total Assets less Current Liabilities	**134,980**	**137,389**	
Provisions for Liabilities	(7,348)	(7,513)	
Total Net Assets/(Liabilities)	**127,632**	**129,875**	
Taxpayers' Equity			
Public Dividend Capital	45,384	45,384	
Revaluation Reserve	11,721	10,596	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	65,307	68,675	7
Total Taxpayers' Equity	**127,632**	**129,875**	

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

1. Both NHS and Non-NHS Debtors are low, 87% of this value is less than 30 days, and action is taken on all debtors over 30 days.

2. Prepayments are currently higher as a number of contracts start at the beginning of the year, this includes software licences, rent and the car insurance for the Trust.

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 was expected in August 2021 but now due September 2021. Outstanding invoices with local authorities have been raised in September 2021.

4. Creditors, invoices outstanding for the Trust to pay, continues to be closely reviewed alongside Better Payment Practice Code (page 17) performance. 99% of aged creditors are less than 30 days old.
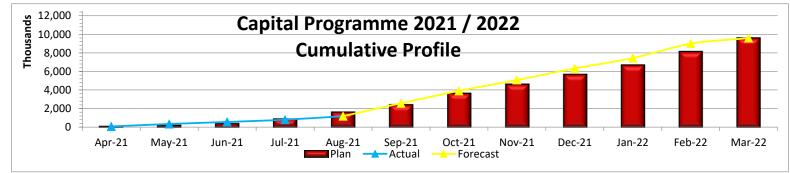
5. Accruals continue to be at a higher level than historically. Work continues to chase invoices to reduce this value.

6. Deferred income remains high and includes £1.3m from Health Education England and £1.6m from CCG's relating to H2 costs.

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

3.1	Capital Programme 2021 / 2022

Capital schemes	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	22	22	2,000	0	
OPS transformation	578	0	0	0	578	0	
Maintenance (Minor) Capital							
Routine Maintenance	3,194	749	581	(168)	3,426	232	
Fire Safety	160	0	0	0	195	35	
Plant & Machinery	455	201	17	(184)	481	26	
Equipment	100	30	34	4	100	0	
Fixtures & Fittings	45	0	0	0	45	0	
Other	643	228	501	273	222	(421)	
IM & T							
Clinical Systems	275	24	1	(23)	275	0	
Hardware	200	50	0	(50)	200	0	
Cybersecurity, Infrastructure	200	75	21	(54)	327	127	
Software	600	100	4	(96)	600	0	
Other	1,140	169	0	(169)	1,140	0	
VAT Refunds						0	
TOTALS	**9,590**	**1,626**	**1,181**	**(445)**	**9,590**	**0**	

Capital Programme 2021 / 2022 Cumulative Profile

Plan — Actual — Forecast

Capital Expenditure 2021 / 22

The Trust capital programme forms part of the overall West Yorkshire & Harrogate ICS capital plan. For 2021 / 22 the Trust component is £9.59m.
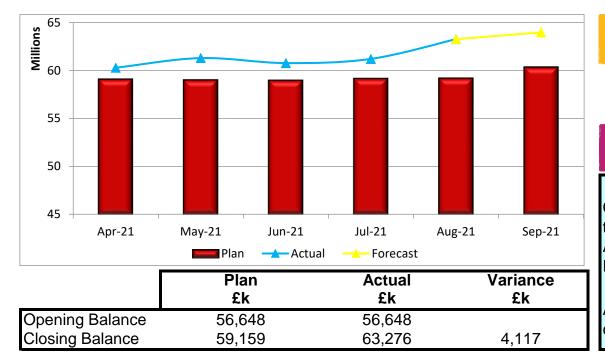
The plan assumed minimal spend at the start of the year with preparatory work and business cases to be finalised as required.
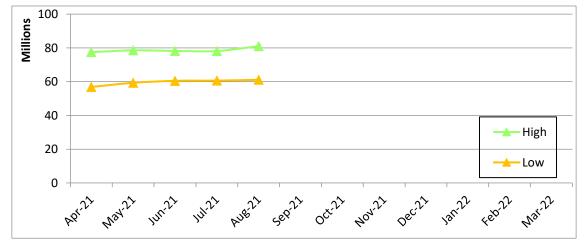
Spend is £0.4m less than originally planned. Detailed readiness and planning activities are on going although there are some delays due to resource / capacity and external influences.

External suppliers have highlighted issues with supply of good and services (staffing, shipping) and also a change in cost base.

Preparatory work continues for the major Bretton Centre En Suite scheme pending formal Trust approval. This is designed to enable work to commence promptly once a decision is made such as aligning partners, planning consents etc. This is non-committal and does not pre-empt a formal decision.

	Plan £k	Actual £k	Variance £k
Opening Balance	56,648	56,648	
Closing Balance	59,159	63,276	4,117

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

Cash has remained higher than planned over the course of the year. This increased in August due to receipt of funding from NHS England relating to the prior financial year.

A detailed reconciliation of working capital compared to plan is presented on page 16.
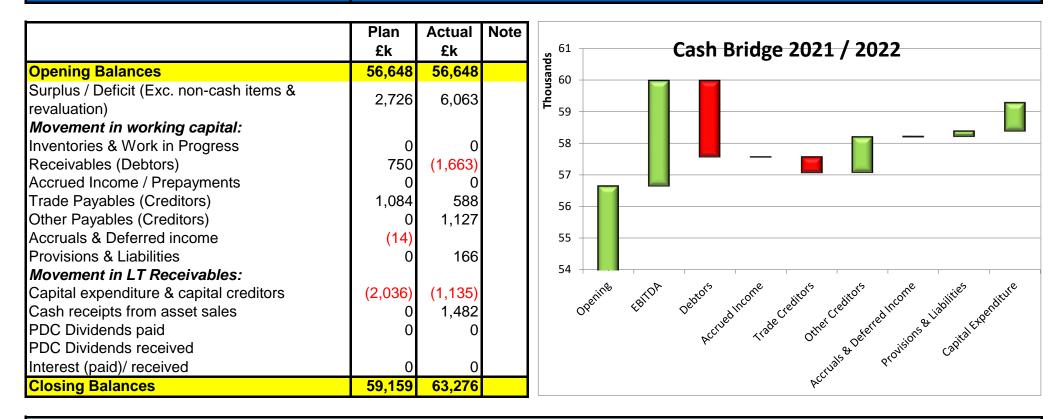
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £81m
The lowest balance is: £61.1m

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)	2,726	6,063	
Movement in working capital:			
Inventories & Work in Progress	0	0	
Receivables (Debtors)	750	(1,663)	
Accrued Income / Prepayments	0	0	
Trade Payables (Creditors)	1,084	588	
Other Payables (Creditors)	0	1,127	
Accruals & Deferred income	(14)		
Provisions & Liabilities	0	166	
Movement in LT Receivables:			
Capital expenditure & capital creditors	(2,036)	(1,135)	
Cash receipts from asset sales	0	1,482	
PDC Dividends paid	0	0	
PDC Dividends received			
Interest (paid)/ received	0	0	
Closing Balances	**59,159**	**63,276**	

Cash Bridge 2021 / 2022

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.
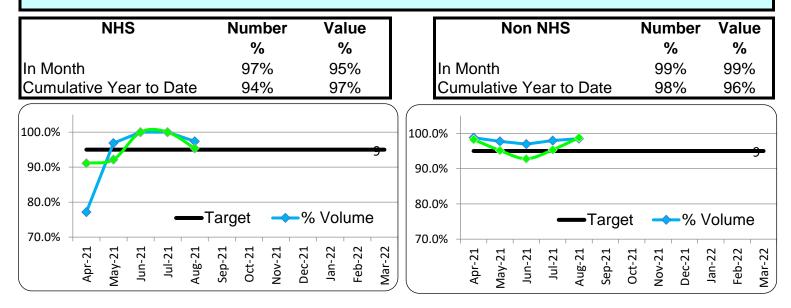
The current main driver is the overall Income and Expenditure position which is better than breakeven and the receipt of £1.5m from the sale of Mount Vernon.

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 August has seen overall 99% of volume and 99% 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%	95%
Cumulative Year to Date	94%	97%

Non NHS	Number %	Value %
In Month	99%	99%
Cumulative Year to Date	98%	96%

	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 (including VAT where applicable).

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 (£)
12-Aug-21	Insurance	Trustwide	Zurich Insurance PLC	HTS03NB150023	539,541
18-Aug-21	Rent	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710173961	371,868
05-Aug-21	IT Software	Trustwide	Phoenix Partnership (Leeds) Ltd	12857	370,332
27-Aug-21	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600017782	192,194
10-Aug-21	Drugs	Trustwide	Bradford Hospitals NHS Trust	319418	109,625
04-Aug-21	Rent	Wakefield	Assura HC Ltd	LINV41642	90,736
05-Aug-21	IT Services	Trustwide	Daisy Corporate Services	3I475427	90,250
25-Aug-21	Drugs	Trustwide	Lloyds Pharmacy Ltd	102184	70,731
06-Aug-21	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	995838	55,602
05-Aug-21	IT Services	Trustwide	Daisy Corporate Services	3I475308	46,979
06-Aug-21	Rent	Barnsley	Community Health Partnerships Ltd	0060207690	46,866
02-Aug-21	Other Services	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710173861	40,991
20-Aug-21	Other Services	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710173961	40,991
26-Aug-21	Rent	Wakefield	Mid Yorkshire Hospitals NHS Trust	1600017609	37,977
31-Aug-21	Drugs	Trustwide	NHS Business Services Authority	1000069941	35,854
21-Aug-21	Purchase of Healthcare	Trustwide	North Yorkshire County Council	600009613	33,309
18-Aug-21	Rent	Barnsley	Dr M Guntamukkala	PG10110	33,132
25-Aug-21	IT Software	Trustwide	MRI Software Emea Ltd	UKQPT2094	32,311
06-Aug-21	Rent	Barnsley	Community Health Partnerships Ltd	0060207689	31,480
27-Aug-21	Mobile Phones	Trustwide	Vodafone Ltd	98514936	31,436
06-Aug-21	Rent	Barnsley	Community Health Partnerships Ltd	0060207693	28,732
19-Aug-21	Rent	Barnsley	Community Health Partnerships Ltd	0060207693	28,732
02-Aug-21	MFD	Trustwide	Kyocera Document Solutions (Uk) Ltd	1243255	25,365
25-Aug-21	Utilities	Trustwide	Edf Energy	000010306674	25,019

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

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

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

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

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

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

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

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.2%	4.2%	4.3%	4.2%	4.2%	
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.9%	4.2%	4.3%	4.2%	4.3%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.0%	78.8%	79.4%	88.2%	87.4%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.2%	82.5%	82.5%	79.5%	76.0%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	96.4%	95.7%	96.1%	94.3%	94.6%	
Equality and Diversity	Resources	Well Led	AD	>=80%	97.2%	97.3%	96.9%	96.6%	95.3%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.0%	86.4%	82.7%	83.6%	82.1%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	75.5%	75.9%	77.7%	79.3%	76.6%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.7%	95.7%	95.6%	93.9%	91.9%	
Information Governance	Resources	Well Led	AD	>=95%	97.7%	96.9%	96.0%	95.2%	93.4%	
Moving and Handling	Resources	Well Led	AD	>=80%	89.9%	90.0%	91.6%	93.0%	93.5%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.1%	91.8%	90.2%	87.0%	85.7%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	93.4%	90.7%	86.8%	78.9%	80.8%	
Prevent	Improving Care	Well Led	AD	>=80%	95.5%	95.6%	96.0%	96.0%	95.8%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.1%	94.5%	94.4%	94.3%	92.3%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.8%	94.1%	93.9%	93.4%	92.6%	
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD				Data unavailable at the time of producing this report			
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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	3.2%	4.2%	5.7%	4.8%	5.1%	
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.0%	4.2%	5.1%	4.7%	4.8%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.2%	80.7%	80.1%	85.5%	86.0%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	82.7%	78.8%	78.0%	79.5%	81.1%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.9%	95.3%	96.8%	96.4%	97.0%	
Equality and Diversity	Resources	Well Led	AD	>=80%	97.8%	97.3%	97.3%	97.2%	97.4%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.6%	86.9%	87.2%	85.5%	83.5%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.1%	76.9%	79.4%	85.2%	90.1%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.3%	95.5%	95.3%	94.2%	94.7%	
Information Governance	Resources	Well Led	AD	>=95%	99.3%	97.5%	96.8%	95.6%	94.4%	
Moving and Handling	Resources	Well Led	AD	>=80%	94.7%	94.7%	95.0%	95.8%	96.9%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.1%	90.3%	83.6%	84.6%	85.0%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.9%	87.2%	79.6%	80.7%	81.5%	
Prevent	Improving Care	Well Led	AD	>=80%	95.9%	96.1%	95.8%	94.8%	95.4%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.2%	95.0%	94.9%	94.7%	94.9%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.5%	94.5%	94.7%	93.9%	93.0%	
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD				Data unavailable at the time of producing this report			
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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	5.5%	4.4%	4.2%	4.6%	5.1%	
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	4.1%	4.4%	4.3%	5.2%	6.6%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.4%	79.9%	80.6%	80.5%	81.7%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	81.8%	86.8%	73.2%	73.0%	74.1%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.6%	94.4%	93.4%	93.8%	94.1%	
Equality and Diversity	Resources	Well Led	AD	>=80%	94.3%	94.1%	94.9%	95.5%	95.4%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.6%	86.4%	85.8%	84.5%	85.0%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	64.3%	64.8%	65.4%	69.1%	69.3%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.7%	92.8%	93.3%	92.4%	92.8%	
Information Governance	Resources	Well Led	AD	>=95%	96.9%	95.1%	93.3%	93.0%	92.0%	
Moving and Handling	Resources	Well Led	AD	>=80%	96.7%	97.4%	97.9%	98.0%	98.3%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	85.7%	87.5%	87.1%	87.3%	88.5%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	78.3%	80.1%	79.7%	81.2%	83.4%	
Prevent	Improving Care	Well Led	AD	>=80%	93.3%	92.3%	92.4%	93.4%	93.7%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.5%	93.9%	94.2%	94.2%	93.4%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.4%	90.2%	91.2%	91.4%	90.9%	
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD				Data unavailable at the time of producing this report			
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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	2.6%	2.6%	2.8%	2.7%	2.8%	
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	2.3%	2.6%	2.7%	2.6%	3.1%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.9%	74.8%	72.2%	81.6%	82.1%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	72.6%	71.3%	71.4%	67.7%	69.3%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	93.1%	94.5%	95.0%	95.0%	92.0%	
Equality and Diversity	Resources	Well Led	AD	>=80%	95.5%	95.5%	96.5%	96.8%	96.6%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	89.3%	81.2%	79.8%	83.1%	81.6%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	28.6%	20.0%	20.0%	33.3%	33.3%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	93.9%	93.6%	93.9%	93.6%	91.6%	
Information Governance	Resources	Well Led	AD	>=95%	97.7%	95.5%	94.9%	91.7%	91.6%	
Moving and Handling	Resources	Well Led	AD	>=80%	98.1%	98.0%	98.7%	98.7%	98.1%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	83.2%	83.7%	84.0%	81.4%	81.2%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	79.8%	81.2%	81.0%	79.1%	79.3%	
Prevent	Improving Care	Well Led	AD	>=80%	92.8%	93.5%	94.1%	94.8%	93.9%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.3%	91.7%	92.6%	94.2%	94.4%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	92.2%	93.0%	94.2%	95.5%	94.4%	
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD				Data unavailable at the time of producing this report			
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							

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	3.2%	2.6%	3.0%	3.0%	3.1%	
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	3.2%	2.6%	2.8%	3.1%	3.6%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	89.3%	89.9%	86.5%	94.2%	92.0%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	89.7%	93.1%	83.3%	83.3%	75.9%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	80.0%	100%	100%	100%	100%	
Equality and Diversity	Resources	Well Led	AD	>=80%	80.2%	89.3%	89.9%	88.2%	89.3%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.6%	86.9%	84.2%	85.3%	83.8%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	97.8%	99.3%	98.5%	98.5%	97.0%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	91.5%	90.3%	91.1%	89.4%	87.2%	
Information Governance	Resources	Well Led	AD	>=95%	97.6%	96.1%	96.0%	95.2%	93.0%	
Moving and Handling	Resources	Well Led	AD	>=80%	99.0%	99.2%	99.3%	98.9%	99.5%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	98.6%	98.2%	98.2%	97.7%	97.2%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	77.3%	68.2%	78.3%	72.7%	76.2%	
Prevent	Improving Care	Well Led	AD	>=80%	98.7%	98.7%	97.2%	97.2%	97.5%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.2%	97.4%	97.5%	97.1%	96.3%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	97.6%	96.9%	97.6%	97.0%	96.6%	
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD			Data unavailable at the time of producing this report				
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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	3.4%	3.4%	4.1%	3.6%	3.5%	
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	3.8%	3.4%	3.7%	3.8%	3.3%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.4%	80.8%	84.1%	86.8%	86.7%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	79.1%	76.5%	75.6%	69.9%	69.8%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	92.8%	94.0%	93.6%	93.6%	93.1%	
Equality and Diversity	Resources	Well Led	AD	>=80%	97.2%	96.9%	96.4%	96.2%	95.9%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.9%	86.7%	85.6%	88.2%	86.6%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	82.5%	84.3%	84.2%	85.4%	86.6%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	94.1%	93.6%	94.4%	91.9%	92.5%	
Information Governance	Resources	Well Led	AD	>=95%	98.4%	98.0%	95.9%	95.2%	94.3%	
Moving and Handling	Resources	Well Led	AD	>=80%	93.6%	93.9%	93.6%	95.7%	95.6%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	88.1%	89.8%	89.5%	84.4%	84.5%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	85.4%	87.0%	86.1%	80.6%	81.0%	
Prevent	Improving Care	Well Led	AD	>=80%	96.1%	95.9%	95.4%	95.9%	95.6%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.5%	94.6%	95.1%	95.9%	94.8%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	91.8%	92.4%	91.1%	90.1%	89.7%	
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD			Data unavailable at the time of producing this report				
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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.1%	6.4%	7.5%	7.0%	7.6%	
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.2%	6.4%	7.0%	7.4%	8.6%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.7%	82.3%	79.2%	84.0%	85.0%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	81.1%	78.2%	77.1%	77.3%	77.8%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	88.4%	90.4%	89.7%	92.1%	91.7%	
Equality and Diversity	Resources	Well Led	AD	>=80%	96.7%	97.8%	97.8%	97.0%	95.9%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.1%	81.5%	82.0%	82.4%	81.0%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.2%	78.3%	79.0%	79.3%	79.4%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.8%	95.0%	94.9%	92.5%	90.9%	
Information Governance	Resources	Well Led	AD	>=95%	97.2%	96.7%	95.8%	94.6%	92.3%	
Moving and Handling	Resources	Well Led	AD	>=80%	98.1%	98.3%	98.6%	97.6%	97.5%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	88.1%	88.3%	87.1%	87.1%	88.2%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	85.2%	85.4%	83.5%	83.3%	84.3%	
Prevent	Improving Care	Well Led	AD	>=80%	94.5%	95.3%	94.7%	94.6%	94.2%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.5%	93.0%	91.8%	91.0%	90.3%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	87.5%	87.4%	86.0%	87.3%	86.8%	
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD			Data unavailable at the time of producing this report				
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Glossary

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

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

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

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

Trust Board 28 September 2021
Agenda item 8.1

Title:	**Community Transformation Programme update**
Paper prepared by:	Director of Strategy and Director of Operations
Purpose:	To provide an update highlight report on the Community Mental Health Transformation Programme for further consideration by Trust Board.
Mission/values:	The programme is in line with the Trust's mission and values, aiming to help people reach their potential and live well in their community.
Any background papers/ previously considered by:	NHS Long Term Plan » The NHS Long Term Plan NHS Long Term Plan » NHS Mental Health Implementation Plan 2019/20 – 2023/24
Executive summary:	In late 2020, places were asked to start developing proposals for central transformation funding to support a programme of change through 2021-2023 delivering: • A new, **inclusive generic community-based offer** based on redesigning community mental health services **in and around Primary Care Networks** • New models will also improve access and treatment for adults & older adults with **a diagnosis of 'personality disorder'**, **eating disorders** and people with **mental health community-based rehabilitation needs** The community mental health transformation is being carried out in line with the NHS Long Term Plan (2019), which hopes to ensure that mental health services are delivered within local community areas. This document summarises the activity that has taken place across the Trust's footprint to establish programmes of work to deliver these objectives in each place, the local governance arrangements, progress so far in each place and highlights some key challenges.
Recommendation:	**Trust Board is asked to:** 1) **RECEIVE and NOTE the progress and update on the Community Mental Health Transformation Programme.**
Private session:	Not applicable.

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Community Transformation Highlight report for Trust Board – September 2021

The purpose of this paper is to provide a highlight report including an overview of the programme and how it is being governed and key aspects of progress and risks.

Introduction/Background

The NHS long term plan sets out the aspiration to establish new and integrated models of primary and community mental health care to support at least 370,000 adults and older adults per year who have severe mental illnesses by 2023/24, so that they will have greater choice and control over their care, and be supported to live well in their communities.

In late 2020, places were asked to start developing proposals for central transformation funding to support:

- A new, **inclusive generic community-based offer** based on redesigning community mental health services **in and around Primary Care Networks**
- New models will also improve access and treatment for adults & older adults with **a diagnosis of 'personality disorder'**, **eating disorders,** and people with **mental health community-based rehabilitation needs**

New CCG baseline uplifts and central transformation funding for community mental health have been established to flow to local systems, to invest in recruiting new members of the community mental health workforce and commissioning new VCSE services.

In addition to the model proposals have been developed to establish mental health practitioners in primary care via the Additional Roles Reimbursement Scheme (ARRS). The intention of the role is to provide a resource which is managed by SWYPFT but working into the Primary Care Network, with 50% of funding will be provided by the PCN and 50% by SWYPFT. Although funded separately to the transformation model, the role and timing of the PCN practitioner implementation align very closely with the transformation aspirations.

Finance

In 2021/22, all ICSs are receiving a fair-share of transformation funding from £121m available for new models (rising to £295m in 22/23 & £366m in 23/24 provisionally).

In late 2020 and early 2021 proposals were developed for each place and funding has now been agreed and paid for the first half of 2021/22. The funding has flowed via the ICS to each place.

How the programme is being managed

The transformed models are to be based on partnership approaches between Mental Health providers, Primary Care Networks, Local Authorities and the Voluntary and Community Sector (VCS).

Plans have been developed in each place through existing or specifically developed partnership or alliance arrangements involving all key partners, and through co-production.

Each place in the SWYPFT footprint has now established a local partnership governance structure to support the programme in that place.

The ICS has been taking a coordinating / or programme level approach, for example, coordinating the West Yorkshire proposals and submissions to NHSE/I, supporting shared practice and joint activity across the places. Some of the joint activity includes focussing on peer support roles and workforce across the system.

The table below sets out the draft developing governance structure from a SWYPFT perspective.

Community Mental Health (CMH) Transformation Framework - DRAFT				
Function	**Group/role**			
Coordinated bids and received funding from NHS (E) for each place. Carries overall accountability for delivery of the plans to NHS (E)	**South Yorkshire & Bassetlaw ICS**	**West Yorkshire & Harrogate ICS**		
Accountable for delivery of the Community MH transformation plan in place through the CCG	Community MH Transformation Mobilisation Group Chair: Patrick Otway Reporting to MH Partnership Delivery Group	Calderdale Programme Steering Group, Chair: Janice Wootton Reporting to the Calderdale Collaborative Community Programme Board	Kirklees Partnership Project Group Chair: Vicky Dutchburn Reporting to Kirklees Integrated Health & Care Leadership Board	Wakefield Community Transformation T&F Group Chair: Charlotte Whale Reporting to Wakefield Integrated Care Partnership Board
Programme management of the delivery of the plan to achieve the CMH transformation in place, in line with submission	**Barnsley** Programme Manager: Hawarun Hussain (up to 31.12.2021) Line manager Dave Ramsay Hosted by SWYPFT	**Calderdale** Programme Manager: Amanda McKenzie Line manager Janice Wootton Hosted by SWYPFT	**Kirklees** Programme Manager: Jen Love Line manager Vicky Dutchburn Employed by Kirklees CCG	**Wakefield** Programme Manager: Emma Hankinson Line manager Charlotte Whale Hosted by the MH Alliance
Co-ordination of the work across the SWYPFT footprint to share learning and approaches and provide opportunities for the consideration of issues for the Trust	**Internal SWYPFT Community MH Transformation Programme Group** – Chair Salma Yasmeen SWYPFT Programme Managers Delivery Group			

The role of SWYPFT

SWYPFT is a key partner in the delivery of the models and whilst not directly leading any of the programmes, is responsible delivering some services into the model and playing a leading role in many strands of activity.

We have established a network programme group, with executive leadership, to share learning from across the programme, check progress, and manage any risks that impact the Trust. We are also setting up a delivery group with programme managers from each place. SWYPFT has supported the recruitment process for the programme manager roles and are hosting programme manager roles in Barnsley, Calderdale and Kirklees (via the MH Alliance).

Features of the model

All of the programmes include the following features:

- Community Mental Health based offer around primary care networks.

- They include a focus on personality disorder, Serious Mental Illness (SMI), Adult Eating Disorders, Physical Health for SMI, and older adults, excluding dementia.

- Increased work with VCS with the opportunity to strengthen peer support, recovery orientated support, and to enhance creative approaches.

- Primary Care Mental Health practitioner roles.

- All places are taking forward a phased approach, building up from a small number of Primary Care Networks (PCNs), in line with the increasing finances.

- Engagement and addressing inequalities are key themes that run through all programmes.

An expected benefit of the model designed around primary care is that it will help to support more people in the primary care system and therefore help manage demand coming into secondary mental health services.

Progress to date and place based updates

Whilst many of the programmes are still in their infancy, mobilisation has now commenced in each place. All places now have programme managers in the role to coordinate local activity (though some are very new in post) and all new community MH models are being established. Some highlights include:

- In Barnsley a series of workstreams are running. These include:
  - Eating disorders, personality disorders, physical health and wellbeing, crisis alternatives and the PCN interface.
  - Recruitment has taken place across the strands and models are being implemented.
  - 12 peer support worker roles now being recruited.
  - For example, on the PD pathway, advanced nurse practitioners and specialist psychological therapists are in post and various stakeholder training has taken place, with more to be organised.
  - The rehab and recovery strand is focussing on the treatment pathway and enabling recovery, supporting people with short to medium term interventions, helping people to develop self management skills and focussing on people that are socially isolated. Roles now in post include the Housing support worker.
  - PCN Practitioner posts now agreed with the clinical leads from the PCN recruitment complete.
  - Workshops to be held with PCNs in the coming months.
  - Work being developed with partner organisation on 'crisis prevention'.
  - Planned expansion of the SPA role doing brief intervention reaching into the primary care practices and working closely with 3rd sector provision to promote self resilience and self management.
- In Calderdale:
  - The Calderdale model has a specific element that focusses on MH hubs and community emotional health and wellbeing workers supporting small cohorts of 200-300 households. Work is now ongoing to identify the local areas to test this model and to recruit the health and wellbeing practitioners.
  - The programme also includes crisis alternatives, community rehab, eating disorders and personality disorders pathways.
  - An additional SPA role will link into primary care as part of the programme.

- o Recruitment is taking place across the programme and plans will now be established to develop an engagement, involvement and co-design approach.
- o Calderdale is leading on the Outcomes 'do once' area on behalf of the West Yorkshire Integrated Care System.
- In Kirklees:
  - o In Kirklees, much progress has already been made in establishing personality disorders pathways.
  - o Kirklees is developing a delivery model for provision of health checks for people with SMI and consideration is being given to how SWYPFT can support GPs in delivery of this service.
  - o As with Calderdale, an additional SPA role will align with primary care.
  - o Work in Kirklees is also ongoing in relation to IPS and employment support (linked to the long term plan).
  - o Kirklees is leading on the Communications 'do once' area on behalf of the West Yorkshire Integrated Care System.
- In Wakefield:
  - o As with other models, the Wakefield transformation has an emphasis on partnership approaches and integration with the VCS, demonstrated through Alliance leadership and governance.
  - o Close working with voluntary services will be strengthened through the new community builder roles.
  - o MH pharmacist roles in the community will also support closer working with PCNs.
  - o Community Builder roles specialising in adult and older adult mental health are now in post as is the new senior project manager, leading the transformation. Recruitment is ongoing for specialist mental health practitioners for the MH hubs, which will focus specifically on the pilot PCN sites.
  - o Wakefield is leading on the Crisis Pathway 'do once' area on behalf of the West Yorkshire Integrated Care System.
  - o Wakefield has formed a task and finish group specifically looking at eating disorders and are exploring proposals that would expand the current CAMHS service to deliver an offer for adults.

Challenges in the implementation

Workforce has been identified as one of the key challenges across the programme as the catchment of people that will work into the new service model will include those that work across our existing mental health services and are already under pressure.

The ICS is coordinating a number of workforce workshops and consideration is being given to whether and how innovative approaches to recruitment can enable the transformation, whilst limiting the impact on existing services and their workforce.

New roles like community builders/connecters are being developed we will need to ensure the roles have clear job descriptions and some level of consistency across places in terms and conditions.

PCN Practitioner Roles:

The NHS Standard contract for 21/22 has outlined the requirement for fully embedded Community Mental health Practitioners to be based in PCN's

Proposals were for 50% of funding to be provided by the PCN and 50% by the Mental Health Provider.

Further work has been undertaken to understand the impact of the requirement on our mental health services and community mental health transformation work. This has highlighted some risks, including that the funding only covers 41% of the costings of a band 6 (not 50%) before any non pay is taken into consideration. The PCN funding for these roles does not cover IT equipment, agile equipment, mileage or training.

The suggested delivery of a service rather than an individual worker would include VAT and the requirement for a minimum of 46 weeks per year couldn't be delivered in cases of long term sickness or maternity.

The challenges that we are facing are not specific to the Trust but are as a result of the way that the roles have been designed. We are working with PCN's/CCG's/ICS in West Yorkshire to develop a practitioner model and an option where PCNs share the Mental Health Practitioner Capacity but retain a named practitioner is being explored as a potential solution. However, there are legal issues with this proposal and workarounds / appropriate models are currently being explored.

In Barnsley, recruitment has progressed on the basis that there is transformation funding related underspend (and other non-rec funding options) though the technicalities are not fully resolved.

Recommendations

Trust board to receive the highlight report for awareness of Community Mental Health Transformation activity.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board
28 September 2021
Agenda item 8.2

Title:	**Serious Incident Report Quarter 1 2021/22 (including Learning from healthcare deaths Quarter 1 2021/22)**
Paper prepared by:	Director of Nursing, Quality and Professions
Purpose:	This report provides information in relation to incidents in Quarter 1 and more detailed information in relation to serious incidents. It also provides assurance that learning from healthcare deaths arrangements are in place. The report provides cumulative data for 2021/2022 deaths. The learning from healthcare deaths report requires publication on the Trust website.
Mission/values:	- We are respectful, honest, open, and transparent - We put the person first and, in the centre, - We are always improving
Any background papers/ previously considered by:	Previous quarterly reports which have been submitted to CGCSC, along with the annual incident reports and our learning journey reports. CGCSC has also received papers about the introduction of the national requirement for learning from healthcare deaths and the policy. This report was reviewed and approved at the Clinical Governance Clinical Safety Committee on 14 September 2021.
Executive summary:	- This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with the Business Delivery Units. Data is also available at service line/team level via Datix. All managers have access to Datix dashboards to interrogate data further. - This report has overall figures for incident reporting. Q1 had 3108 incidents: just slightly higher than the previous quarter (3096). 96% of incidents are graded as "low" or "no harm" showing a positive culture of risk management (the more low/no harm incidents reported mean action taken proactively at an early stage before harm occurs). "Physical aggression/threat (no physical contact): by patient" 326 incidents (10%) remain as the most reported category. "Violence and Aggression" continues to be the highest reported incident type (28%) (876 of all incidents reported in the quarter, consistent with the previous quarter) - There have been no 'Never Events' reported in the Trust during Q1 2021/22 with the last Never Event reported being in 2010/11. NHS England are currently reviewing the Never Event list. - The total number of serious incidents reported through Strategic Executive Information System (StEIS) in Quarter 1 was 8; this is higher than the previous Quarter (Q4 20/21) when there were (6). The type of serious incidents reported this quarter has included: - Death (including suspected suicide) (7) - Patient Choking (1)

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- In quarter 1, the highest category of serious incident is Suicide (apparent) - community team care - current episode (4). This is higher than quarter 4 which was 3 incidents.
- All incidents that are graded red or amber are extracted from Datix for inclusion in a report that is reviewed at the weekly risk panel.
- All deaths are reviewed in line with the learning from healthcare deaths policy.
- We are implementing our Trust wide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern.
- We have taken the lead on the West Yorkshire and Harrogate Health Care Partnership 5-year suicide prevention strategy, which has adopted an evidence-based approach to suicide prevention and zero suicide philosophy for targeted areas and hotspots.
- 8 serious incident investigations have been submitted to the Commissioner during the quarter and 14 previous serious incidents have been closed by Commissioners.
- The actions from incidents are managed at Business Delivery Unit level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational management group.
- Several investigations are outside the 60 working day target; during the Covid-19 period and to present, the 60 working days timescale has been suspended by NHS England and Improvement. However, we have continued to aim to work towards this timescale during this time.
- Discussion in the Clinical Governance and Clinical Safety Committee considered the potential helpfulness of reporting serious incidents per 100,000 population across the BDUs, to ease comparison. The committee also requested further evidence of organisational learning with regards to the stated actions from serious incidents.

Learning from healthcare deaths

- The Learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes.
- The Learning from healthcare deaths policy was reviewed in January 2020.
- The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
  - Death Certification
  - Case record review, including Structured Judgment Record Reviews. The managers 48-hour review on Datix is also classed as a first stage case record review.
  - Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding.
- Total number of deaths reported on Datix by staff between 1/4/2021 – 30/6/2021 (by reported date, not date of death) = 91, all of which have been reviewed. This is a reduction on Q4 202/21 (115)
- Total in scope as described in report = 77

Risk appetite

	• Risk identified – the Trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting, analysing, and investigating healthcare deaths. • This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-6. • The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6. • 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 Trust has developed Datix and worked with performance and information to ensure information is available. A policy has been developed which meets current national requirements. Training to review records has been provided. The outcome which is now the important aspect continues to be developed.
Recommendation:	**Trust Board is asked to RECEIVE the quarterly report on incident management.**

Trust wide Incident Management Report
Quarter 1 2021/22

Incorporating Learning from Healthcare Deaths reporting for the period 01/04/2021-30/06/2021

Report prepared by Patient Safety Support Team

July 2021

Contents
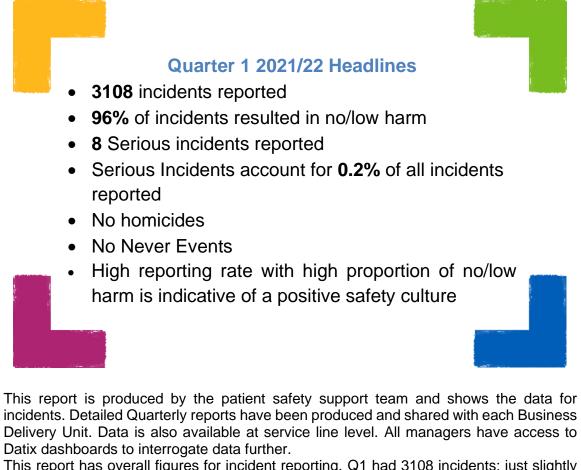
Executive Summary

This report provides information in relation to incidents reported in Quarter 1 2021/22 and more detailed information in relation to serious incidents. A brief analysis of actions arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2021 to 30 June 2021 is included. The report also includes the Trust's report on Learning from Healthcare Deaths to provide assurance that arrangements are in place and to provide cumulative data for the period 1 April 2021 to 30 June 2021. The Learning from Healthcare Deaths report will be available separately on the Trust website.

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

Quarter 1 2021/22 Headlines

- **3108** incidents reported
- **96%** of incidents resulted in no/low harm
- **8** Serious incidents reported
- Serious Incidents account for **0.2%** of all incidents reported
- No homicides
- No Never Events
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

➤ This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each Business Delivery Unit. Data is also available at service line level. All managers have access to Datix dashboards to interrogate data further.

➤ This report has overall figures for incident reporting. Q1 had 3108 incidents; just slightly higher than the previous quarter (3096).

➤ 96% of incidents are graded as "low" or "no harm" showing a positive culture of risk management (the more low/no harm incidents reported mean action taken proactively at an early stage before harm occurs).

➤ "Physical aggression/threat (no physical contact): by patient" 326 incidents (10%) remains as the most reported category.

➤ "Violence and Aggression" continues to be the highest reported incident type (28%) (876 of all incidents reported in the quarter, consistent with the previous quarter)

➤ There have been no 'Never Events' reported in the Trust during Q1 2021/22 with the last Never Event reported being in 2010/11. NHS England are currently reviewing the Never Event list.

- ➢ The total number of serious incidents reported through Strategic Executive Information System (StEIS) in Quarter 1 was 8; this is higher than the previous Quarter (Q4 20/21) when there were (6). The type of serious incidents reported this quarter has included:
  - ➢ Death (including suspected suicide) (7)
  - ➢ Patient Choking (1)
- ➢ In quarter 1, the highest category of serious incident is Suicide (apparent) - community team care - current episode (4). This is higher than quarter 4 which was 3 incidents.
- ➢ All incidents that are graded red or amber are extracted from Datix for inclusion in a report that is reviewed at the weekly risk panel.
- ➢ All deaths are reviewed in line with the learning from healthcare deaths policy.
- ➢ We are implementing our Trust wide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern.
- ➢ We have taken the lead on the West Yorkshire and Harrogate Health Care Partnership 5-year suicide prevention strategy, which has adopted an evidence-based approach to suicide prevention and zero suicide philosophy for targeted areas and hotspots.
- ➢ 8 serious incident investigations have been submitted to the Commissioner during the quarter and 14 previous serious incidents have been closed by Commissioners.
- ➢ The actions from incidents are managed at Business Delivery Unit level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational management group.
- ➢ A number of investigations are outside the 60 working day target; during the Covid-19 period and to present, the 60 working days timescale has been suspended by NHS England and Improvement. However, we have continued to aim to work towards this timescale during this time.

Learning from healthcare deaths
- ➢ The Learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes.
- ➢ The Learning from healthcare deaths policy was reviewed in January 2020.
- ➢ The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
  - • Death Certification
  - • Case record review, including Structured Judgment Record Reviews. The managers 48-hour review on Datix is also classed as a first stage case record review.
  - • Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding.
- ➢ Total number of deaths reported on Datix by staff between 1/4/2021 – 30/6/2021 (by reported date, not date of death) = 91, all of which have been reviewed. This is a reduction on Q4 202/21 (115)
- ➢ Total in scope as described in report = 77

1. Introduction

This report has been prepared by the Patient Safety Support Team to bring together Trust wide information on incident activity during Quarter 1 2021/22 (1 April 2021 to 30 June 2021) including reported serious incidents and Learning from Healthcare Deaths.

Please note that figures within this report may vary from the individual Business Delivery Unit reports due to re-coding/grading changes of incidents whilst producing the reports from a live system. We are improving our methods of centralised data extraction for reports to improve this in the future.

2. Updates from the Patient Safety Support Team

During Quarter 1, the Patient Safety Support Team priority areas have included:

- Mental Health Benchmarking Data including Mental Health standard
- Worked with Daisy and RLDatix Ltd to transfer our Datix servers to being hosted by RLDatix Ltd
- Recruited to Incident Management Support Officer post
- Continue to send data flows for severe harm and death incidents to the CQC.
- Responding to four FOI request (including information related to serious incident data).
- Data production and reporting for monthly and Quarter reports.
- Datix new manager training session and working on delivering new training packages.
- Procedure changes for identifying Notifiable Safety Incidents where Duty of Candour applies and how to respond.

3. Incident Reporting Analysis

This report has overall figures for incident reporting. Quarter 1 (April to June 2021) had 3108 incidents which is slightly higher than the levels in the last quarter (January 2021 to March 2021- Quarter 4) 3096.

96% of all incidents reported on Datix are classed as "low" or "no harm". This shows a positive culture of risk management no or low harm incidents reported mean action taken proactively at an early stage before harm occurs).

Quarter 1 2021/22 Headlines

- **3108** incidents reported

- Increase on reporting compared with Q4 (3096)

- **96%** of incidents remain **no/low harm**

- High reporting rate with high proportion of no/ low harm is indicative of a positive safety culture
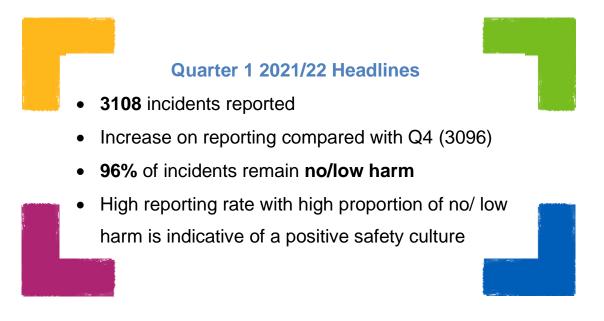
Figure 1 below shows the pattern and number of incidents reported by quarter in the Trust from Q1 2017/18 to Q1 2021/21, revealing a slight upward trend, however the rate fluctuates as would be expected with the nature of incident reporting. Quarter 1 2021/21 was slightly higher than the average for a quarter. However, with the Trust changing profile of services, direct comparisons should be viewed with caution.
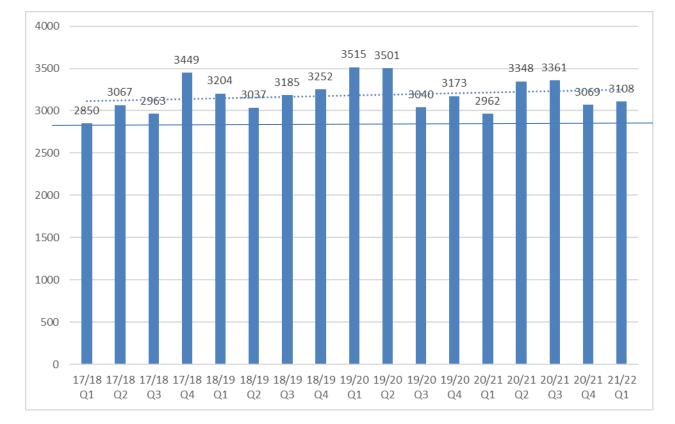
Figure 1 Comparative number of incidents reported by financial quarter Q1 2017/18 to Q1 2021/22

Severity

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).

Changes were made to Datix on 05/02/2021 to embed the Trust's risk grading matrix as a visual tool to aid staff with completing the severity of incidents. The Degree of harm (separately recorded) identifies the level of actual harm that occurred in an incident. This addition has resulted in improvements in the recording of incident severity, bringing in both consequence and likelihood of recurrence ratings. This has resulted in some changes in severity figures, such as seeing more incidents graded yellow in particular. This is due to the consideration of the likelihood of the incident recurring. Managers may regrade incidents as they review incidents, adding further actions taken.

In Figure 2 there have been 30 red incidents reported in Quarter 1 2021/22. This data is live data at the point of producing the report. The incident may be initially graded red for a number of reasons. An example would be a death (for healthcare deaths we encourage staff to report on Datix) which later is updated as natural causes or where the individual has not been involved with Trust services for over six months so this may be re-graded and not reported on STEIS, this can take some time to get this information. Not all red incidents meet the criteria for a serious incident (see section 6).

Figure 2 All incidents reported Trust wide between 01/01/2020 – 30/06/2021 by severity and financial quarter

	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Green	2533	2764	2722	2186	2034
Yellow	279	446	492	714	889
Amber	124	110	118	140	155
Red	26	28	29	29	30
Total	2962	3348	3361	3069	3108

Figure 3 All incidents reported Trust wide between 1/04/2021 - 30/06/2021 by severity and BDU
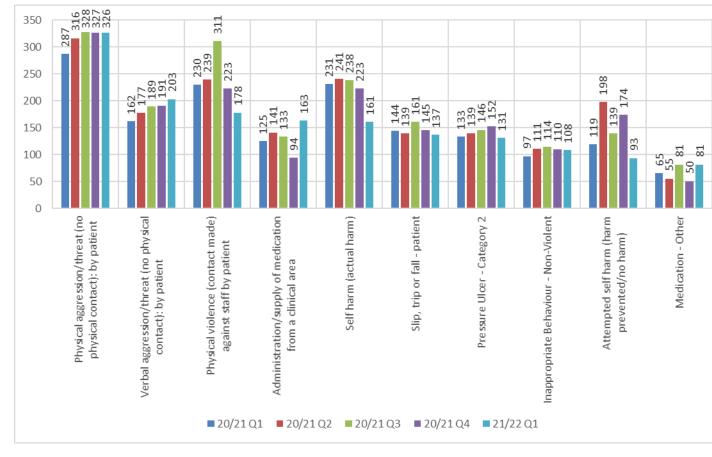
BDU By Severity	Green	Yellow	Amber	Red	Total
Mental Health Inpatient Services	968	494	49	2	1513
Forensic Service	435	189	31	1	656
Barnsley General Community Services	265	46	48	0	359
Learning Disability services	98	44	1	0	143
Kirklees Community Mental Health Services	52	35	9	12	108
Wakefield Community Mental Health Services	74	18	2	4	98
Calderdale Community Mental Health Services	47	20	5	5	77
Barnsley Community Mental Health Services	44	12	1	5	62
CAMHS Specialist Services	26	17	7	1	51
Trust wide (Corporate support services)	23	14	2	0	39
ADHD and Autism services	2	0	0	0	2
Total	2039	893	155	31	3108

Type and Category of incidents

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

Figure 4 Type of incident reported in Quarter 1 by BDU

	ADHD and Autism services	Barnsley Community Mental Health Services	Barnsley General Community Services	Calderdale Community Mental Health Services	CAMHS Specialist Services	Forensic Service	Kirklees Community Mental Health Services	Learning Disability services	Mental Health Inpatient Services	Trust wide (Corporate support services)	Wakefield Community Mental Health Services	Total
All Other Incidents	0	4	12	2	6	60	2	8	96	4	5	199
Care Pathway, Clinical and Pressure Ulcer Incidents	0	4	232	12	8	8	4	6	73	0	12	359
Death (including suspected suicide)	0	11	4	15	0	1	21	4	4	0	21	81
Health and Safety (including fire)	0	1	11	2	1	52	2	12	94	9	3	187
Infection Prevention/Control	0	0	3	1	1	11	0	1	14	1	0	32
Information Governance Incidents	1	3	11	0	11	3	6	2	2	7	7	53
IT Related Issues	0	0	4	1	0	2	3	4	4	2	3	23
Legislation and Policy	0	0	0	2	1	38	0	7	86	2	0	136
Medication	0	12	39	15	0	45	12	8	202	3	6	342
Missing/absent service users	0	0	0	1	0	9	0	3	36	0	0	49
Safeguarding Adults	0	6	8	7	1	30	15	15	26	1	7	116
Safeguarding Children	0	6	3	9	14	9	10	2	4	0	3	60
Security Breaches	0	2	0	1	0	77	1	4	31	6	2	124
Self Harm	0	4	6	5	5	14	17	2	248	0	21	322
Slips, Trips and Falls	0	1	20	1	0	13	1	3	107	3	0	149
Violence and Aggression	1	8	6	3	3	284	14	62	486	1	8	876
Total	2	62	359	77	51	656	108	143	1513	39	98	3108

Figure 5 Trust-wide Top 10 most frequently reported incident categories in rolling 5 quarters (1/01/2020 – 01/06/2021)

Figure 5 shows that in Quarter 1 2021/22 physical aggression/threat (no physical contact) by patient was the highest reported category of incident. Figures for previous quarters are included for comparison.

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

Reporting to National Reporting and Learning System

The Trust captures the severity of all incidents locally on Datix using the risk matrix which scores incidents ranging from green through to red (see Figure 2). This includes actual and potential harm of all incidents and near misses (i.e. psychological harm, potential risks).

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

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

The NHS Patient Safety Strategy [2] published in July 2019 sets out plans for a new national reporting and learning system which will combine NRLS and the Strategic Executive Information System (for reporting serious incidents). The launch date is expected in 2022.

In quarter 1 2021/22, 2746 incidents were reported to the National Reporting and Learning System.

National Reporting and Learning System reports

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

NHS Improvement publishes data from the NRLS system on a six-monthly basis. These reports are designed to assist NHS trust boards to understand and improve their organisation's patient safety culture and reporting of patient safety incidents to the NRLS. The reports have changed over time, but now encourage organisations to compare against themselves over periods of time, rather than with other organisations which may not be comparable for several reasons.

The published reports are added to the NRLS intranet page when released.

NHS improvement have announced that the NRLS summary report will be published annually instead of every 6 months. The latest NRLS Summary Report published in Sept 2020, covers the period 1 October 2019 to 31 March 2020 compares the Trust's data against the same period in 2018/19. The areas compared are:

Reporting culture and reporting patterns
- No evidence of potential under-reporting.
- Our reporting rate per 1,000 bed days remains consistent.

Has the timeliness of your incident reporting improved?
- Our reporting timeliness remained the same in Oct 2019 to Mar 2020, compared with the previous year due to focussed quality improvement time on reviewing incidents internally. This improved the speed with which incidents were uploaded to NRLS. Further work to protect time for this continues.

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

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

Are you improving the accuracy with which you report degree of harm?
- There are some small variations in comparative data by degree of harm. The Patient Safety Support Team quality check local data against provisional data from NRLS on a monthly basis and amendments are made as needed. The actions recommended in the report are in place.

Do you understand your most frequently reported incident types?
- The incident types reported on from the national system do not direct correlate with those collected locally. Our incident coding will be mapped to the new national reporting system during the roll out period.

Have the care settings of your incidents changed?
- There are very small variations in comparative data by care setting, but this would be as expected.

4. Learning from incidents

During the Covid 19 pandemic we have drawn upon our existing improvement initiatives to support the Trust's work to learn from experience.

Learning Library

We have continued to use the #allofusimprove Learning library (our repository of information from a range of sources of learning from experience). Access further details here http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx

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

Examples of recently added content include:

Sharing learning from Covid 19 29.06.21 possible transmission
SBAR - specimen collection from urinary catheters
SBAR choking
Hoarding SBAR.docx
SBAR learning Covid 19 restraints.docx
Cuckooing SBAR.docx
Police portal SBAR.docx
SBAR learning library template WEB119651 SK Core.docx
SBAR learning library template Covid 19 learning- 18 Mar 2021.docx
SBAR learning library template Covid 19 learning- 11 Mar 2021.docx
Learning Library from SJR WEB119450.docx
SBAR learning library template Covid 19 learning- Outbreak.docx
SBAR learning library template Covid 19 learning- travelling with service users.docx
SBAr learning Working Together safeguarding children.docx
SBAR learning Homelessness.docx
Sharing learning from Covid 19 adverse events 28.01.21 staff testing.docx

Sharing learning from Covid 19 adverse events 28.01.21 PPE.docx
Sharing learning from Covid-19 adverse events 21.01.21
SBAR learning library Covid-19 learning
SBAR threats to kill guidance

Greenlight alerts

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

Greenlight alerts are available on the intranet:

There were no greenlight alerts shared in quarter 1.

Bluelight Alerts

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

The Bluelight alerts that have already been circulated in Quarter 1 are available on the intranet and below:

- Bluelight alert 48 - 9 June 2021 - Use of en-suite toilet seat as ligature
- Bluelight alert 47 - 17 May 2021- Risks from nylon string, lace or cord

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

We have continued to use **human factors** techniques in analysing incidents and serious incidents. Information on online training is available here. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

We have continued to use our **Significant event analysis (SEA) tool** to enable incidents to be reviewed quickly to identify learning more quickly involving staff involved in the incident. Further guidance available here. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

Learning from Serious Incidents

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

Learning from Healthcare Deaths

Section 8 of this report contains our report on learning from healthcare deaths.

Incident reports

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

5. Trust wide Serious Incident (SI) Report[3]

Background context

Serious incidents are defined by NHS England as;

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

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

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

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

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

National Update

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

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)

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

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

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

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

- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

There are two major changes anticipated arising from the NHS Patient Safety Strategy relating directly to Incident reporting and management. Both projects have been delayed during Covid 19. This will include:

- Work to connect Datix to the new Learning from Patient Safety Events (LFPSE) previously called the Patient Safety Incident Management System (PSIMS) which will replace NRLS and StEIS systems. Full implementation is anticipated in 2022.
- New Patient Safety Incident Response Framework (PSIRF) which will replace the Serious Incident Framework. Full implementation is anticipated in 2022.

Investigations

Investigations are initiated for all serious incidents in the Trust to identify any systems failure or other learning, using the principles of 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 such as where significant care and service delivery issues are identified.

Headlines

During Quarter 1 2021/22, there were **8 Serious Incidents reported** to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS).

Quarter 1 2021/22 Headlines

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

Never Events[7] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were **no 'never event'**

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

incidents reported by SWYPFT in Quarter 1 2021/22. The last Never Event reported by the Trust was in 2010/11. A revised list of Never Events came into effect on 1 February 2018. This is available on the Trust intranet. NHS England are currently reviewing the Never Event list.

Serious Incident Reporting Analysis
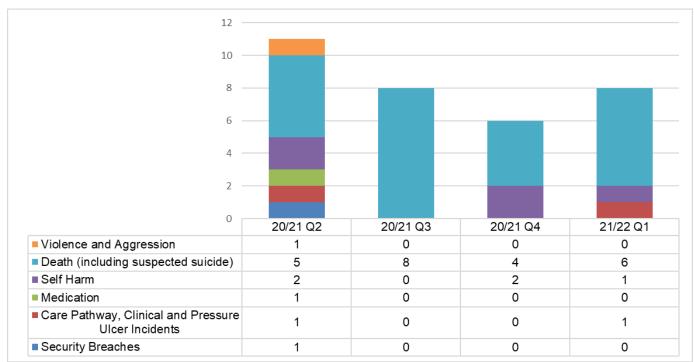
During Quarter 1 2021/22 there have been 8 serious incidents reported on StEIS, as shown in Figure 6 by financial quarter, with 5 comparative data for previous financial years.

Figure 6 Serious Incidents (StEIS) reported to the Commissioner by financial year and quarter up to 30/06/2021 (2017/18 – 2021/22)

Financial Quarter	2017/18	2018/19	2019/20	2020/21	2021/22
Quarter 1	15	8	12	8	8
Quarter 2	18	9	12	11	
Quarter 3	26	10	8	8	
Quarter 4	12	17	15	6	
Total	71	44	47	33	8

Figure 7 shows a breakdown of the 33 serious incidents in a rolling 12-month period (01/07/2020-30/06/2021) by the type of incident and the month reported. The number of SIs reported in any given period of time can vary and given the relatively small numbers involved and the broad definition of an SI, it can be difficult to identify and understand the reasons for this. However, it is important that any underlying trends or concerns are identified through analysis.

Figure 7 Types of All Serious Incidents reported on STEIS in the 12-month period (01/07/2020 – 30/06/2021)

	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Violence and Aggression	1	0	0	0
Death (including suspected suicide)	5	8	4	6
Self Harm	2	0	2	1
Medication	1	0	0	0
Care Pathway, Clinical and Pressure Ulcer Incidents	1	0	0	1
Security Breaches	1	0	0	0

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

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

Figure 8 Serious Incidents reported by team and BDU during Q1 2021/22

	Barnsley Community Mental Health Services	Kirklees Community Mental Health Services	Mental Health Inpatient Services	Forensic Service	CAMHS Specialist Services	Total
Ashdale Ward (based at The Dales, Kirklees BDU)	0	0	1	0	0	1
CAMHS (Barnsley)	0	0	0	0	1	1
Core Team - Barnsley	1	0	0	0	0	1
Early Intervention Service (Insight) - Kirklees	0	1	0	0	0	1
Enhanced Team North 2 - Kirklees	0	1	0	0	0	1
Intensive Home-Based Treatment Team (IHBTT) - Barnsley	1	0	0	0	0	1
Priestley Ward, Newton Lodge	0	0	0	1	0	1
Ward 18, Priestley Unit	0	0	1	0	0	1
Total	2	2	2	1	1	8

Figure 9 Serious Incidents reported by team and BDU during Q1 2021/22
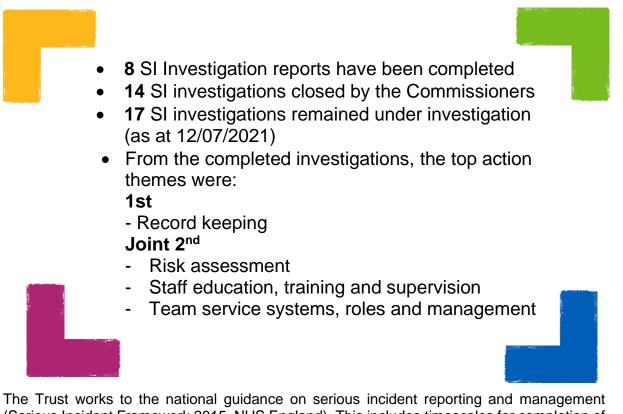
	Barnsley Community Mental Health Services	Kirklees Community Mental Health Services	Mental Health Inpatient Services	Forensic Service	CAMHS Specialist Services	Total
Death - confirmed from physical/natural causes	0	0	1	0	0	1
Death - confirmed related to substance misuse (drug and/or alcohol)	0	0	0	1	0	1
Patient choking	0	0	1	0	0	1
Self harm (actual harm) with suicidal intent	0	0	0	0	1	1
Suicide (apparent) - community team care - current episode	2	2	0	0	0	4
Total	2	2	2	1	1	8

Serious Incident Investigations completed during Quarter 1 2021/22

This section of the report focusses on the serious incident investigation reports that were completed and submitted to the relevant commissioner during Quarter 1 2021/22. Please note this is not the same data as those reported in this period as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

Headlines

- **8** SI Investigation reports have been completed
- **14** SI investigations closed by the Commissioners
- **17** SI investigations remained under investigation (as at 12/07/2021)
- From the completed investigations, the top action themes were:
  1st
  - Record keeping
  Joint 2nd
  - Risk assessment
  - Staff education, training and supervision
  - Team service systems, roles and management

The Trust works to the national guidance on serious incident reporting and management (Serious Incident Framework 2015, NHS England). This includes timescales for completion of investigations of 60 working days. While the Trust tries to achieve this, it has the support of commissioners to complete a quality report above a timely report. The Trust requests extensions from commissioners to agree revised dates and the investigators also keep families informed. During the Covid 19 period, NHS England suspended the 60 working day timeframe. All investigations have continued to progress, and new Serious Incidents have been allocated in lead investigators, demonstrated in the 8 investigations that have been completed during Q1 and sent to commissioners. All meetings, interviews and family contacts have moved to phone contacts and virtual meetings.

Of the 17 investigations that are underway (at 12/07/21), these are at different stages of progress. This is reported to Operational Management Group on a monthly basis.

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

In April 2021 The Trust was successful in achieving accreditation for our Serious incident processes by Royal College of Psychiatrists. The accredited status will run for three years.

SI Action Plans

Each BDU monitors the implementation of their action plans. The Patient Safety Support Team send out information on the current position status based on information completed on Datix

each month in the Clinical risk report for Operational Management Group report. This is providing real time data more regularly and reducing overdue action plans.

Serious Incident learning and themes

During Quarter 1 2021/22, the number of investigations completed and sent to the commissioners was 8. There were 38 separate actions made to improve the system or process to prevent recurrence**.**

This excludes a standard recommendation to share learning. This is to support learning being shared across the teams, service, BDU, Trust and wider health economy.   These recommendations have been removed from the analysis below.
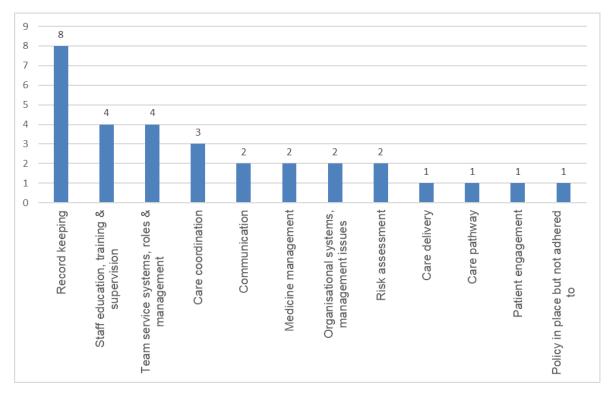
Categorisation of recommendations/actions

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

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

Some commissioners have requested sight of the evidence of completed actions.

Figure 10 shows the action themes arising from the 8 serious incidents completed and sent to commissioners during Quarter 1 2021/22.

Figure 10 Quarter 1 2021/22 completed Serious Incident investigations, by action theme

As shown in Figure 11, suicide including apparent (community team care) incidents had the largest number of actions, which correlates with the number of investigations sent to the commissioners in the quarter.
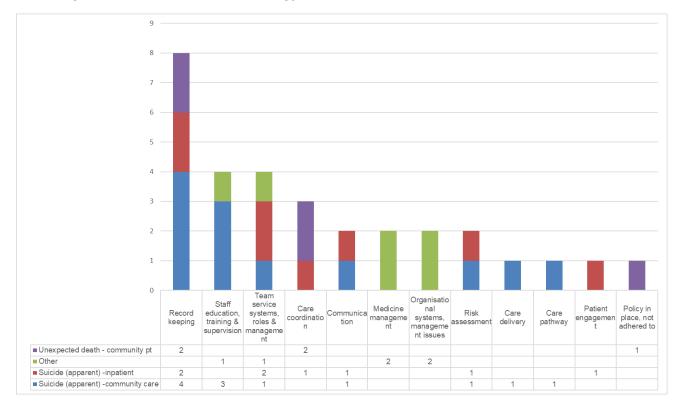
Figure 11 Comparison of action themes from completed Serious Incident investigations in Quarter 1 2021/22, by action theme and serious incident type

	Record keeping	Staff education, training & supervision	Team service systems, roles & management	Care coordination	Communication	Medicine management	Organisational systems, management issues	Risk assessment	Care delivery	Care pathway	Patient engagement	Policy in place, not adhered to
■ Unexpected death - community pt	2			2								1
■ Other		1	1			2	2					
■ Suicide (apparent) -inpatient	2		2	1	1			1			1	
■ Suicide (apparent) -community care	4	3	1		1			1	1	1		

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

Top themes this quarter:
An overview of recommendation from serious incident investigations completed in Q1, are detailed below by action theme:

Record keeping
- An initial Intensive Home-Based Treatment Team Staying Safe Care Plan should be formulated and recorded in the electronic record within 24 hours
- The Trust Care Programme Approach policy regarding the recording of Standard Care Reviews should be reviewed and updated.
- Standard Care Annual Reviews should be clearly identified in the progress notes

- All Intensive Home-Based Treatment Team practitioners to be advised that clinical documentation and risk assessments should be completed as per the Trust guidance on Record Keeping and the Trust policy for assessing and documenting risks.
  The service should also provide assurance that there are processes in place for quality auditing clinical records and practitioners have access to further training if needed.

- In-patient service to ensures that when staff are using pre agreed templates within records that they copy and paste in blank ones rather than from within patient record system and that this is included within a schedule of monitoring and assurance checks within the inpatient unit.

- Standards for record keeping are upheld and that clear evidence of at least annual review is present to embed quality of practice and upholding of policy.

- There were comprehensive records made within Care Director, the local Authority System, documenting a review as well as a care and support plan but this was not recorded on Systm One, the primary recording system.

- Within the multi-disciplinary team (MDT) template (ward rounds) it is recommended that the quality of detail captured regarding risk, changes to risk, discharge planning and risk management be monitored as part of the identified quality assurance and monitoring process established on the ward.

- Written records were incomplete. There was no up to date Comprehensive assessment, Crisis and Contingency plan, current care plan or risk assessment.

Team service systems, roles and management

- To review how information from multidisciplinary meetings / clinical review meetings and information in relation to FACT is recorded in the individual clinical records of service users to ensure that they are clearly headed, comprehensive and accurate.
- Review the comprehensive bespoke ward improvement action plan to ensure that it includes areas of need identified in the investigation, a review of the human factors identified should be conducted to extract themes discussed by staff and patient experience, to enhance the aims and objectives and is inclusive of the staff in the process.

- Review of how preceptorship is allocated in the ward environment. Ensuring experienced staff are used appropriately and highlight any gaps where this cannot be undertaken to a satisfactory standard

- Review the present process in place for community in-reach to inpatient units to help identify early in the admission process, areas of increased service user need/risk and achieve a standard for inpatient CPA reviews and discharge planning inclusive of community care teams and aid the service user.

-
- **Care coordination**

- Ensure that the Core Pathway lead health care professionals maintain the minimum standard for annual care records reviews for care cluster, risk assessment, care planning and non-CPA updated records, this should include the following: A review of care cluster and Non-CPA record update.
  CPA in-reach co-ordination and discharge planning required during inpatient admission.
- The CMHT ensures that care coordination continues alongside any input from the IHBT Team.

- The decision to change the level of care from an allocated care coordinator to being overseen in Out Patient Clinic was not documented with the clinical record and therefore there was no documented rationale for this change.

- The process for allocation and involvement of a care co-ordinator in the discharge process, to ensure that the care coordinator is involved within the discharge meeting is included within the Safer Discharge from Hospital Project and that a monitoring schedule is established to monitor this once established.

Risk assessment
- To provide assurance that processes are in place that ensure all service users accepted on the enhanced care pathway have a risk assessment in place within expected timeframes and that risk assessments are updated when required in line with Trust policies.

- As part of the ongoing inpatient quality monitoring and assurance on the application of Formulation Informed Risk management (FIRM) the ward should ensure that a quality check on the quality of information contained within FIRM Risk tool is completed at regular intervals.

- Ensure that clinical care discussion around positive risk taking are clearly documented within the clinical records, as part of a formulated risk assessment including any crisis management and keep safe/keep with the aims of improving collaborative care planning and sharing information across the wider teams

- In-patient service should ensure that risk assessments are reviewed and updated whenever there are changes in clinical risk as per the Clinical Risk Assessment, Management and Training Policy and that this is included within a schedule of monitoring and action planning.

Staff education, training and supervision

- Develop a formal process for ensuring that staff are competent with the medications they are administering. This may form part of the quality work already commenced with pharmacy colleagues. Work will be undertaken to ensure that this training can be captured on Electronic Staff Record.

- For both services to ensure all practitioners are aware of and have available and easy access to the Trust Guidance for Healthcare Practitioners in Relation to Threats to Kill (December 2020) where threats to kill have been identified.

- For practitioners from both services to ensure that where Domestic Abuse / Domestic Violence / Controlling & Coercive Behaviours / Threats to Kill have been identified, then these are addressed in line with guidance within Trust policies in relation to Safeguarding Adults, Domestic Abuse / Violence and the Trust Threats to Kill guidance, with appropriate support offered to the victim in conjunction with any other mental health related recommendations and interventions. If out of hours, specialist Safeguarding advice should be sought as soon possible when available and if required.

- For the Intensive Home-Based Treatment Team service to access the West Yorkshire Quality Mark Domestic Abuse training offered by the Trust Safeguarding team and the Psychiatric Liaison Team service to access refresher training if needed

- **Care pathway**

- To provide assurance that processes are in place that ensure all service users have care plans, relevant safeguarding care plans and crisis contingency / staying well care plans in place within expected timeframes in line with Trust policies.
- As part of the ongoing quality assurance and monitoring process in place across the inpatient units that a survey is conducted to identify the number of patients who have been involved with and provided with a copy of the care plan/safe plan and that the information be used to help shape the wards improvements in collaborative care planning.

Care delivery

- For the Community Mental Health Enhanced Pathway Team to review the process of agreeing administration days for team practitioners to ensure that the agreed days are used for the purpose they are intended for.
- In-patient service to utilise the findings from the previously recommended inpatient dip sample for collaborative care planning and utilise this information to help solution challenges on inclusion of service user and carers in care planning and safety planning.
- Communication
- Develop an SBAR. Taking the learning from the incident regarding communications on risk, collaborative review of risk and the assessment of a person prior to leave and upon return
- Where individuals that are assessed by the Psychiatric Liaison Team or Intensive Home-Based Treatment Team have been identified as having had recent contact with another NHS mental health Trust or been admitted as an inpatient to another NHS mental health Trust prior to an assessment, it is recommended that direct contact is made or attempted with that relevant NHS mental health Trust to request any additional relevant clinical information to help inform the planned assessments. Attempts to make contact should be proportionate and should not impact on the timeframe to complete assessments, and should be formally recorded in the clinical records.

Medicine management
- A regular review of medication errors plotted against nursing bank/ agency usage should be undertaken and reported at Safe Medicines Practice Group and senior nursing forum
- Introduction of 'protection from interruption' when medication rounds are taking place. This may be in the form of nurse administering medications wearing a visible sign, e.g. coloured tabard, to prevent interruptions.

Organisational systems, management issues

- A more robust approach should be taken to the undertaking of 'Medicines with Respect' training. This should be a Trust wide standard that is produced by the Safe Medicines Practices Group. It is recommended that a written reflection is undertaken and the staff member does not do medications for 3 days to allow them to reflect if this is the first error, subsequent errors in a fixed time frame (i.e. 1-2 years) would lead to an increased number of days withdrawn from medication duties, to allow reflection to be undertaken and reviewed with a more senior nurse. Ideally this would be within the service but out with direct line management.

- The Corporate Nursing Team in conjunction with Learning & Development will consider the development of a Mentorship Programme to further aid the development of Ward Mangers. This will consolidate learning from other middle management programmes offered.

Patient engagement

- It is recommended that the ward reviews how the patient experience is currently captured in respect to the area of patient experience in ward round and involvement in care planning, risk assessment and crisis management/keep safe plans, with the aim to achieve improvements in the care experience for inpatients

Carers/family

- In-patient service completes a survey to identify the number of patients whose details have been updated within 24 hours of admission and that the information be used to inform policy and improve practice.
- Policy and procedure - in place but not adhered to
- The Service user was subject to S117 Aftercare. There was no S117 Care Plan in place reflecting the current needs, monitoring and reviewing arrangements.

6.   Learning from Healthcare Deaths Report Annual Cumulative Report 2021/22 (covering the period 1/4/2021 – 30/6/2021)

6.1   Background context

6.1.1   Introduction

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

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

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

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

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

6.1.2   Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic clinical information system and on its Datix system where the death requires reporting.

The Trust Learning from Deaths policy was updated in January 2020. It sets out how deaths should be responded to, which deaths are reportable, how we should engage families and how reportable deaths will be reviewed. Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny the Trust has adopted in line with the National Quality Board guidance:

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

During the first Covid 19 period earlier in the year, the Learning from deaths policy was considered to see if reporting guidance needed to change. It was felt that the existing reporting requirements did not need to change during this period. There has been a national requirement to report externally any inpatient death related to Covid 19. There is already a requirement to report any inpatient death on Datix, so the guidance did not require revising. This continues to be the case.

6.1.3 Next Steps

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

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

6.2 Annual Cumulative Dashboard Report 2021/2022 covering the period 1/4/2021 – 30/6/2021

Figure 12 Summary of 2021/22 Annual Death reporting by financial quarter to 30/6/2021*
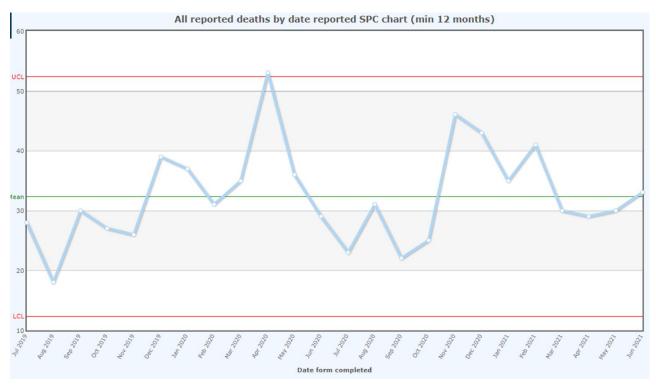
	Reporting criteria	2020/21 total	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	2021/22 Total
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death**	4085	713				
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	411	91				
3	Total Number of deaths which were in scope	335	77				
4	Total Number of deaths reported on Datix that were not in the Trust's scope	76	14				

*Dashboard format and content as agreed by Northern Alliance group

**Data extracted from Business Intelligence Dashboards. Data is refreshed each quarter so figures may differ from previous reports.   Data changes where records may have been amended or added within live systems

As shown in Figure 12, row 2 shows that 91 deaths were reported on Datix during Quarter 1. This is lower than 2020/21 Q4 (115). Deaths reported are mainly deaths of those who have died in the community. All reported deaths are reviewed to understand if the death meets the critieria for being in scope for mortality review (3 levels described earlier). Figure 13 shows a Statistical Process Control chart of all reported deaths (by reported date) between 1/7/2019 – 30/6/2021. There is an area outside the parameters of normal variation which aligns with the impact of Covid 19 (special cause variation) in April 2020.

Figure 13 Statistical Process Control Report of all deaths reported 1/7/2019-30/6/2021 by date reported

In line with national reporting of deaths, we are required to separate our reporting of in scope deaths into learning disability deaths and all other deaths. Figure 14 shows all deaths reported by date reported and BDU.

Figure 14 Breakdown of the total number of in scope deaths reviewed in 2021/22 by service area by financial quarter

Financial quarter - date reported	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 Services	Learning Disability services	Total
21/22 Q1	3	11	15	19	20	5	1	3	77
21/22 Q2									
21/22 Q3									
21/22 Q4									
Total	3	11	15	19	20	5	1	3	77

Figure 15 shows the review process for the in scope deaths.

Figure 15 Summary of total number of all in scope deaths in 2021/22 by the mortality review process

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review		Level 3: Investigation				Total
	Death certified	Manager's 48-hour review	Structured Judgment Review	Learning Disability Mortality Review (LeDeR)	Serious Incident Investigation	Service Level Investigation	Significant Event Analysis (SEA)	
21/22 Q1	35	14	12	5	6	4	1	77
21/22 Q2								
21/22 Q3								
21/22 Q4								
Total								

Figure 16 below is all deaths where the patient did not have a learning disability.

Figure 16 Summary of total number of in scope deaths in 2021/22 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review		Level 3: Investigation			Total
	Death certified	Manager's 48-hour review	Structured Judgment Review	Serious Incident Investigation	Service Level Investigation	Significant Event Analysis (SEA)	
21/22 Q1	35	14	12	6	4	1	72
21/22 Q2							
21/22 Q3							
21/22 Q4							
Total							

The death of any patient with a Learning Disability has to be reported to the Learning Disability Mortality Review Programme (LeDeR). It should be noted that the figures may not tally with the figures above. This is because we identify Learning Disability not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability irrespective of where they were cared for. Figure 14 shows there were 3 deaths reported by Learning Disability teams (all community). Figure 15 and 17 show that 5 deaths were reported to LeDeR. The LD deaths reported to LeDeR included two death reported by Epilepsy services where the patient had a Learning Disabilty but was not under the care of a Learning disabilty service.

Financial quarter - date reported	Reported to LeDeR	Pending reporting to LeDeR	Total
21/22 Q1	5	0	5
21/22 Q2			
21/22 Q3			
21/22 Q4			
Total			

Figure 18 shows 6 deaths reported by inpatient services across the Trust during 2021/22 to date. There were none relating to Learning Disability Services.

Figure 18 Inpatient deaths in 2021/22 by date reported

Financial quarter - date reported	Older People's Services			Working aged adults Inpatients		Forensic Services	
	Beechdale Ward (OPS), The Dales	Crofton Ward (OPS), Wakefield	Willow Ward, Barnsley	Ashdale Ward, Calderdale	Ward 18, Kirklees	Priestley Ward	Total
21/22 Q1	1	1	1	1	1	1	6
21/22 Q2							
21/22 Q3							
21/22 Q4							
Total	1	1	1	1	1	1	6

Figure 19 shows the type of deaths reported that were in scope, by the BDU. During Quarter 1, two deaths were related to Covid 19, both reported by community teams.

Figure 19 Type of deaths in scope during Quarter 1 2021/22

Financial quarter - date reported	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 Services	Learning Disability services	Total
Death - confirmed from physical/natural causes	3	5	10	9	14	4	0	3	48
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	1	2	4	3	0	0	0	10
Suicide (apparent) - community team care - current episode	0	2	0	3	1	0	0	0	6
Death - confirmed from infection	0	1	1	1	2	0	0	0	5
Suicide (apparent) - community team care - discharged	0	2	2	1	0	0	0	0	5
Death - confirmed related to substance misuse (drug and/or alcohol)	0	0	0	1	0	0	1	0	2
Patient choking	0	0	0	0	0	1	0	0	1
Total	3	11	15	19	20	5*	1*	3	77

*The figures in red are the inpatient deaths

Trust Board
28 September 2021
Agenda item 8.3

Title:	**Financial Planning Update re H2 (pre guidance)**
Paper prepared by:	Director of Finance and Resources
Purpose:	To provide the Trust Board with an update of the financial planning process for H2 based on what we know pre the formal guidance being issued. A further verbal update can be provided at the meeting, if the guidance is published in advance of the Board meeting.
Mission/values:	Use of resources
Any background papers/ previously considered by:	Previous H1 plan. Regular finance reports to the Trust Board Detailed review at the Financial Oversight Group
Executive summary:	• The financial regime for H2 is continuing on in a similar block payment theme to H1. • There will be no hard close at H1 so all providers will be able to carry forward their positions into H2 like any normal financial year. • Efficiency requirements are anticipated to be c2% for Trusts not previously in deficit pre changes to the finance regime. • Covid funding is earmarked to be reduced by 5% for H2 with methodologies being agreed via the ICS. • Pay awards will be fully funded. • NHSE/I are negotiating a 3 year settlement with Treasury for 22/23 – 24/25. This will help longer term planning across the ICS and support the delivery of capital investment within the CDEL control totals. • Additional new funding announced is focused on elective and Acute recovery with no additional money ringfenced for mental health. Seeing through the continued investment in the Mental Health Investment Standard and the long-term plan remains an area of focus and we need to continually negotiate for the benefit of our services and service users. • There has been no clarity about the longer-term planning and timetable for 22/23. This is unlikely to get much traction pre December as the outlined planning process for H2 runs until November 21. • A further verbal update can be provided at the meeting if and once we have received the H2 planning national guidance from NHSE/i.
Recommendation:	**It is recommended that the Trust Board DISCUSS and COMMENT on this report.**
Private session:	N/A

With **all of us** in mind.

Planning Update – (Pre guidance) - September 2021

Introduction

At present, we are still awaiting the formal guidance from NHS Improvement (NHSI) in relation to planning for H2 (October – March 22). However, some aspects of intel have started to feed down via the ICS and a national Director of Finance briefing in relation to the anticipated guidance.

The guidance is provisionally due on the 16th September. This however has also been inferred could be a week or so later. The planning process is expected to run through to a final submission in November. This will be a key focus of the FIP agenda for October.

In summary, the bulk of the finance regime will remain in place for H2 aligned to a similar continued approach to that applied during H1.

Summary position – What we know.

H1 Close
There will be no hard close at H1 so all providers will be able to carry forward their positions into H2 like any normal financial year. This could perhaps lead to some providers increasing their H1 reported surplus but it's perhaps irrelevant.

Core Changes

Blocks
The primary block arrangements will continue for H2. The primary changes are;

Covid
Nationally covid funding allocations are being reduced by 5%. This is not expected to be a concern as this remains above our current true covid cost level. The Trust will need to ensure a fair approach is derived and agreed via the ICS as to how this reduction is applied and the impact of winter is felt across the wider system.

Efficiency
Although a headline figure of 3% was quoted (FYE) the actual methodology results in a efficiency requirement of no more than 2% unless you were a provider and system previously working to a stretched target due to previous deficit plans.

In summary, this level of challenge will not be a concern in the short term re H2 but the ask will need to be built into a new efficiency and productivity process for 22/23 on a recurrent basis. The pressure, and efficiency requirement, is likely to increase further in 22/23.

Pay Award
The pay award will be fully funded in H2. As the costs are being expensed in H1, contra income is to be accrued. The full funding will be included in H2. CCGs may feel some pressure from the pay award if they didn't follow the H1 guidance correctly.

Provider to Provider Recharges
The WY ICS agreed a local approach to not reinstate provider to provider recharges in H1. This arrangement is likely to be extended into H2. This isn't the national approach and will need further consideration with regards to Provider collaboratives which are assumed to be treated as an exception.

Other lead providers will be able to commence charging us for adult secure Out of area placements. We can do the same. However, the local agreement could restrict us from recharging other providers within the WY ICS unless part of the pre-agreed block.

H2 planning – ICS headlines
Pending national planning guidance, the ICS has begun consolidating H2 forecast positions for each organisation. At this stage it's a headline surplus / deficit value and communication of key assumptions being made. This is a non-committal value but allows the ICS to gain an early understanding of the potential H2 position and financial risks.

The Trust has continued to provide a detailed monthly forecast, as normal, and on this basis a H2 £2m surplus has been noted. This includes key assumptions around levels of mental health investment and associated recruitment, pressures linked to covid and out of area placements and additional spending requirements.

The detail is being reviewed and validated and a full paper will be shared with FIP as soon as possible.

Timetable
The provisional timetable was developed under the expectation planning guidance would be issued on the 16th September. This is now not expected and thus the below ICS timetable agreed will need to be reworked.

ICS process
1. Allocations announced on 16th September (assumption now delayed a week)
2. ICS issue system wide impact of key assumptions
3. Draft submissions to be made **by noon on 23rd September** (reflecting any other cost changes / efficiencies identified since pre guidance submission where applicable)
4. ICS to present a system wide summary for presentation at Finance Forum on the morning of Friday 24th September. Next steps to be agreed at Finance Forum.

National Process (details pending)

    1. The national process will run through October (Draft) to November (Final). Dates TBC

2022/23 Planning

There has been no clarity about the longer-term planning and timetable for 22/23. This is unlikely to get much traction pre December and the outlines planning process for H2 runs until November 21.

Capital

NHSE/I are negotiating a 3 year settlement with Treasury for 22/23 – 24/25. This will help longer term planning across the ICS and support the delivery of capital investment within the CDEL control totals.

Other general updates

The focus nationally is on funding the elective backlog and the national mental health team is explaining the importance of addressing mental health waiting times. As such the focus on understanding waiting times in each trust for both assessment and treatment needs to be strong. We need to be in a position to ensure our ICSs are aware of them as well.

On a similar basis, reporting and understanding of out of area bed pressures needs to be clear with robust forecasting. This is particular key where the national target to eradicate OOA usage is not achieved or continues beyond 21/22.

Nationally, the number being quoted is there is a backlog of 1.6m people awaiting mental health care. However, none of the recent announced uplift in funds for H2 is ringfenced or earmarked as specifically for Mental Health. We will need to continue to raise this and fight for continued MH parity of esteem.

We have also been encouraged to ensure that this information is made available to our MPs when we meet with them.

Trust Board 28 September 2021
Agenda item 8.4

Title:	**Emergency Preparedness, Resilience and Response [EPRR] Compliance**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) clearly set out the EPRR standards which NHS Organisations and providers of NHS-funded care must meet.
Mission / values:	SWYPFT as a healthcare provider of mental health, learning disability, autism and community services is mandated to provide assurances of compliance with these standards which enable providers of health care to share a common purpose and to co-ordinate EPRR activities.
Any background papers / previously considered by:	Executive Management Team (EMT) reviewed the compliance report on 2nd September 2021.
Executive summary:	The new standards were published on 26 July 2021 with a request for compliance status by 29 October 2021. A self-assessment toolkit was provided which automatically creates an action plan for the following 12 months; this along with the self-assessment is to be submitted to NHS England. This Action Plan will form the core work streams for the 2021/22 action plan for EPRR and as such supersedes any previous EPRR work programmes. Due to the Coronavirus pandemic, NHSE have reviewed the standards for 2021 and reduced this year's assurance requirements to give organisations the opportunity to recover from the pandemic. The standards that have been removed are still a legal requirement under the Civil Contingencies Act 2004 and will be re-implemented next year. Organisations should continue to assure themselves that these standards are being met. SWYPFT is mandated to provide assurances against 37 standards. These standards enable providers of health care to share a common purpose and to co-ordinate EPRR activities. In addition to this the Trust must also provide assurance against "Deep Dive" standards, which change every year; however, these do not form

With **all of us** in mind.

	part of the final position of the Trust. This year the Deep Dive seeks assurance regarding medical gases and oxygen governance and systems, which is split across 7 standards. Out of the 37 areas requiring compliance, a rolling programme of works has enabled the Trust to achieve total compliance (green) in 35 areas, 1 area of partial compliance (amber) and 1 non-compliant (red), these standards are: • Risk assessment (Partial) – a review of the Community Risk Register and local Risk Register is underway to ensure they are still fit for purpose. This will be completed prior to compliance submission. • Shelter and Evacuation (Non-Compliant) – the creation of a plan support whole site evacuation is required. This is a complex plan, which is being discussed across the region in Task and Finish groups to progress within all organisations. Last year the Trust declared SUBSTANTIAL compliance; this year the Trust will again be declaring SUBSTANTIAL compliance. **Risk Appetite** This plan is in line with the Trust's risk appetite for both clinical services and emergency planning.
Recommendation:	**Trust Board is asked to APPROVE the EPRR compliance report and action plan.**
Private session:	Not applicable

Trust Public Board – 28 September 2021
South West Yorkshire Partnership NHS Foundation Trust Compliance against the NHS England Core Standards for Emergency Preparedness, Resilience & Response

EPRR Core Standards 2021 – Action Plan

Standard	Detail	Organisational Evidence/Comments	Compliance Status	Lead	Target Date
Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Review required. West Yorkshire Community Risk Register (WY CRR) obtained – to review organisational risk assessments and register to ensure any updates captured.	Partially compliant	EH	October 2021
Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Works underway regionally to look at this standard due to complexities from a mental health point of view and also multisite/multi geographical location perspective	Non-compliant	EH	October 2022

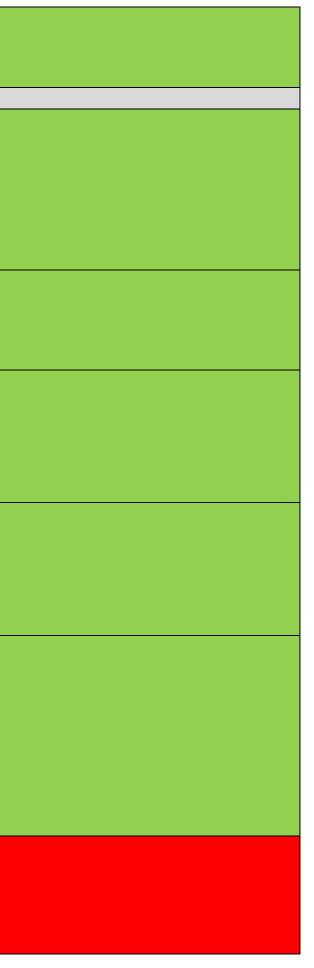| Standard	Detail	Evidence - examples listed below	Organisational Evidence	Self assessment RAG
				Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	• Name and role of appointed individual	Alan Davis, Director of HR, Organisational Development and Estates	Fully compliant
EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy in place - review underway	Fully compliant
EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on:• training and exercises undertaken by the organisation• summary of any business continuity, critical incidents and major incidents experienced by the organisation• lessons identified from incidents and exercises• the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	• Public Board meeting minutes• Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Presented as part of the Safety Services Annual Report in July 2021	Fully compliant
EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Recruited EPRR Assistant during COVID-19 due to clear work pressures within the department	Fully compliant
Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	• Process explicitly described within the EPRR policy statement	See EPRR Policy and Major/Critical Incident plan	Fully compliant
Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Review required	Partially compliant

|				
Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Assessments and matrix in place. Datix utilised to report	Fully compliant
Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Plan in place - under review July 2021	Fully compliant
Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Arrangements should be: • current (although may not have been updated in the last 12 months)• in line with current national guidance• in line with risk assessment • signed off by the appropriate mechanism• shared appropriately with those required to use them• outline any equipment requirements • outline any staff training required	As above	Fully compliant
Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Adverse Weather Plan in place - under review July 2021	Fully compliant
Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Adverse Weather Plan in place - under review July 2021	Fully compliant
Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Community and Mental Health organisations do not usually have any single agency plan in place for mass casualties. After consultation with NHS England EPRR specialists, they advise that if mass casualty plans are in place across the local health economy, and so long as our Trust is signed up to respond in support of that plan, then that is sufficient for compliance.	Fully compliant
Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Works underway regionally to look at this standard due to complexities from a mental health point of view and also multisite/multi geographical location perspective	Non compliant
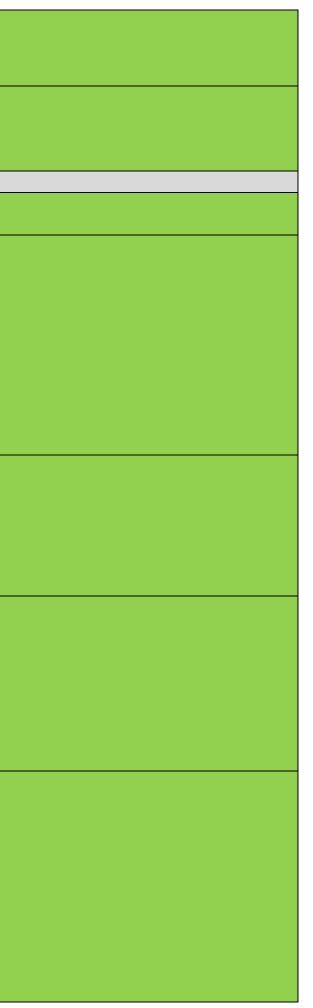
|				
Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Arrangements should be: • current (although may not have been updated in the last 12 months)• in line with current national guidance• in line with risk assessment • signed off by the appropriate mechanism• shared appropriately with those required to use them• outline any equipment requirements • outline any staff training required	Plan in place - processes and exercising schedule being prepared	Fully compliant
Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Media Policy references VIP management Internal and External security teams available to provide secure provision for protected individuals. Regular risk panels undertaken where such cases will be discussed.	Fully compliant
On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	On call management system in place with dedicated packs for on call managers based on their locality and services along with director on call packs. Communication tests completed quarterly to ensure mechanisms continue to be fit for purpose	Fully compliant
Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements		Physical and virtual arrangements in place	Fully compliant
Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans	Trust wide suite of BCPs in place along with departmental BCPs	Fully compliant
Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	• Documented processes for completing, signing off and submitting SitReps	Detailed in the Major/Critical Incident Plan	Fully compliant
Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response• Using lessons identified from previous major incidents to inform the development of future incident response communications• Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes• Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Detailed in the Major/Critical Incident Plan. Media Policy in place and published	Fully compliant
Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Media policy section 5.7	Fully compliant
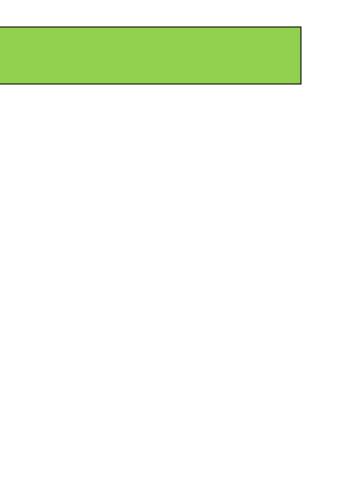
Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	On Call Packs Media Management Policy quotes: In the media management policy it states under 'responsibilities': "Directors on call will receive media queries via the Pinderfields switchboard." And under 'responding to media': "Any queries received out of hours must be referred to the director on-call." Provision of pre-determined comms lines to Directors for out of hours, along with contact for Head of Communications should assistance be required.	Fully compliant
Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Numerous MOU/MAA in place with providers across the patch including West Yorkshire Low and Medium Secure Evacuation Plan, COVID PPE and resources. Regional MOU Plan would be utilised as and when needed with the wider health economy.	Fully compliant
Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	• Documented and signed information sharing protocol• Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Information Sharing Protocols and Inter-agency framework for sharing information in place	Fully compliant
BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	EPRR Policy and Business Continuity Procedures	Fully compliant
BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	As above	Fully compliant
Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	DPST Achieved	Fully compliant
Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Local BCPs in place covering topics stated	Fully compliant
BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	• EPRR policy document or stand-alone Business continuity policy • Board papers • Audit reports	Each BC exercise is reported upon to Business Development Units and provided to the Safety and Resilience Trust Action Group (TAG) - actions from reports are monitored by BDU Senior Management and the Emergency Planning Team.	Fully compliant

BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• EPRR policy document or stand-alone Business continuity policy• Board papers• Action plans	Each BC exercise is reported upon to Business Development Units and provided to the Safety and Resilience TAG - actions from reports are monitored by BDU Senior Management and the EP Team. Lessons learned are shared in appropriate forums.	Fully compliant
Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	• EPRR policy document or stand-alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	System in place to support the identification of business continuity plans from providers and suppliers. This system further supports the national procurement systems. All suppliers contacted to provide assurance of BCPs; works progressing to obtain copies of Business Continuity Plans	Fully compliant
Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN (chemical, biological, radiological and nuclear) incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Detailed in the HAZMAT procedure	Fully compliant
HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	As above	Fully compliant
HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities	As above	Fully compliant
Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf• Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• Completed equipment inventories; including completion date	As above	Fully compliant
Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	As above	Fully compliant

| FFP3 access | Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7. | | PPE stocks maintained and accessible | Fully compliant |

Trust Board 28 September 2021
Agenda item 8.5

Title:	**Service Demand Forecast and Capacity Modelling**
Paper prepared by:	Director of Provider Development
Purpose:	The purpose of this paper is to provide a summary of the key points from the Board discussion at the Strategic meeting on 24 August 2021.
Mission/values:	The development of joined-up care and service response to demand through place-based arrangements is central to the Trust's delivery of responsive services and support in places. 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 service development 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. At the Trust Board Strategic meeting on 24 August 2021, the Board received and discussed a presentation in respect of the work being undertaken in the Trust with regard to service demand forecast and capacity modelling, particularly in context of COVID recovery and health inequalities.
Executive summary:	The Trust is undertaking on-going work in relation to service demand and capacity modelling, particularly in relation to mental health services, and within the following framework: • The wider context and drivers for service demand. • Understanding demand and need (data and insight) relating to mental health services). • Implications for quality, safety, workforce and delivering inclusive services that address inequalities. • Approach to COVID recovery and reset. There is an evidence base for the mental health impacts of some of the aspects of the pandemic that have been seen in previous crises. However, we don't know how comparable this historical analysis will be with the current situation. The Trust has developed a demand modelling tool in close collaboration with local Place-based multi-agency 'health intelligence cells' (or equivalent) to model potential future impact and continue to monitor changes in service demand. This has also been shared with partners within the West Yorkshire mental health, learning disabilities and autism

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collaborative. The tool's benefits include: using population prevalence which allows impact forecasting across the whole mental health service portfolio including primary care, IAPT and CAMHS; the model factors in when increase in people might present in services and primary conditions.

We continue to evolve our approach to using data and insight to inform operational service delivery, recovery and reset across the Trust.

We are particularly mindful that we need to test our demand predictions against real activity data and evolving research over time, and update our assumptions accordingly. This is also in the context of the need to plan services to be able to respond to population needs and address health inequalities.

This work is reported for governance purposes through the Trust's Strategic Recovery and Reset Group. The implications for service safety, quality and our workforce are a key consideration, along with addressing health inequalities.

The key next steps for this work include:

- Refinement of the modelling tool with clinical input to review evidence and refine assumptions.
- Application of the tool at a local level to inform capacity planning for mental health services.
- Validation of generated demand – when will people present to services.
- Supporting Integrated Care Partnerships in each place to inform pathway development to ensure service provision meets increases in demand.
- Evolving evidence review to plan and prepare for any future impacts from Covid-19.
- Community mental health transformation in each district provides opportunities for service changes.

Recommendation:	**Trust Board is asked to RECEIVE and NOTE the summary in this report of the key points relating to the Trust's work on service demand forecast and capacity modelling.**
Private session:	Not applicable.

Trust Board 28 September 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 Health and Care Bill. 2) To provide an update on how the two Integrated Care Systems that the Trust is part of continue to develop their response 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. An update on the NHSEI Integrated Care System Design Framework was also provided to Trust Board in June and July.
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*. In June, NHSE/I published further guidance that was set out in the *Integrated Care System Design Framework*. *The Health and Care Bill* was discussed at the July Board. Trust Board has considered and discussed the details set out in all these 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.

National developments and update

The Health and Care Bill 2021-22 - The bill sets out how the Government intends to reform the delivery of health services and promote integration between health and care in England.   This is the first major primary care legislation on health and care in England since the Health and Social Care Act 2012.   The proposed reforms reflect the proposals set out in the white paper that was published in the spring and discussed at a previous Trust Board meeting.

The Health and Care Bill was introduced in the House of Commons on 6 July 2021 and the second reading took place on 14 July 2021.   The bill will be debated in parliament throughout autumn and winter 2021 and is expected to come into effect in April 2022.

National Guidance
A significant amount of national guidance has been published during the months of August and September.   These are being reviewed in detail by the executive team to ensure that Trust strategies and plans are consistent and aligned with the national guidance.

Early review of the guidance published reinforces the Trust's strategic approach to development in places and as a partner in 2 Integrated Care Systems.   The initial review also highlights strategic priorities that we need to maintain a focus on as discussed during the August Strategy Board.   The summary table (1) attached highlights the key national guidance that is being reviewed and considered.

The Trust is part of two advanced ICSs and is also part of place-based partnerships and provider collaboratives.

WYH ICS has continued to develop the ICS system development and transition plan in response to the white paper and recent national guidance.   A governance working group, chaired by Tim Ryley, the Accountable Officer for Leeds CCG, has been established and is working to align place and system governance arrangements.   The group reports regularly to the Future Design and Transition Group and the Chairs and Leaders Reference Group.   We are a key partner in each of our places and continue to contribute to place arrangements as they evolve - this is set out in more detail in the WYH ICS update paper.

SYB ICS has also established an overarching Steering Group and a Change and Transition Programme Board that provide oversight and support.   A more detailed update on the ICS response to the white paper and related national guidance is included in a separate Board paper.

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	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/legislative update** • **Note update on local ICS response to the white paper**
Private session:	Not applicable.

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Support and guidance

NHS

June 2021	ICS Design Framework	Future ambitions for ICBs
June 2021	Guidance on the employment commitment	What commitment means in practice
July 2021	NHSE direct commissioning functions	Confirming plans for 2022/23 and beyond
August 2021	Pre-Delegation Assessment Framework	Framework to ascertain system capability to assume delegation
August 2021	Working together at scale	Guidance on provider collaboratives
August 2021	Model constitution supporting notes	Additional information and advice on developing ICB constitution
August 2021	ICB functions and governance	Expected governance requirements for ICBs
August 2021	HR framework to support people change	National policy ambition and practical support
August 2021	People function and operating model	Builds on the priorities set out in the People Plan
August 2021	ICB Readiness to Operate Statement	Template for ROS and accompanying checklist
August 2021	Due Diligence guidance	Due diligence process underpinning legal transfers
August 2021	What Good Looks Like	Guidance to digitise, connect and transform services
September 2021	Delivering together for residents	Guidance on involving people and communities
September 2021	Partnerships with the VSCE sector	Guidance on supporting close working with the VSCE sector
September 2021	Effective clinical and care professional leadership	Guidance on distributed clinical and care professional leadership
September 2021	Working with people and communities	Guidance on collaboration with local people and communities
September 2021	Thriving places	Support for systems defining place-based partnerships

▶ **Key documents soon**

Supporting information on managing ICB resources	ICB financial governance guides

Guidance on the functions and governance of the integrated care board, and the model constitution

NHS England and NHS Improvement (NHSE/I) published several integrated care system (ICS) guidance documents and accompanying resources on 19 August to support systems' transition into statutory integrated care boards (ICBs) by 1 April 2022. These include:

1. *Interim guidance on the functions and governance of the ICB*
2. The model ICB constitution and supporting notes (NHSE/I ICS implementation hub)
3. A list of statutory clinical commissioning group (CCG) functions to be conferred on ICBs (NHSE/I ICS implementation hub)
4. *Building strong ICSs everywhere: guidance on the ICS people function*
5. Other guidance, including: an HR framework for developing ICBs, an ICB readiness to operate statement, and due diligence guidance (NHSE/I ICS implementation hub)

This briefing summarises these resources and provides detailed commentary on the ICB functions and governance guidance, model constitution and ICS people guidance. Please contact senior policy manager Georgia Butterworth (georgia.butterworth@nhsproviders.org) if you have any comments or questions.

Summary

- The *Interim guidance on the functions and governance of the ICB* summarises the indicative mandatory governance requirements for ICBs, as set out in draft legislation and NHSE/I policy:
  - Each ICB must set out its governance and leadership arrangements in a constitution for NHSE/I approval by the end of Q4, following an engagement process.
  - The guidance confirms the minimum requirements and current expectations regarding ICB board appointments and membership. For example, ICB designate chief executives must be identified by the end of November, and other ICB board roles confirmed by the end of Q4.
  - Systems are expected to develop a "functions and decision map" alongside the constitution, showing governance arrangements are in place within the ICB and with ICS partners.
  - The ICB board will be responsible for: formulating a strategy for the organisation; holding the organisation to account for the delivery of the strategy; and shaping a healthy culture for the organisation and wider ICS partnership.

- The guidance also includes key considerations for system leaders as they design these arrangements, including for example managing conflicts of interest.
- The ICB functions and governance guidance document should be read alongside the model constitution and interim guidance on CCG functions to be conferred on ICBs:
  - The Health and Care Bill (the Bill) requires each ICB to have a constitution. NHSE/I has developed a template based on the CCG constitution to guide its development and associated consultation.
  - This model constitution covers the composition of the board, appointments process (including a nomination and selection process for partner members) and arrangements for remuneration.
  - The model constitution sets out further detail on how ICBs must ensure a balance of perspectives on the board (e.g. from all provider types) and in the ICB's decision-making process. We have been calling for this mechanism and are pleased to see it embedded here.
  - The interim guidance on CCG functions transferring to ICBs sets out the complete list of statutory CCG functions that NHSE/I expect to be conferred on ICBs in April 2022. The guidance also summarises actions that designate ICB leaders should take, with CCGs, to prepare to discharge their statutory functions as ICBs.
- The ICS people function guidance builds on the priorities set out in the People Plan and aims to support ICBs and their partners to deliver outcome-based people functions from April 2022.
- The HR framework provides practical support for CCGs as they transition to statutory ICBs. NHSE/I states that the ICS readiness to operate statement and checklist will support system leaders to assess progress and transition towards the establishment of ICBs. The due diligence guidance outlines legal processes in relation to the establishment of ICBs and the abolition of CCGs.

1. Summary of the guidance on ICB functions and governance

This interim guidance builds on the ICB governance arrangements outlined in the Bill and *ICS design framework*. The statutory instruments and guidance enabling the ICB and integrated care partnership (ICP) cannot be made formally until the Bill is enacted, which is expected in April 2022, so this interim guidance aims to support system partners to make the necessary preparations. It confirms the 'must do' requirements (subject to legislation) and sets out key considerations to inform local discussions on the design and implementation of ICBs and ICPs (see Annex 1).

NHSE/I expects system leaders to use the guidance and accompanying resources to inform aspects of their transition to statutory organisations in April 2022, including:

- The development of the ICB constitution, following engagement with relevant partners and confirmation that ICB designate board members are supportive of its terms, with a final version being approved by NHSE/I by the end of Q4.
- ICB board recruitment, with designate chief executives identified by November; a designate finance director, medical director, director of nursing and other executive roles in the ICB identified before the end of Q4; and designate partner members and any other designate ICB senior roles identified by the end of Q4.
- Commissioning functions organised across the ICS footprint, with decisions on arrangements at system and place level being finalised by the end of Q3.
- Functions and decision map showing arrangements within the ICB and with ICS partners, with a final version due before the end of Q4.

NHSE/I expect the core components of the ICB governance arrangements to include:
- A statutory committee called the ICP, with the expectation that each ICB will need to align its constitution and governance with the ICP. The guidance highlights the key role of ICPs, as set out in the *ICS design framework*, and refers to new ICP guidance that will be issued by the Department of Health and Social Care, in partnership with NHSE/I and the Local Government Association.
- A statutory body called the ICB, with the expectation that each ICB will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. The guidance references the 12 key functions of the ICB as outlined in the *ICS design framework*.
- Place-based partnerships, with the expectation that ICBs will be able to arrange for decisions to be made by/with place-based partnerships, with the ICB remaining accountable for NHS resources at place-level. Each ICB should therefore set out the role of place-based leaders within its governance arrangements.
- Provider collaboratives, with the expectation that provider collaboratives agree specific objectives with one or more ICB, as highlighted in NHSE/I's recent guidance (August 2021).

NHSE/I notes that this is not an exhaustive list and states that systems will want to consider a much wider range of governance vehicles to conduct their business.

ICB commissioning functions

From April 2022, the statutory functions that currently sit with CCGs will be conferred on ICBs, along with staff, assets and liabilities (including commissioning responsibilities and contracts). Relevant CCG duties will be transferred, including those regarding health inequalities, quality, safeguarding, children

in care and children and young people with special educational needs or disability. The full expected list of CCG functions to be conferred has been published (see summary in section 3 below).

NHSE/I reiterates the intention to delegate some direct commissioning functions to ICBs as soon as operationally feasible from April 2022. NHSE/I wrote to trusts in July setting out these changes. Statutory ICBs will also have the flexibility to deliver commissioning activities differently e.g. with providers/local authorities, subject to legislation.

Decision-making within an ICB

With regards to decision making, NHSE/I expects ICBs to publish a scheme of reservation and delegation which sets out:

1. Functions that are reserved to the board
2. Functions that have been delegated to an individual or committees/sub committees
3. Functions delegated to another body or to be exercised jointly with another body

ICBs must also develop a functions and decision map that:

- Is locally defined
- Sets out where decisions are taken
- Outlines the roles of different committees/partnerships
- Is easily understood by the public

Board of the ICB, including membership, remuneration and committees

The guidance provides a list of the minimum membership of the unitary board of the ICB, which reflects the list in the *ICS design framework*. It also outlines the unitary board's key responsibilities as:

- Formulating a strategy for the organisation
- Holding the organisation to account for the delivery of the strategy
- Shaping a healthy culture for the organisation and the wider ICS partnership

The guidance makes clear that ICB executives will be employed or seconded to the ICB and will be paid as employees. Independent chairs and non-executive members will be remunerated for their time (in line with forthcoming NHSE/I guidance). The legislation will also allow for the 'partner' members to be remunerated where relevant. The board will decide remuneration for board members not employed by the ICB, but all bodies should ensure no members are paid twice for the same time by different organisations.

The guidance outlines the ways in which ICBs must demonstrate how they are driving equality, diversity and inclusion (EDI), ensuring for example that: the workforce represents the diversity of the NHS; the culture promotes inclusion and embraces diversity; and employees and board members display inclusive behaviour.

The guidance outlines the fact that the legislation is expected to require all ICBs to establish an audit committee and a remuneration committee, as well as giving ICBs the power to appoint individuals who are not board members or ICB staff to be committee members and to delegate its functions to be exercised by or jointly with partners e.g. trusts, local authorities, other ICBs, or NHSE/I.

ICBs will have statutory duties regarding the management of conflicts of interest, including maintaining one or more registers for board members, committee members and employees. The guiding principle for any conflict of interest policy is to ensure that decisions are made in the public interest by avoiding any undue influence. ICB boards are encouraged to set aside the necessary time to debate and explore these issues as part of their developmental journey.

NHS Providers view

This interim guidance document on ICB functions and governance begins to build on the requirements set out in the *ICS design framework* (June 2021) and the Health and Care Bill (as introduced in July 2021). It provides some further clarity on the role and responsibilities of the ICB, while leaving scope for the ICB and its constituent organisations to determine local governance infrastructures. We support NHSE/I's intention to maintain a permissive framework for systems and will engage with trust leaders to assess whether this guidance enables sufficient local flexibility for systems to continue designing what works best for their local populations, services and circumstances. As the new ICS model evolves, the guidance will also need to be adaptable in the context of any issues that may arise.

Trust leaders and their local partners are already involved in many different forms of collaboration, which all aim to improve services and patient care, and deliver efficient use of resources, in a similar vein to the new Triple Aim policy which will be implemented through the Bill. Trusts and their partners are already designing, delivering and overseeing collaborative strategies, and managing risk effectively, in the absence of the ICB structure. Systems and NHSE/I national and regional teams must continue to acknowledge this reality and work with it, rather than create a whole separate ICB governance infrastructure. Building on what works in existing ICS governance, and keeping focused on the purpose and aims, will be crucial to the success of system working.

We have engaged extensively with NHSE/I in the design of ICBs, including emphasising the importance of the full range of provider types having sufficient access and input to the ICB decision-making process. While we welcome the requirement in the model constitution on ICBs to establish a mechanism which enables the views of trusts to feed into ICB decisions, this ICB governance guidance only states that the constitution must confirm that ICB board members are supportive of its terms; it does not explicitly require the ICB to ensure all trusts and wider partners are involved in the development of the constitution and/or supportive of its terms, nor provide recourse to a challenge function in extremis. If the ICB is not established by its constituent organisations, it risks setting up a divisive culture in the system. This risk is exacerbated by the articulation of ICBs as separate bodies to their constituent organisations, rather than being a sum of their parts. The ICB needs to be accountable to its local populations and constituent organisations to realise its ambitions.

We support the principles of subsidiarity, minimal bureaucracy and clear accountabilities as set out in Annex 1 to inform the design and development of local system governance arrangements. We also support the focus on ICBs demonstrating how they are driving EDI throughout the system, and the emphasis on the ICP challenging all partners to demonstrate progress in reducing inequalities and improving outcomes. NHSE/I regional teams will need to support systems to develop clear decision-making arrangements and accountabilities. The guidance refers to ICB boards not only formulating the strategy for the organisation but also holding the organisation to account for the delivery of the strategy. It also states that provider collaboratives will agree specific objectives with one or more ICB, and agree how to achieve those objectives, but the ICB will be accountable. These complex arrangements will be challenging for trusts and their partners to navigate and avoid overlapping, unclear accountabilities.

Another challenge for ICBs and their constituent organisations will be how to manage conflicts of interest. While trusts and their partners already navigate these challenges, the new provider selection regime and collaborative approach to decision-making will make contracting and commissioning decisions more complex. We look forward to continuing to work with NHSE/I and partners to explore these outstanding questions and concerns in more detail.

2. Model constitution and supporting notes

NHSE/I has developed a model constitution – based on the current CCG constitution – for system leaders and CCGs to guide the development of, and consultation on, their ICB constitution. The

model constitution is based on the proposed requirements as set out in the Bill. The constitution will need to be updated in line with any changes to the legislation and NHSE/I policy.

The ICB can apply to the newly merged NHSE to vary the constitution (NHSE/I will publish an application procedure), or NHSE can vary the constitution under its own initiative. The constitution should set out a local procedure for who may propose a change to the constitution and how this is done, who will be consulted on any proposed changes, and how the decision about proposed changes will be taken prior to an application being made to NHSE (typically this will be the ICB board).

The supporting notes accompanying the model constitution suggest content beyond the legal requirements (as currently drafted) of what needs to be included in the ICB constitution, for example:

- Explaining how the ICB differs from CCGs, and drawing out mutual accountability arrangements;
- Referring to how this constitution aligns with the ICP's terms of reference; and
- Clarifying that ICBs may decide to have more than one 'ordinary member' from each sector, and more than two independent non-executive members, beyond the statutory minimum and NHSE/I policy requirements.

Composition of the board of the ICB

The constitution of the ICB must set out board roles and membership and ensure a balance of perspectives on the board. For example, the ICB must ensure that the perspectives of all sectors and types of provider within the ICB's area are included (e.g. acute, mental health, community and specialist). ICBs will need to ensure that the views of patients, carers and the public are heard and included in the board decision-making process, along with clinical and professional groups. Beyond the composition of the board itself, ICBs should ensure there are mechanisms for including the full range of perspectives through its decision-making model and structures. ICBs will also be expected to comply with good governance practices, including on board size, to allow appropriate decision-making to take place. The constitution recommends limiting the number of participants as most parties will play their largest role in the partnership or in operational fora and task and finish groups.

Appointments process for the board

The constitution of the ICB must set out board roles, the process of appointing partner members and eligibility criteria that must be fulfilled. Each member of the ICB must:

- By law be subject to the chair's approval (excluding the chief executive who is approved by NHSE/I)
- Comply with the criteria of the fit and proper person test
- Be willing to uphold the Nolan Principles
- Fulfil the requirements in the role specification
- Meet the eligibility criteria set out in the constitution (some nationally and some locally defined)

The constitution will also set out the appointments process for ICB board members, including the terms and number of terms permitted. NHSE/I will publish a process to describe how chairs and chief executives will be appointed, and how appointments proposed by ICBs will be approved.

The Bill states that the partner members are to be 'nominated jointly' by their respective sector. The constitution must set out the appointment process of partner members, including who may take part (regulations will set out which organisations can take part in any nomination process), what the procedure entails and what the decision-making arrangement is. The process should reflect NHSE/I guidance. As a minimum, it must include two parts:

1. An element that is designed to build the confidence of stakeholders that the perspective of the individual will contribute to the board discussions (the nomination process).
2. An element that is designed to assess that the individual can demonstrate they have the skills, knowledge, experience and attributes required to fulfil the role (the selection process).

The partner member from the trust sector will need to be an executive director of a trust within the ICB's area. The *ICS design framework* states this will often be the chief executive.

While the ICB board should normally include medical/nursing/finance director roles, NHSE/I recognises they may be fulfilled in different ways, such as by different job titles or holding other responsibilities with a wider portfolio. They may be an employee of another organisation as well as the ICB. The medical director must be a registered medical practitioner, but the director of nursing does not have to be a registered nurse or midwife.

ICBs may choose to appoint more than the minimum requirement of two independent members. It is good practice for one independent member to be appointed as a senior independent member. The ICB may want to add other local criteria, such as requiring non-executive members to have a connection to the ICB area. The ICB should consider whether individuals who have served in

equivalent roles on the boards of previous and current NHS bodies locally could be sufficiently independent. The chair's terms of appointment will be determined by NHSE/I.

Arrangements for remuneration will be agreed by the remuneration committee in line with the ICB's policy and any NHSE/I guidance. Remuneration for chairs, non-executives and chief executives will be set by NHSE/I. The duties of the remuneration committee will be locally determined, such as setting the ICB pay policy and setting remuneration for board members.

Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required, and the constitution will set out the process for voting (which should be considered a last resort).

Arrangements for the exercise of ICB functions

The ICB may grant authority to any of its members/employees or a committee/sub-committee to act on its behalf. The ICB may also arrange for functions to be exercised by a joint committee or enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund. The ICB remains accountable for all its functions, including those it has delegated, so the constitution should describe local arrangements for assurance. ICB committees may include or be formed from individuals who are neither employees of nor board members of the ICB.

Arrangements for conflict of interest, accountability and transparency

The ICB will be required to manage actual and potential conflicts of interest to ensure the integrity of the ICB's decision-making processes. For example, where independent providers hold contracts for services, NHSE/I sees it would be appropriate for the ICB to involve them in decisions, such as about pathway design at place level, but this would be distinct from contracting and commissioning considerations. NHSE/I may issue guidance for ICBs in due course, but ICBs should follow NHS-wide guidance for now. ICBs may choose to appoint a conflicts of interest guardian.

The ICB will demonstrate its accountability to local people, stakeholders and NHSE/I. Board and committee meetings will be held in public, with papers and minutes published. The ICB will comply with the requirements of the NHS provider selection regime and ensure there are appropriate governance structures that will deal with any challenges following decisions. ICBs will need to publish their intentions for arranging services in advance, publishing contracts awarded and keeping records of decision-making.

NHS Providers view

We welcome the publication of the model constitution for ICBs as a helpful means of supporting systems to prepare for their transition to statutory bodies in April 2022. Creating template documents that can be adapted locally is helpful for systems and their constituent organisations to avoid reinventing the wheel. The Bill includes a lot of detail as to what must be in the ICB constitution, so while we support NHSE/I's intention to enable maximum local flexibility, we are conscious there is little latitude for NHSE/I to streamline the statutory requirements. We will continue to engage with trust leaders on how emerging frameworks and guidance documents are carrying through the ambition of local flexibility to implementation.

We welcomed the opportunity to feed into the development of the model constitution and are pleased to see that much of our feedback has been incorporated in this final draft. In line with our feedback, the model constitution provides some helpful precision about the nature of the unitary board and clarity about the ICB's powers, including making delegations and being accountable for all delegated decision-making. It also clarifies the role of the ICB board and senior independent member. We look forward to continuing to work closely with NHSE/I to develop a clear policy framework for ICBs and their constituent organisations.

Constitutions should be used by boards as tools to assist them in the governance of their organisations and should also act to assure stakeholders that appropriate governance infrastructures are in place. Constitutions need to be adaptable to local conditions and changing circumstances, as well as able to change provisions that do not work well in practice. The Bill includes a provision that constitutional changes submitted by ICBs will not take effect until approved by the newly merged NHSE. It is important therefore that NHSE is able to approve proposed constitutional changes promptly through a simple process and should confine its role to ensuring that any proposed changes are lawful.

One of our priority concerns on behalf of trust leaders is the importance of ICB boards taking account of the views of key stakeholders, particularly constituent organisations within the ICB area, in making decisions. We therefore welcome the emphasis in the supporting notes on ensuring a balance of perspectives on the board of the ICB, including all sectors and types of providers. We have also called for a mechanism to include this full range of perspectives through the ICB decision-making structures and welcome this requirement in the supporting notes. These arrangements will be crucial to

sustaining the ICS as a sum of its parts, and we urge NHSE/I to apply this consultative focus consistently, including in the establishment of the first constitution and any subsequent amendments.

The role of non-executive board members will be crucial on the ICB, facilitating strong challenge and assurance at board level. Trust leaders have stressed the need for non-executives to form a majority on the board, and we will continue to call for this to be adopted as best practice. While the model constitution emphasises consensus decision-making, it is important for ICBs to welcome effective challenge and well-reasoned dissent. Trust leaders will also want to consider how their organisation's non-executives could be linked into the new ICB governance infrastructure.

We remain concerned about the ICB chair being appointed (and possibly removed) by NHSE/I with approval from the Secretary of State for Health and Social Care, and no involvement of the ICB members or wider system partners. This is concerning as the chair needs to have the confidence of the ICB and system partners. We urge NHSE/I to ensure a significant role for these bodies in the recruitment of the chair, even if powers of appointment lie elsewhere, and include a description of the chair's independence in the handbook referenced in the supporting notes.

3. List of statutory CCG functions to be conferred on ICBs

This document forms part of the ICB functions and governance guidance. It sets out a list of current CCG statutory functions that will be conferred on ICBs, subject to the Health and Care Bill being passed. NHSE/I expects most CCG statutory functions to be conferred on ICBs in April 2022, along with the transfer of all CCG assets and liabilities. Some functions and duties may be amended or strengthened.

The guidance also summarises actions that designate ICB leaders should take, with CCGs, to prepare to discharge their statutory functions as ICBs. NHSE/I expects ICS/ICB leaders to work with CCGs through the list of statutory functions in the document to ensure responsibility for each function is clear within their proposed new ICB arrangements and that the ICB will have the capacity to carry them out effectively. This includes deciding what statutory functions should be delivered at ICS or place level – this will be for local determination. The Bill also makes provision for ICBs to delegate certain functions to trusts, but ICBs will still be held to account for the discharge of these functions. There will be some functions that ICBs will not be able to delegate to providers e.g. managing conflicts of interest.

4. Building strong ICSs everywhere: guidance on the ICS people function

The ICS people function guidance builds on the themes and priorities set out in the NHS people plan, published in July 2020, helping to set a framework for the consideration and undertaking of workforce activity at system level. The document clarifies how partners within an ICS are expected to contribute to this, but does not seek to describe "the full breadth of ICS workforce arrangements". It sets out priorities for the remainder of this financial year, points towards requirements for greater collaboration over resource decisions at system level from April 2022 (which will require further guidance) and provides a relatively detailed steer on the type of responsibilities trusts and other partners may consider for delivery at system level.

The document makes it clear that NHSE/I "does not prescribe a 'one size fits all' approach to establishing, developing and delivering the ICS people function". On the contrary, this guidance has been produced with an intention to "support local flexibility", recognising that systems will have different approaches and existing levels of collaboration on workforce activity, and that each ICS will need to proceed in a manner chosen "according to their particular circumstances".

Priorities for action: 2021/22

While some systems will be more 'advanced' towards undertaking a greater level of workforce activity at ICS level, the guidance prescribes a small but significant list of immediate 'preparatory' actions for system leaders and partners within the ICS as part of establishing the people function. They are asked to:

1. Agree the formal ICB and ICP governance and accountability arrangements for people and workforce in the ICS, including appointed SROs;
2. Agree how and where specific people functions are delivered within the ICS (for example, ICB, provider collaborative, place-based partnership);
3. Review, refresh or establish (where not in place) the ICS People Board in line with wider ICS governance and accountabilities, with clear reporting arrangements into the ICS Board; and
4. Assess the ICS's readiness, capacity and capability to deliver the people function, by identifying gaps and developing the necessary infrastructure to address these.

NHSE/I encourages system leaders and partners to utilise its System Development Progression Tool, among other resources, to support this process.

Principles and ambitions of the people function: from April 2022

Within the guidance, NHSE/I had created "10 outcomes-based functions", which could be described as overarching principles and ambitions for the workforce within each ICB. These ten broad workforce priority areas will form the basis on which system leaders and partners seek to make their areas better places to work for staff:

1 Supporting the health and wellbeing of all staff
2 Growing the workforce for the future and enabling adequate workforce supply
3 Supporting inclusion and belonging for all, and creating a great experience for staff
4 Valuing and supporting leadership at all levels, and lifelong learning
5 Leading workforce transformation and new ways of working
6 Educating, training and developing people, and managing talent
7 Driving and supporting broader social and economic development
8 Transforming people services and supporting the people profession
9 Leading coordinated workforce planning using analysis and intelligence
10 Supporting system design and development

These 'functions' align very closely with the priorities of the people plan and the document provides a chart of intended outcomes, overarching ICB responsibilities within the functions, and a set of potential (non-mandatory) workforce activities that could be delivered at system level to meet the stated ambitions.

From April 2022, ICBs will be expected to coordinate and allocate the resources required to enable delivery of the people function, with buy in from all constituent partners within the system and with support from national and regional teams.

"One workforce" and principles of subsidiarity

The guidance contains a strong focus on a "one workforce" approach within ICBs, urging system leaders to consider where activity at scale can have the greatest impact for local communities. It emphasises that the ICB will hold responsibility for clinical and non-clinical staff working in primary and community care (alongside secondary and tertiary care), and that ICBs will be expected to support and collaborate with those who provide wider community services, including in local government, other public services and in the voluntary sector.

However, the document makes clear that the principles of subsidiarity will be applied to staff support and workforce management, noting the many advantages (and necessities) of workforce activity

carried out 'below' system level, whether by provider organisations, primary care networks, at place, or through provider collaboratives.

The guidance states that individual organisations within as system will continue to have direct responsibility for the staff in their own organisations. Further clarification is provided on the type of activity carries out at regional level and by national NHS bodies as well, with an emphasis on the continued responsibility of the seven regional people boards to support the identification and delivery of at scale work within and across ICBs.

NHS Providers view

The ICS people function guidance will provide a useful reference point for trusts as many seek to work more closely with system partners on workforce issues, and indeed on the delivery of key workforce activity across wider footprint areas. During the development of this guidance (and the HR framework discussed below), trust leaders have sought clarification on the question of 'who will do what' when it comes to staffing issues, particularly given the steer from NHSE/I to set up ICBs as the primary forum for workforce planning in the NHS. This aim for workforce planning is yet to happen in many places, so – while the maturation of regional people boards have certainly aided progress – trust leaders will be pleased to see the guidance contains a clear message around individual organisations retaining responsibility for their employed staff, and will largely support the absence of a 'one size fits all' approach to delivery of workforce activity at system level.

We welcome the focus on developing infrastructure for the ICS people function in the short-term and support the emphasis on building effective governance structures while assessing readiness for system-level delivery. While the guidance helps to provide a framework for realising the benefits of workforce activity at scale, it is crucial not to lose sight of the ever-present barriers to achieving this, not least the very large and persistent workforce gaps facing the service, which can limit the ability of staff to work more flexibly across organisational boundaries. Current operational pressures will also constrain trust leaders and people professionals in their efforts to speedily put new, legally binding policies in place and form effective collaborations with system partners to implement them.

5. Other guidance documents for ICBs

HR framework for developing ICBs

NHSE/I has developed an HR framework to support CCGs and ICSs as they develop and transition towards the new statutory ICBs. It reiterates NHSE/I's ambitions to provide employment stability and

ensure a safe and effective transfer of staff, as well as giving guidance on how to manage the transition. All staff below board level will 'lift and shift' from one organisation to the other, to minimise disruption. All board-level staff will not be covered by the employment commitment and will be affected by the need to establish designate executive ICB roles. There is some flexibility built into the framework around which roles are considered board level.

ICB readiness to operate statement and checklist

This guidance is intended to support existing ICS leaders, and designate ICB leaders as they are appointed, to prepare for the legal and operational establishment of ICBs and abolition of CCGs on 1 April 2022. It includes a template ICB readiness to operate statement (ROS) and accompanying checklist. It describes how the checklist will be used to support preparations for, and assess progress towards, the establishment of ICBs. Key actions from the guidance include:

- The requirement for each designate ICB CEO and their relevant regional director to co-sign the ROS in March 2022. The ROS is a high-level statement to confirm that all critical elements are in place ready for the establishment of the ICB on 1 April 2022 and arrangements are in place for the ICB to fulfil its role within the wider ICS.
- Reporting on progress against the ROS checklist at the end of Q2 and Q3 2021/22 and in mid-February 2022. The checklist reflects core elements in the *ICS design framework* as well as the due diligence activities needed to prepare for the duties of CCGs to be transferred to ICBs.

Due diligence, transfer of people and property from CCGs to ICBs, and CCG close down

This guidance is to support CCGs and ICSs to transition effectively to ICBs. The guidance sets out the definition of due diligence and the planning processes involved in ensuring an effective transfer of CCG duties. It also covers information on the legal documentation and process for abolishing CCGs and closing down activities. The key actions from the guidance include:

- CCG accountable officers ensuring that their teams plan for and undertake robust and proportionate due diligence, making use of the due diligence checklist (on the NHSE/I ICS implementation hub).
- In March 2022, CCG accountable officers should provide written assurance of due diligence to the relevant NHSE/I regional directors and (if appropriate) the designate ICB chief executive.

Title:	**South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) Update including Mental Health, Learning Disability and Autism Provider Alliance (MHLDA)**
Paper prepared by:	Interim Chief Executive 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 partnership 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.
Executive summary:	**<u>SYB ICS Update</u>** **1. Coronavirus (COVID-19) Position** Covid case rates in SYB remain at around 300-400 (per 100,000). There are higher-than-expected rates among vulnerable groups where case rates for the over-60s are at 250 per 100,000. This could ultimately translate into an increase in hospitalisations. One of the main causes for concern among public health teams is that this level of prevalence is likely to rise in the coming weeks, especially now that schools have returned and subsequent Covid testing frequency will start to increase. Of the Covid patients admitted to hospitals the majority are unvaccinated or have only had one vaccine dose (instead of two). There are preparations for a reassessment of workforce priorities given the Joint Committee on Vaccination and Immunisation (JCVI) advice on eligible groups, especially in regards to 12-17 year-olds and the vaccine booster campaign.

With **all of us** in mind.

These new vaccination commitments will have a knock-on effect on workforce demand, so plans are being developed to realign workforce skills based on priority areas with the highest clinical need/capacity.

2. Leadership

Pearse Butler has been appointed the South Yorkshire and Bassetlaw Integrated Care System Independent Chair and Chair Designate of the future organisation, the South Yorkshire Integrated Care Board. Most recently Pearse was the Chair at Blackpool Teaching Hospitals NHS Foundation Trust.

3. Information Sharing

The need to reboot/reset information sharing across SYB has been recognised and is being rebooted. Chief executives have agreed to support this critical transformation priority in their organisations and place partnerships, given its role as a critical operational and transformation enabler.

This includes the endorsement of information sharing strategic objectives:

> To deliver a "Minimum Viable Service" (MVS) shared record across SYB by March 2022 using the Yorkshire and Humber Care Record, accelerating delivery where funding exists, including in Barnsley place (£0.3m revenue)

> To provide the SYB public access to their health and care information in 2022/23 as part of joined up SYB wide digital services for Our Public Common offer, using the Yorkshire and Humber Care Record.

> To share and link wider health, care and local authority datasets across SYB using the Yorkshire and Humber Care Record in 2022/23 to enable SYB population health and tackling health inequalities objectives.

4. Net Zero Commitment

In line with the commitment across the NHS the SYB ICS has unanimously stated its support and commitment to achieve net zero carbon emissions. This will be addressed in parallel with other initiatives including equality and diversity, population health and addressing health inequalities

5. Bassetlaw Transition

Following the recent announcement on boundary changes work has commenced on aligning the district of Bassetlaw with

Nottingham and Nottinghamshire Integrated Care System using the following principles:

- Bassetlaw will move into the Nottingham and Nottinghamshire ICS but continue to work closely with South Yorkshire ICS on a patient flows basis.
- Continue to develop the direction of travel working closely with health and care partners to maintain excellent services and access and to improve the health and wellbeing of the population irrespective of administrative boundaries
- Consultation with both ICSs to any future changes to patient care whilst recognising none are planned or envisaged.
- Committed to the current capital allocation awarded for Bassetlaw District Hospital and primary care

6. National Awards

SYB has been successful in receiving nominations for two national awards including being shortlisted for the 2021 Health Service Journal (HSJ) Awards with special recognition for the SYB ICS in the category of '*Integrated Care System of the Year*' based on the work involved in the transformation of the hyper acute stroke unit (HASU) pathway which has been firmly established by our Integrated Stroke Delivery Network

7.ICS Development

Work continues on the development of the ICS in readiness for it becoming a legal entity in April 2022. One key aim is to ensure a safe transition to the new arrangements whilst also creating the right starting position for the new organisation. Staff and functions from 4 clinical commission groups (Barnsley, Doncaster, Rotherham and Sheffield) will transfer into the ICS and focus is being applied to providing more certainty on positions and structures at an early a time as possible.

The work is being completed in two phases, the first of which is for the period leading up to the establishment of the ICS from April 2022 and the second phase is the work required post establishment of the ICS. Phase 1 has five steps which are 1) giving clarity and certainty to people affected by change 2) creating the space and environment to engage people in shaping the new organisation 3) progressing with recruitment to the integrated care board 4) building on the functional design and establishing the structure and form of the new organisations 5) confirming the operating model and designate leadership team

8.Health & Care Compact

The development of a Health & Care Compact has previously been reported to Trust Board. This is a non-legally binding agreement co-produced by the partners in the ICS that outlines principles and how organisations intend to work with each other. Together with terms of reference a final version has now been

developed following the adoption of comments from partners on the previous drafts shared in July 2021.

These documents will now be used as a foundation for the work that is being taking forward in response to the NHS England guidance for ICS development and to inform the South Yorkshire Constitution.

9. Mental Health, Learning Disability & Autism Alliance

Key headlines for these services are summarised below:

Pressure on inpatient services remains very high compounded by staff absence (sickness, Covid-related absence, and annual leave). This has led to an increase in use of out of area bed placements in recent weeks

Outpatient and admissions are above pre-pandemic levels.

Access to specialist eating disorder treatment for children and young people remains highly constrained.

Action being taken includes: a) Individual providers continue to focus on length of stay and alternatives to admission b) Potential to commission additional independent sector capacity to provide an alternative to out of area placement working within Continuity of Care principles wherever possible is being explored c) Working with South Yorkshire Police to improve the crisis response for people in the community and d) Working across the Children & younger people (CYP) mental health providers to offer support to general healthcare providers

Actions have been established to increase the uptake of physical health checks for people with a severe mental illness

Operational pressures in S136 capacity: have been identified by providers and a task and finish group will meet to discuss the issues and potential solutions across SYB.

A proposal is being developed to strengthen support to the workforce in suicide prevention & bereavement, both preventative and for those affected by suicide. This will form part of the workforce resilience support offer for staff across SYB.

CYP access was a focus of the Mental Health Deep Dive meeting with NHSEI regional and national colleagues. A range of actions have been identified to support an improvement in access which is currently lower than the national average.

Development of the SYB Mental Health Provider Alliance is being pursued with support offers from NHSEI Service Improvement Team. Shadow governance arrangements will be revisited with inaugural meetings to take place in the early Autumn. A shadow board meeting will be held in October with Chairs and Chief Executives from each MH Provider in SYB

	10. 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 in addition to establishing our place response to the Health & Care Bill through the development of shared governance arrangements. Currently work is focused on the Barnsley Provider Alliance mobilisation Discussions to develop deeper integration and provider collaboration have continued with partners. **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.

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 June 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. **WY&H Partnership response to the white paper** Work continues 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**

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	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 and launch of an anti-racist campaign and social movement in collaboration with the violence reduction unit. The campaign was launched in August and the Trust is a key partner and has signed up to the campaign. **Mental Health, Learning Disabilities and Autism Collaborative** An overview of key work streams and developments being progressed collaboratively are included in the paper. **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, developing plans to respond to system pressures and place-based governance to respond to the white paper. An update paper on the progress in Wakefield that is being taken to all partners' governing bodies is the subject of a separate Board agenda item. **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 28 September 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, operational priorities and winter planning

The national Covid-19 infection rates continue to rise and the case rates remain higher in Yorkshire and the Humber. West Yorkshire organisations, including the NHS Trusts, are encouraging people to continue following existing Covid-19 guidance to help protect themselves and others; this includes continuing to wear masks in crowded indoor spaces, on public transport, in health and care settings and in other areas where it would help people feel safer or more comfortable. The bi-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 winter planning has continued despite significant increased need and demand across all systems and places.

System pressures have continued across the region in all places and sectors. Partners across each of the places continue working together to develop plans to respond to system pressures and increased need as well as developing winter plans. The WYH Strategic Health Co-ordination Group has been re-established and the WYAAT gold command and escalation framework has been reinstated.

3. WY&H Partnership response to the white paper

Work has continued to develop the partnership governance and operating arrangements in line with the establishment of the ICS as a statutory body from 1 April 2022. The future governance arrangements and operating model are being developed and overseen through an established Design and Transition Group and Chairs and Leaders Reference Group and reported through the Partnership Group. Now that the national guidance has been published, the draft constitution and other governance documents will be shared with the partnership as they are developed. The proposed arrangements will be 'stress tested' through partner workshops, using case studies during September and October 2021. The partnership is well placed to transition to 'shadow' operation in November 2021, in preparation for new statutory arrangements from April 2022. The recruitment process for the Chair is now complete and awaiting ratification. Recruitment to the CEO role for the ICS is well underway in line with national timescales. Other senior roles will be appointed to once the CEO and Chair take up their respective roles. **The Trust has continued to work with partners in each of its places to support the development of place-based arrangements in response to the white paper and recently published guidance and the CEO and Chair are part of the ICS oversight groups.**

4. West Yorkshire Adversity, Trauma and Resilience (ATR) Programme

The programme aims to ensure a partnership approach that involves working together with people with lived experience and colleagues across all sectors and organisations to ensure WY is a trauma informed and responsive system by 2030 and develop a whole system approach to tackling multiple disadvantages. The WY population should be able to access and receive

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integrated support from a range of professionals across health, education, social care, youth justice, the police and the voluntary sector to ensure that their needs are met in a co-ordinated way. Significant work is underway across the partnership to:

- Prevent adversity and trauma across the life course;
- Engage in efforts, build on assets and strengthen protective factors for our population;
- Reduce harm for our population who experience adversity and trauma;
- Reduce inequalities that contribute to adversity and trauma and inequalities caused by adversity and trauma; and
- Ensure an understanding of adversity and traumatic events and the impact they have on an individual, their life chances and opportunities.

The Trust is a key partner in this programme and is working towards being a trauma informed Trust by integrating and developing trauma informed pathways to care and approaches and we already have a number of good practice examples of this approach across key services.

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 formal launch of the anti-racism campaign and social movement in collaboration with the violence reduction unit at Fieldhead.   The work of the partnership, including the work on equality, has been shortlisted for 5 HSJ awards.   Race Equality Network members are engaged in the WY&H Future Design and Transition Groups. The Fellowship High Potential cohort 2 has been launched and £1.15million of NHS Charities funding has been allocated to grassroots community groups and the VCS to address inequalities. **The Trust is a key partner in the programmes and formally signed up to the anti- racism campaign and will continue to progress this work through the priorities set out in the annual equality and involvement action plans.**

6. Measuring delivery of our 10 Big Ambitions
Work has continued to develop supporting measures for the partnership's ten big ambitions set out in the strategy.   A mixed approach, including the use of hard data which will allow the partnership to track numerical progress over time and key process measures which will make the biggest difference in delivering the objectives, will be used. **Key measures that the Trust is contributing to as part of the work that we do with partners in each of our places is being reviewed and considered as part of the ICS performance updates in our Integrated Performance Report.**

7. West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Update
The Trust Board was appraised at the July 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 since the July meeting include:

West Yorkshire Adult Secure Lead Provider Collaborative:
The Collaborative 'go live' position has been confirmed with NHS England as 1 October 2021 at the earliest, subject to a satisfactory outcome of the financial offer discussions.   The updated Business Case and Partnership Agreement is the subject of a separate agenda item on the Private agenda.

Further progress has been made in terms of progressing recruitment to posts at Leeds and York Partnership NHS Trust (LYPFT) to implement the commissioning capacity requirements for the West Yorkshire Collaboratives.

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WY Mental Health, Learning Disabilities and Autism (MHLDA) Programme:
The September meeting of the WY MHLDA programme board covered a wide-ranging agenda. There were presentations and papers on the progress of work programmes including, Workforce strategy and implementation plan, proposals for further discussion on the governance of the Programme Board and the programme of collaborative work going forward. The West Yorkshire Suicide Prevention website was launched on 10 September, www.suicidepreventionwestyorkshire.co.uk, and there was an update on the staff mental health wellbeing hub.

8. Local Integrated Care Partnerships - Key developments

We continue to work with partners to develop and deliver joined-up Covid-19 response including winter plans and recovery approach in each of the places that we provide services.   We have also continued to work with partners to develop our place approach and response to the white paper and related national guidance.

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 that will be formally reported to the emerging place based Integrated Care Partnership Board that is made up of health and care leaders including VCS partners.   A draft MoU is being developed and a system development plan that will be shared with Board at a future meeting for consideration.

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 July Trust Board meeting on the work of the ICP.   A separate paper summarising Wakefield's further progress in relation to the White Paper *Integration and Innovation: working together to improve health and social care for all*, which has been taken to all partners' governing bodies, is on the Trust Board agenda as a separate item.

The detailed workstreams on the next phase of the development of the ICP continue.   Multi-agency command arrangements continue to remain in place in light of the increase in service pressures in the district and winter planning arrangements are being finalised.

Kirklees

The Kirklees Integrated Health and Care Leadership Board continues to meet monthly.   The most recent meeting took place on 2 September 2021.   The meeting focused on an update in respect of the arrangements for implementing a collaborative approach to delivering general community health services; a presentation on the shadow ICP arrangements, including agreement to progress further detailed work to establish a Committee of the West Yorkshire Integrated Care Board (ICB) at Kirklees Place.

The Kirklees ICP Design Team continues to meet frequently, with the establishment of several workstreams on which the Trust is represented.

Like other districts, due to increasing service pressures, particularly on the urgent care services, the multi-agency command arrangements continue to remain in place.

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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

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Trust Board 28 September 2021
Agenda item 9.3

Title:	Wakefield Place-Based Partnership Governance Arrangements – Update Report
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 Place-based partnership governance arrangements in the context of the White Paper. • An update on the next steps for the Wakefield Place.
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. At the Trust Board meeting on 29 June 2021, the Board received an update of the Wakefield Place context through the paper "*The next stage on our system journey*".
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 pro-active member of the Wakefield partnership. It was agreed at the Wakefield ICP Board that the attached paper should be used as a common briefing by all organisations in order to brief their governing bodies on progress in respect of Place-based partnership governance as appropriate.
Recommendation:	**Trust Board is asked to NOTE and provide comments on the update on progress in Wakefield (in the context of progress across West Yorkshire) in mobilizing the requirements of the NHS White Paper.**
Private session:	Not applicable.

With **all of us** in mind.

West Yorkshire and Wakefield Place Based Partnership Governance Arrangements

1. Introduction

This paper provides an update on the progress in Wakefield district and West Yorkshire towards implementing changes outlined in the White Paper *Integration and Innovation: working together to improve health and social care for all* which was published in February 2021.

The paper describes the local context and reflects where we need to be by autumn 2021 to support our readiness across the Wakefield system and West Yorkshire to manage the transition needed for mobilisation in April 2022.

2. National Guidance

The NHS Bill has now had its second reading in Parliament. The Bill will now be considered in detail by parliamentary committees before a third reading and progression to the House of Lords.

Further guidance has been issued on the implementation of these reforms, including guidance on the duties of CCGs that will be conferred on the new integrated care systems, the proposed model constitution, and arrangements for establishing partnerships within local places.

3. West Yorkshire

It has already been agreed that West Yorkshire will have a single ICS, which will become the statutory body (replacing CCGs) and will serve a population of more than 2 million people across the five places of Bradford, Calderdale, Kirklees, Leeds and Wakefield.

At its meeting on 1 June 2021, the WY&H Partnership Board considered a report on the development of partnership governance arrangements in response to the White Paper and further discussion took place at the Partnership Board meeting in September 2021 regarding proposals for the future constitution of the ICS.

The guidance determines that the ICS will be made up of a statutory NHS body – the Integrated Care Board (ICB) and a statutory joint committee - the Integrated Care Partnership (ICP) - bringing together the NHS, Local Government and partners. ICSs will be able to delegate significantly to place level and to provider collaboratives.

The West Yorkshire ICB will be directly accountable for NHS spend and performance within the system. As a minimum, the ICB board must include a chair and 2 non-executive director, the ICB Chief Executive and clinical and professional leaders, and representatives from NHS trusts, primary care and local authorities. Others may be determined locally.

The West Yorkshire ICP will be a wider group than the ICB and will develop an integrated care strategy to address the health, social care and public health needs of their system. The membership and detailed functions of the ICP will be up to local areas to decide.

The legislation introduces a duty to co-operate to promote collaboration across the healthcare, public health and social care system. ICSs, NHS England and NHS providers will be required to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better care for all people, and sustainable use of NHS resources.

A Governance Working Group, has been established for West Yorkshire, chaired by Tim Ryley, Accountable Officer for Leeds CCG, and has representation from across the five places, providers and sectors including NHS commissioners, provider collaboratives, local authorities, voluntary, community and social enterprise (VCSE) sector, Healthwatch and our Race Equality Network.

The Group is sharing learning from across our places and system, advising on where consistency is required and on the linkages between place, ICB and ICP arrangements.

Work is underway to develop proposals for how the new West Yorkshire system will organise itself, with leads appointed to coordinate work across the five places to develop proposals for the future planning and delivery arrangements.

Recruitment for the chair of the Integrated Care Board is underway and the successful candidate will be announced in mid-September. The recruitment process to appoint a substantive accountable officer is also underway and it is expected appointments to other senior posts will follow in the autumn.

Functions of CCGs, primary care commissioning and some specialised commissioning currently undertaken by NHSE will be transferred into the ICS. The ICS will be able to delegate significantly to place. This is currently being worked through led by the design programmes of the ICS supported and influenced by place leads across West Yorkshire.

West Yorkshire and Harrogate Health and Care Partnership is already well-established. It has clearly defined, strong places, mature provider collaborations and an inclusive approach to system working. To a large extent West Yorkshire ICS is already operating in shadow form. An important aspect of West Yorkshire ICS operating model is the principle of subsidiarity.

The presumption is that most of the functions and duties of the integrated care system will be carried out within the five districts, with the majority of decisions being made locally. Some decisions will be reserved to the Integrated Care Board and some activities will be carried out once across West Yorkshire where this secures the best outcomes for the population. It is expected that firm proposals on the duties and decisions that will be undertaken within local areas will be put forward by the end of the calendar year.

4. Arrangements for integrated working in Wakefield

The legislation allows place-based arrangements between local authorities, the NHS and providers of health to be determined by local areas. The statutory ICB will work to support places to integrate services and improve outcomes.

Health and Wellbeing Boards will continue to have an important role in local places, representing the wider partnership that contributes to health and wellbeing, including elected members, and setting the strategy for health improvement for the district. NHS provider organisations will remain separate statutory bodies and retain their current structures and governance but will be expected to work collaboratively with

partners.

The proposal is that Wakefield Health and Care system moves towards mobilising shadow arrangements from October 2021 and develops a shadow committee across Wakefield health and care partners which by April 2022 will have formal delegated powers from the Integrated Care System for West Yorkshire to have oversight for allocation of health and care resources and the delivery of health improvement priorities and care services.

4.1   Where are we now?

Partners across Wakefield have a long history of working together to develop, agree and deliver improved population health. The approach taken in Wakefield has always been inclusive, bringing together commissioners, NHS, Social Care & Independent providers and colleagues from the third/voluntary sector as well as Healthwatch. In 2010 partners came together in Wakefield to ensure that local people receive person-centred coordinated care, delivered at the right time, in the right place and by the right person. The focus has been on people and place, ensuring people are getting the care they need as close to home as possible.

Wakefield has a clear strategy to improve Health & Wellbeing, demonstrating a strong commitment to delivery of a set of shared outcomes and a robust governance structure led by Health & Wellbeing Board and the Wakefield Integrated Care Partnership.

Wakefield delivers innovative models of integrated care through both Wakefield Families Together model of care and our Connecting Care hubs model, which are both made up of local health, social care, housing, voluntary and community sector organisations. The Wakefield Integrated Care Partnership plays a key role in delivering the Health and Wellbeing Plan, overseen by the Health and Wellbeing Board.

In Wakefield our partnership has evolved and matured over the years, resulting in strong relationships, high levels of trust and demonstrable improvements to the outcomes and experience of care to local people. Our approach has been for form to follow function. For example, we have brought teams together around work areas without changing terms and conditions by using matrix management models.

We have done significant work on developing mutual accountability and embedding a distributed leadership model across Wakefield, whereby leader from one organisation takes on a district wide role for a programme for example, Workforce, Citizen Engagement, Health and Housing, Mental Health Alliance.

The system appetite for innovation, sharing good practice and testing new models of care led to Wakefield district being involved in three vanguard programmes between 2016-2018. This enabled Wakefield to test the blueprint for models of care outlined in the Five Year Forward View, including general practice and care homes. Over the last four years the Wakefield system has supported the establishment of many provider collaboration models such as provider alliance/lead provider/MOU

arrangements between partners when it makes sense for partners to work collectively together for example Wakefield's Mental Health Alliance. Our mature approach to this way of working was acknowledged in our peer review led by ICS and Local Government Association in November 2018.

The Trust Board will recall that at its meeting in June 2021 it received an update of Wakefield's local context through the paper "The next stage on our system journey".

4.2 What is the Wakefield system doing to be ready for April 2022 transition and where do we need to be by October 2021?

Whilst the White Paper describes important national changes, Wakefield has already made significant progress towards operating as an integrated system, with a focus on transformation to respond to the needs of communities. Our district approach is based on a commitment that:

- Our Health and Wellbeing Board sets the place strategy and tracks the Wakefield £.
- The Integrated Care Partnership implements the strategy as a team of teams with peer accountability.
- We have an agreed set of system principles.
- The system is focused on people who live in the district having a good life.
- The Health and Wellbeing Board has both elected members and engaged citizens at the heart of its approach.
- We are committed to developing our partnership to increase and direct resources. Our seven Primary Care Networks match care integration to our neighbourhood need.

The Wakefield partnership has committed to co-production of local arrangements to respond to the White paper and support development of the West Yorkshire design and delivery framework.

The Partnership has mobilised seven development programmes, under the leadership of a Senior Responsible Officer (SRO), that will ensure our partnership is ready to operate in this new legislative framework by April 2022 and to go forward with shadow arrangements from October 2021.

There has been a series of OD sessions throughout the last six months that have enhanced our development further too.

The seven development programmes and SROs are as follows:

1. System development – Jo Webster

2. Developing and supporting the Wakefield Health and Wellbeing Strategy – Anna Hartley

3. Children's and Young People Services – Beate Wagner

4. New models of care and provider collaboratives – Martin Barkley

5.   Wakefield System People Plan – Linda Harris

6.   Infrastructure and systems – Jane Hazelgrave

7.   Clinical & Professional Leadership – Dr Greg Connor

It will be our commitment to the delivery of the three core components outlined below for our Wakefield system that will ensure our success as a partnership in achieving our 'must dos' for readiness of our transition in April 2022.

1. Ambition and vision- articulated through a co-produced, outcome-focused Health and Wellbeing Strategy, which informs all decisions and influences beyond the partnership.
2. System and governance infrastructure which mirrors ICS arrangements & provides assurance on quality, safety, financial and service performance across the partnership.
3. 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.

In May 2021, the Partnership agreed to adopt the following leadership style and behaviours for our Wakefield system and these have driven the way the programme of work has been shaped with partners across the ICP supporting the design of our future arrangements:

➢ 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.

In May 2021 the ICP agreed that Wakefield needed to develop a shadow system structure from Autumn 2021.

Work over the last few months has been focused on what the ambition and vision of the system will be, leadership and behaviours (who and how it will operate) and our local Wakefield health and care system governance arrangements. Five options for place arrangements were proposed in the ICS Design Framework published in June 2021. West Yorkshire ICS governance task and finish group considered these approaches and recommended that local places across West Yorkshire may want to consider adopting either the sub-committee or joint committee models to progress their place arrangements.

The national guidance recommends that decision-making meetings are held in public. This is the approach the Wakefield system has always adopted in current committees such as the Wakefield Health and Wellbeing Board and organisational partner governing bodies or Boards. It is proposed that the committee of the place

based partnership has public transparency of the work programme and public accountability of the delivery and allocation of the assets and resources.

The Wakefield governance working group is now working on detailed proposals decision making and assurance arrangements. This work is still evolving but will be progressed for the shadow arrangements going live in October 2021.

The final version of the ICP development framework became available in mid-August 2021 and there is local work to progress to ensure the district will meet our local ambitions to be a thriving integrated care partnership. Confirmation of resources and decision-making authority to be delegated to place is expected towards the end of the calendar year, according to latest the published timeline.

This work will continue through September and October 2021 overseen by our Integrated Care Partnership seven development programmes as described above.

The proposal is to retain the current Wakefield ICP membership in the shadow arrangements and to review this as the Provider Collaborative role develops in preparation for the post-April 2022 governance arrangements being proposed for approval by the constituent organisations on spring 2022.

It is further proposed that the assurance committees of the CCG will gradually reorientate their work to provide assurance to the partnership on delivery of partnership objectives and management of risks until formal assurance arrangements are established from April 2022.

4.3 Developing a Wakefield Provider Collaborative

Since the Wakefield Provider Collaborative Design Group was established in June 2021, significant progress has been made in developing and shaping how the Collaborative could work together to build on what already exists and to deliver plans to achieve inclusive service recovery, restoration and transformation across Wakefield place.

At its meeting in August 2021, the Integrated Care Partnership considered the arrangements for the Wakefield Provider Collaborative.

The functions of the Wakefield Provider Collaborative presented to the Integrated Care Partnership include; reducing health inequalities (as providers); ensuring effective use of population health management to inform our service delivery, improvement and transformation; providing integrated, strong seamed integrated care, that no one falls through and that eliminates duplication; ensures a coordinated approach between providers to the achievement of Wakefield Health and Wellbeing Plan; the ongoing development of a service models that will enable the above functions to be fulfilled; and the provision of mutual aid and support.

4.4 Developing System Professional Leadership in Wakefield

International evidence shows that engaging clinicians in the leadership of healthcare organisations improves the outcomes of the people they serve. Clinicians are

closely involved in clinical commissioning through the CCG and influence pathway development and investment decisions based on health gain and clinical evidence. In parallel with the collaboration between health and social care organisations in Wakefield, there have been increasing efforts to break down barriers between professional groups. These include transformation programmes for planned and urgent care, the Clinical Advisory Group and the Mental Health Alliance.

Changes to the Wakefield Place arrangements provide an opportunity to address some persisting problems:

- there are too few opportunities for professionals to get to know each other and understand each other's roles in our system due to work pressures and workforce gaps
- social care, nursing, pharmacy and allied health professionals are under-represented in existing structures which also lack diversity and provision for succession planning

These affect the three types of professional involvement:

- leadership (at corporate level as well as department, unit or team level)
- expertise (technical knowledge and experience)
- representation (sectors or professions ensuring a voice and influence for their system perspective)

With this in mind, it is proposed that Wakefield develops a "System Professional Leaders Forum" to encompass all health and social care professionals to advise the place based partnership on strategic issues and addressing the problems outlined above. This will grow from the exploratory meeting of System Professional Leaders and become an advisory and reference group for the Wakefield place based partnership committee.

4.5 Citizen Engagement in Future Wakefield Place Arrangements

Wakefield Integrated Care Partnership has been reviewing the governance mechanisms that are in place in respect of patient and public engagement and representation of citizen voice in its decision-making processes.

In May 2021 the Wakefield Integrated Care Partnership agreed that citizen voice would be represented at the ICP through the following ways:

• Continuation of engagement as one of the Enablers for the ICP going forward and regular updates/reporting at ICP meetings to provide up to date information on planned and completed activity and feeding in the patient and public voice into the ICP.

• Continuation of the Patient and Community Panel to advise on and quality assure engagement and equality activity. This would be supported by development of the Panel to include increased diversity, strengthened links to currently under-

represented groups, mental health, LD, young people and other cohorts either through membership or working links. This arrangement would support the principle of no action or decision being made prior to evidence of appropriate patient and public involvement taking place.

• A task and finish group of the Patient and Community Panel to be established specifically to consider the business of the ICP and relevant documentation prior to each ICP meeting. This Task and Finish Group will be led by Healthwatch Wakefield's Chief Executive Officer.

• Current ICP Enabler reporting to be utilised alongside these arrangements and Healthwatch Wakefield Chief Executive Officer, as SRO for the Enabler, remain the point of contact for this including reporting to the Health and Wellbeing Board.

• Overview of feedback received utilising patient experience monitoring mechanisms and linking to Quality work at Place. This aspect would link with the proposal on place based approach to quality, as outlined in the work of the CCG's Quality Team.

• Service user stories at ICP meetings, represented in various formats.

• The voice of the citizen to be represented at ICP meetings as a standing agenda item, building on local engagement and patient experience work.

• Current engagement mechanisms to continue to ensure that Wakefield has varied channels and approaches across the ladder of involvement, from sharing of information to co-production.

• Make recommendations to the Board on any anticipated issues via the Enabler SRO.

6   Next Steps

The expectation from West Yorkshire ICS is that places will introduce shadow arrangements from autumn 2021. Implementation guidance for 2021-22 confirms that until the Bill is passed, there should be no change to current formal accountability and decision-making arrangements. If the Bill is passed, CCGs will be statutorily dissolved into ICS in April 2022 and new formal arrangements will need to be in place.

The timeline that is being worked to is detailed below:

Time period	Deliverables
September 2021 – October 2021	• Appointment of Chief Officer to ICS and Chair of ICS • Develop future governance arrangements in the light of legislation, national guidance (ICS and place) • Co-produce terms of reference, scope and MOU for ICS Board/Partnership/Governing Body, Partnership Board and committees • Establish ICS shadow governance arrangements • Develop terms of reference, scope and partnership agreements for Wakefield place based partnership arrangements and committees
Autumn 2021	• Shadow working: start to adopt new ways of working (decisions will still have to be ratified while ever CCGs remain statutory bodies) • Launch of Wakefield Provider Collaborative • Launch of shadow place committee • Launch of Wakefield Professional Leaders Strategic Forum • CCG citizen engagement and assurance committees reorientated to provide assurance to the Wakefield partnership Engagement work programme • Proposals developed for future governance and assurance arrangements
Spring 2022	• Approval process for future place governance arrangements
April 2022	• New formal governance arrangements are in place (CCG disestablished and Connecting Care Executive replaced with new arrangements)

4   Recommendation

The Trust Board is asked to:

• Note and provide comments on the update on progress in Wakefield (in the context of progress across West Yorkshire) in mobilizing the requirements of the NHS White Paper.

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Agenda item 9.4 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	Next meeting scheduled for 7 Oct 2021
Member	Interim Chief Executive / Director of Strategy
Items discussed	
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143

Calderdale Health and Wellbeing Board

Date	12 August 2021
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	12th August 2021 • Climate Emergency - progress update • Supporting Carers in Calderdale • Covid update by exception • Homelessness & Rough Sleeping Strategy • Forward Plan for October
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

Kirklees Health and Wellbeing Board

Date	15 July 2021 Next meeting scheduled for 30 September 2021
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	• Showcasing Innovation - The Kirklees Local Offer • The Kirklees SEND system • Children and Young People's Plan priority updates • Developing the Kirklees Joint Health and Wellbeing Strategy
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

With **all of us** in mind.

Wakefield Health and Wellbeing Board

Date	Next meeting scheduled for 23 September 2021
Member	Chief Executive / Director of Provider Development
Items discussed	- Sustainable Communities - Giving Every Child the best start in life - Preventing ill health PDF Agenda pack 23.9.21.pdf
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://sybics.co.uk/about/meetings-and-minutes

West Yorkshire & Harrogate Health & Care Partnership Board

Date	7 September 2021 Next meeting scheduled for 7 December 2021
Member	Chief Executive
Items discussed	- Adversity, Trauma and Resilience - Update from the WY&H Partnership CEO Lead - Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues - The structure, dynamics and impact of the voluntary, community and social enterprise (VCSE) sector - The Health and Care Bill: Developing our governance arrangements - Measuring delivery of our 10 Big Ambitions
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard

wakefieldcouncil

Chief Executive

Our Ref	CH52/KMcG
Please Reply To	**Kathryn McGowan**
Telephone No	(01924) 305338
Email	kmcgowan@wakefield.gov.uk
Date	15 September 2021

To: Members of Health and Wellbeing Board

Dear Member

HEALTH AND WELLBEING BOARD – THURSDAY, 23 SEPTEMBER 2021

I am writing to invite you to a meeting of the Health and Wellbeing Board to be held at **1:30 pm** on **Thursday, 23 September 2021** in the **Council Chamber, County Hall, Wakefield.**

PLEASE NOTE THAT THE LIFT IS OUT OF ACTION IN COUNTY HALL.

The Agenda for the meeting is detailed on the following page.

Yours sincerely

Andrew Balchin
Chief Executive

Note to the public and press: This meeting is open to members of the public to attend, however, capacity is limited in all meeting rooms and locations. Please email committeeservices@wakefield.gov.uk in advance of the meeting if you are wishing to attend the meeting in person so a seat(s) can be reserved. Seats will be allocated on a first come first served basis. You will receive an email confirmation of your allocation – please present this email in order to gain access into the meeting.

As a courtesy to colleagues will you please turn all electrical devices to silent prior to the start of the meeting.

HEALTH AND WELLBEING BOARD

Thursday, 23 September 2021

AGENDA

REPORT TO BE PRESENTED BY

1. Acceptance of Apologies for Absence.

2. Minutes. (Pages 1 - 7)

    To approve as a correct record, the Minutes of the Meeting of the Health and Wellbeing Board held on 15 July 2021.

3. Chair's Announcements.

4. Urgent Items.

    To note any items which the Chair has agreed to add to the agenda on the grounds of urgency.

5. Members Declarations of Interest.

    Members are reminded of the requirement to make an appropriate verbal Declaration at the meeting on any item (s) on this agenda in which they have an interest. Having done so, Members are asked to complete a form detailing the Declaration, which will be available at the meeting.

6. Public Questions.

    At this point in the meeting responses will be provided to members of the public who have submitted questions to the Health and Wellbeing Board in advance of the meeting.

    Members of the public wishing to submit a question to the Board should do so in writing by no later than midday on Monday, 20 September 2021 to Gemma Gamble (gemma.gamble@nhs.net).

7. Action Log. (Pages 9 - 13)   **Ruth Unwin**

    FOCUSED AGENDA ITEMS

8.   Caring through Covid Awards.

The Caring through COVID Awards seek to celebrate the outstanding staff working in social care across Wakefield District. There are 10 awards categories, including the Unsung Hero award, the Compassionate Care award and the Outstanding Care in a Crisis award. Information on the awards can be found here. The results will be revealed at the virtual ceremony on Thursday 23 September in which former ITV News Calendar presenter and well-known journalist Christine Talbot will be compeering.

One award, the Putting People First Award, will be decided via a public vote, which is live online now. This award seeks to recognise a team or individual who embodies the character of 'putting people first' and empowers people to have more control over their required support. To view the bios and cast your vote, visit https://bit.ly/CaringCOVIDAwardsVote.

If you would like to post a message of support for our awards nominees on social media, please use the hashtag #CaringThroughCOVID.

Chair

9.   West Yorkshire and Wakefield Place Based Partnership Governance Arrangements. (Pages 15 - 25)

Ruth Unwin

BREAK

10.   Ensuring a healthy standard of living for all.

Members will be given a presentation.

Mark Lynam

11.   Summer Loving Campaign.

Members will be shown a video.

Charlotte Parker and Megan Booth

ITEMS FOR INFORMATION

12.   Connecting Care Executive Meeting. (Pages 27 - 35)

13.   Date and Time of Next Meeting.

The next meeting of the Health and Wellbeing Board will commence at 1.30 pm on Thursday 18 November 2021 in the Kingswood Suite, Town Hall, Wakefield.

HEALTH AND WELLBEING BOARD

Thursday, 15 July 2021

Present:

Councillor M Cummings	Chair
Dr A Sheppard	Deputy Chair
Councillor J Carrington	WMDC
Councillor K Scott	WMDC
Ms B Wagner	Corporate Director, Children and Young People
Ms A Hartley	Director of Public Health
Mrs J Webster	Corporate Director, Adults and Health and Chief Officer, CCG
Ms N Esmond	Adults, Health and Communities
Ms B Brown	CCG
Mr S Hardy	Executive Member CCG
Mr M England	Mid Yorkshire NHS Trust
Mr S Rayner	South West Yorkshire Partnership NHS Foundation Trust
Chief Superintendent Mark McManus	West Yorkshire Police
District Commander Lee Miller	West Yorkshire Fire and Rescue

32.   APOLOGIES FOR ABSENCE
Apologies for absence submitted prior to the meeting were accepted on behalf of Andrew Balchin, Sarah Roxby, Maddy Sutcliffe and Suzannah Cookson.

33.   MINUTES
Resolved – That the Minutes of the meeting of the Health and Wellbeing Board held on 25 March 2021 be approved as a correct record.

34.   CHAIR'S ANNOUNCEMENTS
Councillor Cummings, the new Chair for the Health and Wellbeing Board, introduced herself and welcomed everyone to the meeting.

Councillor Cummings asked Matt England to give a position statement to the Board with regards to the impact of Covid-19 on the Mid Yorkshire NHS Trust.

35.   MEMBERS DECLARATIONS OF INTEREST
No declarations of interest were made.

36.   PUBLIC QUESTIONS
No public question had been received.

37.   ACTION LOG
Jo Webster gave an update to the Board on the Action Log which continued to be a standing item on the agenda to help inform strategies and plans going forward.

The White Paper had recently received its second reading in Parliament and a progress report would be brought to the next meeting.

HEALTH AND WELLBEING BOARD - THURSDAY, 15 JULY 2021

The Wakefield Integrated Care Partnership had been tasked with developing proposals to respond to the inequalities raised at the March meeting of the Board. These issues had been presented to the Health and Wellbeing Board development session held in July.

Members had now shared details of the appropriate lead for climate change for their organisations with Gary Blenkinsop, Wakefield's Lead for Climate Change.

Resolved – That the Action Log be noted.

38. **FEEDBACK FROM THE HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION**
Consideration was given to a report outlining the proposed approach to the Health and Wellbeing Board Strategy re-fresh and to provide outcomes from the development session held in July 2021.

Work would take place over the summer to re-fresh the Strategy developed in 2018 as a three-year strategy seeking to secure stakeholder and public commitment to improve health and reduce inequality and refocus the strategy around the ambition for people to live longer in good health.

The Chair had attended the development session and found it very informative. The Chair agreed that the focus should now be on health prevention and quality of life in addition to looking at what the system as a whole needed to improve upon especially in terms of the hardest to reach residents/patients as they were the easiest to ignore.

Jo Webster felt that the Strategy should be based around The Marmot Review and its principles as it addressed the social determinants of health inequalities through concerted action. It was suggested that a future agenda item be tabled to discuss the re-fresh strategy in more detail along with a suggestion for an ambassador to co-ordinate the whole process.

Following a discussion around the engagement and development timeline of the strategy re-fresh, it was felt that the timeline should be reconsidered in order to give more realistic timeframes in order to extend the engagement element.

Resolved – (1) That the report be noted.

(2) That the development and engagement timetable be reconsidered.

(3) That the Health and Wellbeing Strategy re-fresh be considered at a future meeting.

39. **FOCUSSED DISCUSSION - WHAT WE HAVE LEARNT FROM COVID OPPORTUNITIES AND CHALLENGES**

(1) **Patient Story**

The Board were informed that the patient story video would be tabled at a future meeting.

(2) **What does the data tell us?**

Anna Hartley, Director of Public Health gave a presentation detailing the shape of

HEALTH AND WELLBEING BOARD - THURSDAY, 15 JULY 2021

the pandemic since March 2020 explaining that the Delta variant had recently become dominant in Wakefield causing a surge in infections, particularly in young people. Despite the surge in infections, the number of patients in hospitals with Covid-19 remained low.

In wave 1 of the pandemic, there was a steep rise in deaths registered with around 330 attributed to Covid-19 and 40% of those being care home residents. In wave 2, around 520 deaths were registered, which was a smaller peak, but took place over a longer duration and 22% were care home residents.

Anna Hartley went on to explain the inequalities of Covid-19, stating that people from deprived areas were twice as likely to be admitted to hospital with a confirmed case and twice as likely to die from it than people in the least deprived areas.

The wider impacts of the pandemic included the economic one which had seen a sharp rise in the number of claimants and this had not recovered. Children's education had also been impacted upon with three lockdowns seeing schools close. School attendance had dropped significantly recently; down to around 70% of pupils with almost 7,000 pupils off school isolating. Attendances at A&E's fell dramatically at the start of the pandemic but during the roadmap out of lockdown, numbers had increased quickly. Violent crimes fell during the lockdowns.

Since the start of the pandemic, the Public Health's Team had done a large amount of work including daily reviews of ongoing 'situations' regarding outbreaks, compliance, complaints or exposure events. Established local contact tracing including door knocking. Community engagement in terms of vaccine hesitancy, information about isolation support payments, walk up vaccination sessions in low take up areas and surge testing. A Vaccine Inequalities Working Group had been set up in partnership with the CCG and wider stakeholders to target work at particularly vulnerable groups. The Team had provided a range of intelligence reports for both internal and external stakeholders covering a whole variety of issues. The Team also produced a weekly briefing for the public which had received over 100,000 views.

In response to a question, Chief Superintendent McManus stated that levels of domestic violence had remained constant throughout the pandemic, the crime was always under reported and given the financial impact of Covid-19 there could be an increase in levels in the future. It was stated that West Yorkshire Police and other services were under immense pressure from the impacts of the pandemic particularly in regard to mental health issues.

A discussion took place about the importance of being vaccinated as it was making a difference but the vulnerable were still at risk. Ahead of 19 July, concerns were expressed about the lifting of restrictions on social contact and urged everyone to still wear masks and social distance wherever possible.

Resolved – That the presentation be noted.

HEALTH AND WELLBEING BOARD - THURSDAY, 15 JULY 2021

(3) Healthwatch Patient Feedback

The Healthwatch Patient Feedback presentation would be tabled at a future meeting.

40. HEALTH AND WELLBEING BOARD OUTCOMES

(1) Sustainable Communities

Consideration was given to a report and presentation by Anna Hartley, Director of Public Health detailing progress made on the Creating Healthy Places and Communities work stream. The Health and Wellbeing Board had adopted four of the six Marmot outcomes, one of which included this work stream.

It was proposed to have three work programmes to sit under the 'creating healthy communities' work and be based on the World Health Organisations (WHO) framework - 'People, Places and Practice'. This would provide a whole system approach:-

(i) People – supporting communities to be strong and healthy concentrating on early years and families, children and young people and targeting local communities. This would help to improve health literacy.

(ii) Place – creating a physical environment that would positively encourage people to make healthy choices concentrating on policy, transport and growth and influencing regional policy and practice.

(iii) Practice – embedding a way of working across the partnership that would support delivery on the inequalities agenda including education and training; collaboration and partnerships; OBA, monitoring and evaluation.

The Covid pandemic, whilst being devastating to health, had brought about a shift in community engagement and empowerment with the community hubs taking a leading role in providing support to the most vulnerable. Anna Hartley had been pleased to be able to provide funding to support that work.

Anna Hartley was also pleased to announce that a Service Manager for Healthy Places and Communities was currently being recruited and would provide much needed capacity to manage the work programme in the future.

Resolved – (1) That the update on the progress of this work stream be noted.

(2) That the proposals outlined in the report and presentation for creating healthy places based on the WHO principles of people, place and practice be supported.

Simon Topham from Citizens Advice then gave a presentation on the Help at the Hub project (HATH).

The Recovery Board, Residents Recovery Group started work in August 2020. It was immediately agreed to build on existing local assets and work in partnership with the Third Sector and public sector. It was also agreed to ensure effective and sustainable support for residents and communities across the District who were most affected by Covid-19 including social, economic and health impacts.

HEALTH AND WELLBEING BOARD - THURSDAY, 15 JULY 2021

Existing local community Hubs were identified as the base from which to deliver universal services to support communities. It was recognised that Hubs identified to become HATH partners, required a record of strong leadership and governance, resources to open 5 days per week with trained staff to signpost residents, active partnership work and a wide range of facilities including meeting rooms and publically accessible IT equipment.

There was a need to ensure a wide geographical spread in order that all areas of the District had easy access to HATH services. Eight community Hubs were chosen; Pontefract, Castleford, Ossett, Ryhill, Knottingley, Horbury, Wakefield and South Elmsall. These locations were prominent and accessible and already delivered a wide range of services and local support which HATH built upon it.

Services identified as the main priorities for HATH were the economic impacts, skills and education, food and emotional support. Partners working at the Hubs currently or about to start included the Housing Advice Team, Live Well Team, DWP, Citizens Advice, Step-Up, Adult Education, Turning Point and Polish Community Centre.

It was recognised there was a need to build the financial security and sustainability of the Hubs. A monthly fee was provided in return for them taking part in the project and for offering facilities to Citizens Advice with similar agreements with other agencies.

A mental health first aid training course had been offered free of charge to Hubs staff and a SafeTalk suicide prevention and awareness course was also planned.

A number of success stories were shared with Members.

The Chair was extremely proud of the work done so far and hoped it would continue with partnership being the key.

Resolved – That the presentation on the Help at the Hub project be noted.

(2) **Giving Every Child the best start in life**

Beate Wagner, Corporate Director for Children and Young People gave a presentation on 'giving every child the best start' which linked to the Health and Wellbeing Board Strategy.

It was explained that the Children and Young People's Partnership Board had four priorities:-

- Wakefield Families Together; an integrated 'one team, one conversation' with accessible and deliverable pathways at the earliest point of need
- That all children and young people enjoyed good emotional and mental wellbeing, were resilient and felt supported
- That all children within the District had the best start in life and were happy, healthy and safe
- That all children and young people benefitted from an inclusive education and were well prepared for the transition into adult life

Beate Wagner explained that early challenges of the pandemic, in spring and summer 2020, had included frequent changes to the guidance, staff re-deployment,

HEALTH AND WELLBEING BOARD - THURSDAY, 15 JULY 2021

restrictions to school attendance, capacity to design, develop and implement online learning and to provide staff with appropriate IT equipment to mobilise new ways of working.

In response to the pandemic, monthly meetings were established with all key partners to ensure the needs of high risk women, babies and pre-school children had the correct pathways in place. Weekly safeguarding forums were also established to ensure that vulnerable children were identified and supported but partners ensured that, between them, someone had eyes on every single child identified.

Further responses to the pandemic included the distribution of activity packs to vulnerable children under 5, an expansion of the imagination library, the '50 things to do before you're 5' objective, involvement in the development of a new tool to support identification of communication problems at the 2 to 2½ year contact and supporting children with Special Educational Needs with the Parent Carer Forum playing a vital part.

Beate Wagner detailed for Members the key challenges faced in planning for the recovery along with the key opportunities which included temporary funding to provide additional activities for children, young people and parent/toddler activities until March 2022. A continued development of the universal and targeted support for families with babies and young children. The success of the WF Connect programme, Youth Hub and Family Hub developments. Activities for young people including National Citizenship, Duke of Edinburgh and Branching Out. The pandemic had seen increased support for Young Carers and Education Recovery supported by the Tutoring programme. Volunteers had played a vital role which maximised support services were able to give to the community.

In order to support residents, a number of mental health schemes were established/enhanced:-
- Wellbeing for Education Return
- Launch of the Night Owls Service
- WF-ICAN and community navigators delivered early intervention
- Mental Health Support Teams – further funding had been secured and from January 2022 resource capacity would be increased
- System-wide consultation and planning to commence from September 2021

Beate Wagner stated that recovery planning would be informed by the Health and Wellbeing Board along with feedback from our young people, the Safeguarding Partnership, health professionals and partnerships, the Police, the Local Authority and the Partners Recovery Board. It was felt that the Children and Young People Partnership was in a good position to hold the ring on what recovery looked like for children, young people and families. Beate Wagner was pleased to announce that the Service Director for Health and Wellbeing was now in post and well positioned to devise system-wide solutions supported by an integrated virtual team.

Resolved – That the presentation be noted.

(3) Preventing ill health

Consideration was given to a presentation by Kerry Murphy, Public Health Manager detailing how partners and communities had worked together to address vaccine inequalities across the District.

HEALTH AND WELLBEING BOARD - THURSDAY, 15 JULY 2021

Wakefield had taken an Asset Based Community Development approach and the Vaccine Inequalities Working Group met regularly with various partners and in turn reported to the Health Protection Board, Vaccine Steering Group, multi-agency Covid Partnerships and Communications Engagement Network.

Initially, priority groups were identified for targeted work which included the homeless, asylum seekers, gypsies and travellers. Others identified included those with severe mental illness, learning disabilities, autism and dementia, sensory impairment, those with HIV not known to GP's and members of black and minority communities, faith communities, migrant works and sex workers.

The group created a number of initiatives which included the Roving Vaccination Team delivering vaccinations in community settings, development of bespoke vaccine hesitancy training, creation of a transport pathway for people living with disabilities and their carers, online outreach and engagement with priority groups through Covid Community Champions and VCS lead sessions.

The role of Covid Community Champions and engagement undertaken during the pandemic was detailed for the Board. It had been recognised early that the power of skilled conversations and trusted message givers would play an important part in the take up of vaccinations and some of the successes of this work were detailed.

Building on the success, the next steps were to localise vaccination, evaluate the Roving Vaccination model and plan for its sustainability, capture the learning from the Vaccine Inequalities Group's partnership working approach, understand how the learning could be transferred to other areas of health inequality and understand the needs of different populations.

The Chair and Members of the Board congratulated everyone involved in this work.

Resolved – That the presentation be noted.

41. **ITEMS FOR INFORMATION**

(1) **Connecting Care Executive Minutes**

   Resolved – That the Minutes of the Connecting Care Executive meeting held on 11 March 2021 be noted.

42. **DATE AND TIME OF NEXT MEETING**
   Resolved – That the next meeting of the Health and Wellbeing Board be held at 1.30pm on Thursday 23 September 2021. Venue to be confirmed.

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Wakefield Health and Wellbeing Board – Action Log

Month	Minute Ref	Action	Board Lead	Delegated Board	Required to come back to Board	Timescale	Completed
18 July 19	6	Further analysis to be undertaken on data available for those with Learning Disabilities (LD) in employment – information around quality of employment, type of employment and pay levels for people with LD.	**Anna Hartley**	Not Applicable	No		Yes
18 July 19	6	Each HWBB organisation to consider the introduction of an LD Champion.	**All Organisations**	Health and Wellbeing Board	No		Yes
18 July 19	6	Further exploration by HWBB member organisations regarding involvement in the Project Search programme.	**All**	Health and Wellbeing Board	No		Yes
19 Sept 19	-	Final copy of the Better Care Fund to be shared with the HWBB following submission on the 27th September.	**Mel Brown**	Connecting Care Executive	Yes		Yes
19 Sept 19	-	Terms of Reference and Structure of the new Healthy Communities Group to be shared with the HWBB.	**Anna Hartley**	Healthy Communities Group	Yes	June 2020	Yes
14 Nov 19	38	Data on Referrals – further analysis to be undertaken into reconciling attendances for self-harm against referrals to specialist support for	**Martin Barkley/Anna Hartley**	Not Applicable	No	Sept 2020	In progress

Month	Minute Ref	Action	Board Lead	Delegated Board	Required to come back to Board	Timescale	Completed
		children and young people.					
14 Nov 19	41	Each action and comment arising from the presentation given by the volunteer family and children's worker to be formally responded to.	**Suzannah Cookson**	Maternity Quality Partnership	No		Yes
14 Nov 19	41	Presentation given by the volunteer family and children's worker to be shared with the leads involved in developing maternity community hubs and into maternity forums locally.	**Suzannah Cookson**	Not Applicable	No		Yes
14 Nov 19	42	Board to consider the opportunity to link the skills of adults who are socially isolated with young people who may need additional support.	**Andrew Balchin/Beate Wagner/Mel Brown**	Integrated Care Partnership	No	Nov 20	Being considered as part of ongoing programmes of work.
14 Nov 19	45	Risk and Resilience Programme to be linked to all Primary Care Homes	**Sean Rayner**	Primary Care Home Steering Group	No	May 20	Yes
16 Jan 20	60	Consideration of the Healthy Schools Programme being considered at a future Board meeting or under one of the sub groups.	**Beate Wagner**	Health and Wellbeing Board/Children and Young People's	Yes	Nov 20	Complete and added to the forward plan.

Month	Minute Ref	Action	Board Lead	Delegated Board	Required to come back to Board	Timescale	Completed
				Partnership			
16 Jan 20	64	Partners to provide detail on behalf of their organisations in response to the questions raised in the health inequalities/labour market presentation. In addition for a further discussion to be held later in the year.	**Merran McRae**	Health and Wellbeing Board	Yes	Sept 20	Completed as part of the Step Up discussion at the July Health and Wellbeing Board meeting.
9 July 20	7 (2)	The Plan on a Page for successful transformational funding bids relating to Wakefield to be shared with Board members for information.	**Anna Hartley**	Health and Wellbeing Board	No	Sept 20	Plan on a Page Bids have been circulated to Board Members
9 July 20	7 (3)	Opportunities to be explored to ensure connectivity between primary care work on shielding and social prescribing and the work on carers.	**Mel Brown**	Integrated Care Partnership	No	Sept 20	Carers Wakefield have presented their work to the Primary Care Networks Clinical Directors Meeting to identify opportunities for connection and the work is built in to the ICP workstreams.

Month	Minute Ref	Action	Board Lead	Delegated Board	Required to come back to Board	Timescale	Completed
9 July 20	7 (4)	As a result of the discussion round tackling inequalities through employment it was agreed to: •Hold a discussion between key Board leads to discuss the skills needed to enter in to the health system •To explore the possibility of opportunities for unpaid carers to move in to a paid role •To raise some of the points from the discussion at the Integrated Care System People Board	**Linda Harris**	Integrated Care Partnership and	No	Sept 20	Presentation provided to the HR Directors group with regards to Step Up programme expansion with support being given to a joint post to facilitate the next stage of the work. The work is also being included in the next reiteration of the Wakefield Local Place based people plan.
24 Sept 20	16 (3)	Report to be shared setting out a research project based on the Born in Bradford project, involving a multi-agency data gathering exercise.	**Anna Hartley**	Health and Wellbeing Board	Yes	March 21	Report being covered as part of the July agenda.
24 Sept 20	16 (3)	Partners to consider the possibility of offering a webinar on relevant subject matter to assist businesses in supporting their staff.	**All**	Health and Wellbeing Board	No	January 21	All partners with relevant subject matter have now contacted regarding webinars.

Month	Minute Ref	Action	Board Lead	Delegated Board	Required to come back to Board	Timescale	Completed
24 Sept 20	16 (3)	Partners to share details of available services to support maximising the Make Every Contact Count approach.	**Anna Hartley**	Health and Wellbeing Board	No	January 21	All partners with relevant services have now shared with colleagues in Regeneration and Economic Growth at the Council.
25 March 21	26	A progress report with regards to the White Paper to be brought to the July meeting.	**Jo Webster**	Health and Wellbeing Board	Yes	July 21	Complete discussion took place at the H&WBB development session
25 March 21	27	The Integrated Care Partnership are tasked with developing proposals to respond to the inequalities raised in the discussion, to be presented to the HWBB development session.	**Anna Hartley/Mel Brown**	Integrated Care Partnership	Yes	Sept 21	Completed factored into the H&WBB development session scope
25 March 21	28	Members to share the details of the appropriate lead for climate change from their organisation with Gary Blenkinsop as the Wakefield health and care lead for climate change.	**All**	Health and Wellbeing Board	No	April 21	Members have provided details with regards to climate change leads.

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	REPORT TO THE HEALTH AND WELLBEING BOARD 23 September 2021
wakefieldcouncil *working for you*	

REPORT OF: RUTH UNWIN, DIRECTOR OF CORPORATE AFFAIRS, WCCG

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1. **SUBJECT**: West Yorkshire and Wakefield Place Based Partnership Governance Arrangements

2. **PURPOSE OF REPORT**
   The purpose of this paper is to provide an update on progress across West Yorkshire and within the Wakefield district towards implementing the legislative changes set out in the NHS White paper.

   This paper describes our local context and arrangements in place now in Wakefield and reflects where we need to be by October 2021 to support our readiness across the Wakefield system and West Yorkshire to manage the transition towards mobilisation in April 2022.

   The paper sets out how the five places that make up the West Yorkshire health and care system are working to design the arrangements for the new statutory organisation and the programmes leading this redesign work.

   It is proposed that the Wakefield Health and Care system moves towards mobilising shadow arrangements from October 2021. This will involve the Wakefield Integrated Care Partnership operating as a shadow committee to consider how best to use the resources available to the district to improve health outcomes and secure safe and effective care services for the district.

   The CCG will still be legally responsible for decisions relating to the NHS in the district up to April 2022 but will increasingly take advice and assurance from the shadow committee. From April 2022, the place based partnership committee will have authority to make decisions for which the Integrated Care System for West Yorkshire is legally accountable. This will enable decisions about the delivery of health and care and oversight of resources for health improvement and health outcomes across Wakefield District.

   It is proposed that the place based partnership committee will work alongside a Wakefield Provider Collaborative, which will be responsible for delivering transformation programmes to improve health and care outcomes and services for the Wakefield population. It is also proposed to develop a Wakefield Professional Leaders Strategic Forum to provide advice and guidance to the place based partnership and to strengthen arrangements for public engagement across the partnership

by reorientating the work of the Patient and Community Panel to advise and assure the place based partnership.

3.   **RECOMMENDATION**
        The Health and Wellbeing Board are asked to:

        • Note the update on progress across West Yorkshire and in
          Wakefield in mobilising the requirements of the NHS White Paper.

Lead Board Member: Councillor Maureen Cummings

Contact Officer: Ruth Unwin

Telephone No: 07909 338 416
E-mail address: ruth.unwin@nhs.net

Appendix(ces)   *Attached*

West Yorkshire and Wakefield Place Based Partnership Governance Arrangements

1.   Introduction

This paper provides an update on the progress in Wakefield district and West Yorkshire towards implementing changes outlined in the White Paper *Integration and Innovation: working together to improve health and social care for all* which was published in February 2021.

The paper describes the local context and reflects where we need to be by autumn 2021 to support our readiness across the Wakefield system and West Yorkshire to manage the transition needed for mobilisation in April 2022.

2.   National Guidance

The NHS Bill has now had its second reading in Parliament. The Bill will now be considered in detail by parliamentary committees before a third reading and progression to the House of Lords.

Further guidance has been issued on the implementation of these reforms, including guidance on the duties of CCGs that will be conferred on the new integrated care systems, the proposed model constitution, and arrangements for establishing partnerships within local places.

3.   West Yorkshire

It has already been agreed that West Yorkshire will have a single ICS, which will become the statutory body (replacing CCGs) and will serve a population of more than 2 million people across the five places of Bradford, Calderdale, Kirklees, Leeds and Wakefield.

At its meeting on 1 June 2021, the WY&H Partnership Board considered a report on the development of partnership governance arrangements in response to the White Paper and further discussion took place at the Partnership Board meeting in September 2021 regarding proposals for the future constitution of the ICS.

The guidance determines that the ICS will be made up of a statutory NHS body – the Integrated Care Board (ICB) and a statutory joint committee - the Integrated Care Partnership (ICP) - bringing together the NHS, Local Government and partners. ICSs will be able to delegate significantly to place level and to provider collaboratives.

The West Yorkshire ICB will be directly accountable for NHS spend and performance within the system. As a minimum, the ICB board must include a chair and 2 non-executive director, the ICB Chief Executive and clinical and professional leaders, and representatives from NHS trusts, primary care and local authorities. Others may be determined locally.

The West Yorkshire ICP will be a wider group than the ICB and will develop an integrated care strategy to address the health, social care and public health needs of their system. The membership and detailed functions of the ICP will be up to local areas to decide.

The legislation introduces a duty to co-operate to promote collaboration across the healthcare, public health and social care system. ICSs, NHS England and NHS providers will be required to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better care for all people, and sustainable use of NHS resources.

A Governance Working Group, has been established for West Yorkshire, chaired by Tim Ryley, Accountable Officer for Leeds CCG, and has representation from across the five places, providers and sectors including NHS commissioners, provider collaboratives, local authorities, voluntary, community and social enterprise (VCSE) sector, Healthwatch and our Race Equality Network.

The Group is sharing learning from across our places and system, advising on where consistency is required and on the linkages between place, ICB and ICP arrangements.

Work is underway to develop proposals for how the new West Yorkshire system will organise itself, with leads appointed to coordinate work across the five places to develop proposals for the future planning and delivery arrangements.

Recruitment for the chair of the Integrated Care Board is underway and the successful candidate will be announced in mid-September. The recruitment process to appoint a substantive accountable officer is also underway and it is expected appointments to other senior posts will follow in the autumn.

Functions of CCGs, primary care commissioning and some specialised commissioning currently undertaken by NHSE will be transferred into the ICS. The ICS will be able to delegate significantly to place. This is currently being worked through led by the design programmes of the ICS supported and influenced by place leads across West Yorkshire.

West Yorkshire and Harrogate Health and Care Partnership is already well-established. It has clearly defined, strong places, mature provider collaborations and an inclusive approach to system working. To a large extent West Yorkshire ICS is already operating in shadow form. An important aspect of West Yorkshire ICS operating model is the principle of subsidiarity.

The presumption is that most of the functions and duties of the integrated care system will be carried out within the five districts, with the majority of decisions being made locally. Some decisions will be reserved to the Integrated Care Board and some activities will be carried out once across West Yorkshire where this secures the best outcomes for the population. It is expected that firm proposals on the duties and decisions that will be undertaken within local areas will be put forward by the end of the calendar year.

4. Arrangements for integrated working in Wakefield

The legislation allows place-based arrangements between local authorities, the NHS and providers of health to be determined by local areas. The statutory ICB will work to support places to integrate services and improve outcomes.

Health and Wellbeing Boards will continue to have an important role in local places, representing the wider partnership that contributes to health and wellbeing, including elected members, and setting the strategy for health improvement for the district. NHS provider organisations will remain separate statutory bodies and retain their current structures and governance but will be expected to work collaboratively with partners.

The proposal is that Wakefield Health and Care system moves towards mobilising shadow arrangements from October 2021 and develops a shadow committee across Wakefield health and care partners which by April 2022 will have formal delegated powers from the Integrated Care System for West Yorkshire to have oversight for allocation of health and care resources

and the delivery of health improvement priorities and care services.

4.1 Where are we now?

Partners across Wakefield have a long history of working together to develop, agree and deliver improved population health. The approach taken in Wakefield has always been inclusive, bringing together commissioners, NHS, Social Care & Independent providers and colleagues from the third/voluntary sector as well as Healthwatch. In 2010 partners came together in Wakefield to ensure that local people receive person-centred coordinated care, delivered at the right time, in the right place and by the right person. The focus has been on people and place, ensuring people are getting the care they need as close to home as possible.

Wakefield has a clear strategy to improve Health & Wellbeing, demonstrating a strong commitment to delivery of a set of shared outcomes and a robust governance structure led by Health & Wellbeing Board and the Wakefield Integrated Care Partnership.

Wakefield delivers innovative models of integrated care through both Wakefield Families Together model of care and our Connecting Care hubs model, which are both made up of local health, social care, housing, voluntary and community sector organisations. The Wakefield Integrated Care Partnership plays a key role in delivering the Health and Wellbeing Plan, overseen by the Health and Wellbeing Board.

In Wakefield our partnership has evolved and matured over the years, resulting in strong relationships, high levels of trust and demonstrable improvements to the outcomes and experience of care to local people. Our approach has been for form to follow function. For example, we have brought teams together around work areas without changing terms and conditions by using matrix management models.

We have done significant work on developing mutual accountability and embedding a distributed leadership model across Wakefield, whereby leader from one organisation takes on a district wide role for a programme for example, Workforce, Citizen Engagement, Health and Housing, Mental Health Alliance.

The system appetite for innovation, sharing good practice and testing new models of care led to Wakefield district being involved in three vanguard programmes between 2016-2018. This enabled Wakefield to test the blueprint for models of care outlined in the Five Year Forward View, including general practice and care homes. Over the last four years the Wakefield system has supported the establishment of many provider collaboration models such as provider alliance/lead provider/MOU arrangements between partners when it makes sense for partners to work collectively together for example Wakefield's Mental Health Alliance. Our mature approach to this way of working was acknowledged in our peer review led by ICS and Local Government Association in November 2018.

4.2 What is the Wakefield system doing to be ready for April 2022 transition and where do we need to be by October 2021?

Whilst the White Paper describes important national changes, Wakefield has already made

significant progress towards operating as an integrated system, with a focus on transformation to respond to the needs of communities. Our district approach is based on a commitment that:

- Our Health and Wellbeing Board sets the place strategy and tracks the Wakefield £
- The Integrated Care Partnership implements the strategy as a team of teams with peer accountability
- We have an agreed set of system principles
- The system is focused on people who live in the district having a good life
- The Health and Wellbeing Board has both elected members and engaged citizens at the heart of its approach
- We are committed to developing our partnership to increase and direct resources Our seven Primary Care Networks match care integration to our neighbourhood need

The Wakefield partnership has committed to co-production of local arrangements to respond to the White paper and support development of the West Yorkshire design and delivery framework.

The Partnership has mobilised seven development programmes, under the leadership of an Senior Responsible Officer (SRO), that will ensure our partnership is ready to operate in this new legislative framework by April 2022 and to go forward with shadow arrangements from October 2021.

There has been a series of OD sessions throughout the last six months that have enhanced our development further too.

The seven development programmes and SROs are as follows:

1. System development – Jo Webster

2. Developing and supporting the Wakefield Health and Wellbeing Strategy – Anna Hartley

3. Children's and Young People Services – Beate Wagner

4. New models of care and provider collaboratives – Martin Barkley

5. Wakefield System People Plan – Linda Harris

6. Infrastructure and systems – Jane Hazelgrave

7. Clinical & Professional Leadership – Dr Greg Connor

It will be our commitment to the delivery of the three core components outlined below for our Wakefield system that will ensure our success as a partnership in achieving our 'must dos' for readiness of our transition in April 2022.

1. Ambition and vision- articulated through a co-produced, outcome-focused Health and Wellbeing Strategy, which informs all decisions and influences beyond the partnership.
2. System and governance infrastructure which mirrors ICS arrangements & provides assurance on quality, safety, financial and service performance across the partnership.

3.   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.

In May 2021, the Partnership agreed to adopt the following leadership style and behaviours for our Wakefield system and these have driven the way the programme of work has been shaped with partners across the ICP supporting the design of our future arrangements:

➢   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.

In May 2021 the ICP agreed that Wakefield needed to develop a shadow system structure from Autumn 2021.

Work over the last few months has been focused on what the ambition and vision of the system will be, leadership and behaviours (who and how it will operate) and our local Wakefield health and care system governance arrangements. Five options for place arrangements were proposed in the ICS Design Framework published in June 2021. West Yorkshire ICS governance task and finish group considered these approaches and recommended that local places across West Yorkshire may want to consider adopting either the sub-committee or joint committee models to progress their place arrangements.

The national guidance recommends that decision-making meetings are held in public. This is the approach the Wakefield system has always adopted in current committees such as the Wakefield Health and Wellbeing Board and organisational partner governing bodies or Boards. It is proposed that the committee of the place based partnership has public transparency of the work programme and public accountability of the delivery and allocation of the assets and resources.

The Wakefield governance working group is now working on detailed proposals decision making and assurance arrangements. This work is still evolving but will be progressed for the shadow arrangements going live in October 2021.

The final version of the ICP development framework became available in mid-August 2021 and there is local work to progress to ensure the district will meet our local ambitions to be a thriving integrated care partnership. Confirmation of resources and decision-making authority to be delegated to place is expected towards the end of the calendar year, according to latest the published timeline.

This work will continue through September and October 2021 overseen by our Integrated Care Partnership seven development programmes as described above.

The proposal is to retain the current Wakefield ICP membership in the shadow arrangements and to review this as the Provider Collaborative role develops in preparation for the post-

April 2022 governance arrangements being proposed for approval by the constituent organisations on spring 2022.

It is further proposed that the assurance committees of the CCG will gradually reorientate their work to provide assurance to the partnership on delivery of partnership objectives and management of risks until formal assurance arrangements are established from April 2022.

4.3 Developing a Wakefield Provider Collaborative

Since the Wakefield Provider Collaborative Design Group was established in June 2021, significant progress has been made in developing and shaping how the Collaborative could work together to build on what already exists and to deliver plans to achieve inclusive service recovery, restoration and transformation across Wakefield place.

At its meeting in August 2021, the Integrated Care Partnership considered the arrangements for the Wakefield Provider Collaborative.

The functions of the Wakefield Provider Collaborative presented to the Integrated Care Partnership include; reducing health inequalities (as providers); ensuring effective use of population health management to inform our service delivery, improvement and transformation; providing integrated, strong seamed integrated care, that no one falls through and that eliminates duplication; ensures a coordinated approach between providers to the achievement of Wakefield Health and Wellbeing Plan; the ongoing development of a service models that will enable the above functions to be fulfilled; and the provision of mutual aid and support.

4.4 Developing System Professional Leadership in Wakefield

International evidence shows that engaging clinicians in the leadership of healthcare organisations improves the outcomes of the people they serve. Clinicians are closely involved in clinical commissioning through the CCG and influence pathway development and investment decisions based on health gain and clinical evidence. In parallel with the collaboration between health and social care organisations in Wakefield, there have been increasing efforts to break down barriers between professional groups. These include transformation programmes for planned and urgent care, the Clinical Advisory Group and the Mental Health Alliance.

Changes to the Wakefield Place arrangements provide an opportunity to address some persisting problems:

- there are too few opportunities for professionals to get to know each other and understand each other's roles in our system due to work pressures and workforce gaps
- social care, nursing, pharmacy and allied health professionals are under-represented in existing structures which also lack diversity and provision for succession planning

These affect the three types of professional involvement:

- leadership (at corporate level as well as department, unit or team level)
- expertise (technical knowledge and experience)

- representation (sectors or professions ensuring a voice and influence for their system perspective)

With this in mind, it is proposed that Wakefield develops a "System Professional Leaders Forum" to encompass all health and social care professionals to advise the place based partnership on strategic issues and addressing the problems outlined above. This will grow from the exploratory meeting of System Professional Leaders and become an advisory and reference group for the Wakefield place based partnership committee.

4.5 Citizen Engagement in Future Wakefield Place Arrangements

Wakefield Integrated Care Partnership has been reviewing the governance mechanisms that are in place in respect of patient and public engagement and representation of citizen voice in its decision-making processes.

In May 2021 the Wakefield Integrated Care Partnership agreed that citizen voice would be represented at the ICP through the following ways:

- Continuation of engagement as one of the Enablers for the ICP going forward and regular updates/reporting at ICP meetings to provide up to date information on planned and completed activity and feeding in the patient and public voice into the ICP.

- Continuation of the Patient and Community Panel to advise on and quality assure engagement and equality activity. This would be supported by development of the Panel to include increased diversity, strengthened links to currently under-represented groups, mental health, LD, young people and other cohorts either through membership or working links. This arrangement would support the principle of no action or decision being made prior to evidence of appropriate patient and public involvement taking place.

- A task and finish group of the Patient and Community Panel to be established specifically to consider the business of the ICP and relevant documentation prior to each ICP meeting. This Task and Finish Group will be led by Healthwatch Wakefield's Chief Executive Officer.

- Current ICP Enabler reporting to be utilised alongside these arrangements and Healthwatch Wakefield Chief Executive Officer, as SRO for the Enabler, remain the point of contact for this including reporting to the Health and Wellbeing Board.

- Overview of feedback received utilising patient experience monitoring mechanisms and linking to Quality work at Place. This aspect would link with the proposal on place based approach to quality, as outlined in the work of the CCG's Quality Team.

- Service user stories at ICP meetings, represented in various formats.

- The voice of the citizen to be represented at ICP meetings as a standing agenda item, building on local engagement and patient experience work.

- Current engagement mechanisms to continue to ensure that Wakefield has varied channels and approaches across the ladder of involvement, from sharing of

information to co-production.

- Make recommendations to the Board on any anticipated issues via the Enabler SRO.

5   Next Steps

The expectation from West Yorkshire ICS is that places will introduce shadow arrangements from autumn 2021. Implementation guidance for 2021-22 confirms that until the Bill is passed, there should be no change to current formal accountability and decision-making arrangements. If theBill is passed, CCGs will be statutorily dissolved into ICS in April 2022 and new formal arrangements will need to be in place.

The timeline that is being worked to is detailed below:

Time period	Deliverables
September 2021 – October 2021	• Appointment of Chief Officer to ICS and Chair of ICS • Develop future governance arrangements in the light of legislation, national guidance (ICS and place) • Co-produce terms of reference, scope and MOU for ICS Board/Partnership/Governing Body, Partnership Board and committees • Establish ICS shadow governance arrangements • Develop terms of reference, scope and partnership agreements for Wakefield place based partnership arrangements and committees
Autumn 2021	• Shadow working: start to adopt new ways of working (decisions will still have to be ratified while ever CCGs remain statutory bodies) • Launch of Wakefield Provider Collaborative • Launch of shadow place committee • Launch of Wakefield Professional Leaders Strategic Forum • CCG citizen engagement and assurance committees reorientated to provide assurance to the Wakefield partnership Engagement work programme • Proposals developed for future governance and assurance arrangements
Spring 2022	• Approval process for future place governance arrangements

Time period	Deliverables
April 2022	• New formal governance arrangements are in place (CCG disestablished and Connecting Care Executive replaced with new arrangements)

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the update on progress across West Yorkshire and in Wakefield in mobilising the requirements of the NHS White Paper.

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Connecting Care Executive Meeting

Agenda item 3

Thursday 10 June 2021
11.00 to 1.00pm
Via Microsoft Teams

Present:	
Melanie Brown (MB) Chair	Director of Commissioning and Integrated Care, WCCG
Angela Nixon (AN)	Group Finance Manager, Adults Health & Communities, WMDC
Caroline Carter (CC)	Group Finance Manager, Children & Young People, WMDC
Suzannah Cookson (SC)	Chief Nurse, WCCG

In attendance:	
Jenny Lingrell (JL)	Joint Service Director, WMDC and WCCG
Martin Smith (MS)	Head of Connecting Care, WCCG
Elizabeth Goodson (EG)	Senior Finance Manager Partnerships, WCCG
Aimee Willett (AW)	Assistant Governance Manager, WCCG
Janice Ward (JWa)	Reablement Service Manager, WMDC
Michelle Domoney	Minute Taker

		Action
1.	**Welcome and apologies:** Andrew Balchin (AB), Anna Hartley (AH), Beate Wagner (BW), Stephen Crofts (SCr), Jo Webster (JoW), Jonathan Webb, Dr Ann Carroll, Gary Jevon, Nichola Esmond and Dr Adam Sheppard submitted their apologies.	
2.	**Declarations of Interest:** No declarations were made.	
3.	**Minutes from 11 March 2021:** The minutes were approved as an accurate record.	
4.	**Action Log:** Reviewing the action log, CCE members noted all actions were either closed or on today's meeting agenda.	
5.	**FOR DECISION: Night Turning Pilot: Funding Request:** Referencing the supporting paper, MS talked CCE members through the context behind the pilot, highlighting: • The MY Community Team approached the CCG prior to January 2021 to advise they used to turn their patients via their Integrated Care Team (ICT) at night however	

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due to capacity and lack of clarity with the service specification, they advised they could not continue to provide this service. WCCG, WMDC and Community meet to discuss how this service gap could be filled and discussed with MY a possible way forward. The Reablement Team came forward advising they could provide a service; adding there are other functions staff could do at night if demand was lower than expected;

- The Reablement Team agreed to run a pilot to understand the level of demand, the requirements of patients etc. Referrals to the service would come from the District Nursing Team.

Providing details on the pilot itself, JW highlighted:

- The ICT Team provided good information on the service they had been offering and provided specific training for staff on night pressure care;
- 4 existing staff members were commissioned onto a night rota to work in pairs on a district wide rota basis;
- There have been issues regarding capacity noting the amount travel required to provide this service;
- Since the pilot commenced on 11 January 2021 it has run from 11.00pm to 7.00am 7 days a week which, along with the rest of the Reablement Team, has provided a complete 24 hours service;
- The ICT Team model was followed, however running the pilot has identified some changes which need to be made in terms of communications;
- A simple referral system has been created for District Nurses to refer into via an email inbox using a similar referral form to one they already use. The inbox is monitored and visits are arranged as soon as referrals are received;
- There has been a waiting list on a couple of occasions and when there is a wait, the District Nurses do not appear to refer as frequently. In addition, details of the pilot may not have been widely known therefore the quality of data obtained regarding demand may have been impacted.
- There are opportunities to develop and expand the service further to reduce travel time across the district therefore increasing capacity and improving efficiency;
- Feedback received from professionals, GPs and service users has been excellent;
- The pilot has been successful from a Reablement Team's perspective with data provided to support its value acknowledging there is more that could be done and more data which could be collected;
- The Reablement Team are enthusiastic to continue the service programme in the long term; there are opportunities to pick up other service gaps in addition to night turns, though recruitment and additional training which would be required.

On behalf of CCE, MB thanked The Reablement Team for picking up this additional service during a pandemic.

CCE members acknowledged the work that has taken place and asked if any of the data collected showed the pilot prevented hospital admissions and how the pilot could connect with the wider safe transfer of care and community strategy. MS confirmed the original intention was for the pilot to dove tail with the reablement review David Hamilton was leading, adding this short pilot would demonstrate a return and feed into the review which was due to conclude in March in terms of how ICT and Reablement could work together, however Covid-19 has delayed the progress and completion of the reablement review therefore the reablement team are to continue with the pilot until the end of June 2021. MS highlighted there is a need for this service and that it should be part of a wider strategy. The request for further funding will allow the pilot to

continue whilst also allowing the wider strategy to catch up with the operational work.

MB expressed her gratitude to the Reablement and ICT teams for working together on finding a solution however suggested the proposal outlined in the supporting paper may not be a long term solution, adding it needs to be part of the Ageing Well Transformation System discussions which are taking place. MB advised Tilly Poole is leading an Ageing Well programme PMO in which there is some slippage of funding for 2021/22. MB therefore suggested the Night Turning Pilot is included on the agenda for the up and coming Ageing Well Programme 'rabble' meeting where funding will be discussed. **ACTION:** MB will ensure MS receives an invitation to this meeting and discuss the pilot with Debbie Newton in her next one to one meeting.

MB also suggested a wider discussion needs to take place regarding the integrated approach between the Reablement and ICT Teams, that a discussion takes place regarding the recurrent funding which is needed to provide night turning services, adding MYHT and WMDC do need to develop this as a joint piece of work.

Noting there is a gap in service and we do not want to put patient care at risk, MB suggested CCE agrees to support the pilot until March 2022 and that the Reablement and ICT Teams return to a future meeting to describe an integrated approach with suggestions on how the service can be funded recurrently.

MS confirmed he has submitted a request for Ageing Well monies to support the pilot and acknowledged finances need to be aligned to the wider strategy. Noting the total investment is an additional £200k to the system, MB advised the outcomes and impact of the service as well as future demand modelling need to be understood in more detail

Discussing if the pilot has been part of the fortnightly Reablement Review meeting agenda, JWa confirmed the pilot has not specifically been part of those discussions however steps are being taken to see how the team can come together; acknowledging from the discussions today, this needs to take place sooner rather than later and therefore MS and JWa will speak to Teresa Kirk regarding inclusion at a future meeting.

Noting the request for £200k is a large investment for the CCG and WMDC to jointly meet recurrently, MB asked if CCE members were happy with the proposal of supporting the pilot in its current form until March 2022 noting MS and JWa would return to a future meeting to present a future service model with suggestions on how to fund the service recurrently.

The CCE approved the pilot will continue in its current form until March 2022.

6.	**FOR DECISION: Connecting Care Executive Workplan 2021/22:**
	Referencing the supporting paper, MB highlighted the proposed key work areas which are predicated on the Terms of Reference, adding the items listed are proposed and are based on work areas covered in previous years though there could be new areas which need to be included.
	Discussing other items for inclusion the following was suggested:
	• EG asked if the annual agreement of uplifts for care homes, domiciliary care providers and CHC should be included when seeking sign off. MB advised

	there is a joint working section on the workplan which includes a generic CHC and Adult Social Care reference, however agreed the annual agreements do require a specific reference. Discussing when this should be timed for inclusion at CCE, January 2022 was proposed; • Mental Health Support Team update: Noting this programme of work is likely to be extensive, MB suggested an update is given late Autumn 2021 when key action points to be delivered become known from NHSE; • Development of Residential Homes for Children: JL advised there will be opportunities for joint commissioning and alignment between the care provision and emotional wellbeing and mental health support. The CCE approved the workplan as a working document for 2021/22. **ACTION:** Workplan to be updated to include the above additions.	
7.	**FOR DISCUSSION: Performance Objectives within the Better Care Fund: Achievements in the key areas:** After providing background information on the BCF for new members, MS advised: • No guidance was published for last year due to Covid-19; instead the advice from NHSE was to roll over the BCF plan from the previous year; • There were different funding streams to support Covid-19 for criteria to reside and discharges out of hospital; • Due to Covid-19, two new schemes were added and reporting requirements on Delayed Transfer of Care (DToC) were paused; • The year-end report was completed by MS and MB on behalf of the Health and Wellbeing Board (HWBB) (for which CCE is a sub-committee) due to short completion timescales; • The year-end report confirms (as a Wakefield system) all mandatory requirements have been met; • Included in the supporting papers for information is the now signed Section 75 agreement between health and care and the BCF plan which was submitted to NHSE. The plan reflects all the good work which has taken place as a system over the last year despite the pandemic. MS highlighted there are more joint roles in place, the senior leadership structure between health and care has changed and includes examples of good working practice i.e. Live Well Wakefield, Connecting Care Hubs; • The guidance for this year is still pending though it is expected to be standalone noting the White Paper changes the BCF; • Aligned commissioning has always been in place, however steps are being taken to move towards joint commissioning of services. MS asked CCE to agree to sign off the BCF 2020/21 Year End report retrospectively on behalf of the HWBB and note the Section 75 agreement for 2020/21 has been signed. Asking about the direction of travel, MB asked if it would be correct to assume	

the same minimum requirements would be required for this year as last and is there any indication if an updated plan needs to be submitted noting nothing has been requested as part of the planning round. MS advised he is part of the regional BCF network and nothing has been received to indicate this year's requirements. MB suggested BCF is added to the forward plan for WCCG Governing Body for January or March 2022 to ensure sign up to the BCF Partnership Agreement. MB recommended Wakefield does not wait for guidance to be released, suggesting steps should be taken locally to plan so that the legal teams and WMDC and WCCG colleagues are not under pressure to obtain the required (Section 75) agreements at short notice.

AN asked if financial allocations have been advised, adding it would be very helpful to receive this information as soon as possible. EG advised the planning guidance for last year described the proportion which was to be uplifted by a higher value; that is to continue again this year and will share with AN what that percentage is.

The CCE approved the BCF 2020/21 Year End report retrospectively on behalf of the HWBB.

ACTION: For the next CCE a generic paper is to be written which gives MS (for WMDC) and MB (for WCCG) delegated sign off. The paper is to include a timetable on the BCF Financial Plan for 2021/22 in terms of inclusion on future forward plans for CCE, WMDC Cabinet and WCCG Governing Body meetings.

On behalf of CCE, MB thanked MS, AN, EG and the wider teams for their continued hard work with the BCF.

8.	**FOR DISCUSSION: Update on Joint ASC Commissioning:**

Providing a verbal update, MS advised:
- Rates between WMDC, the Independent Sector Liaison Group (ISLG) and WCCG for the care sector which includes care homes, domiciliary care and supported living have been agreed. A new additional payment has also been agreed for those looking after residents with dementia and work will continue between ISLG, WMDC and WCCG to bring costings and quality models more closely together;
- Providers calls are still taking place, though have moved to fortnightly. The District Nursing teams attended the last meeting to advise on how they will be working differently, shared information regarding who the lead district nurse is for their areas and what new ideas the teams have. Skills for Care have also attended a recent meeting and provided an update on how they could support with the care workforce;
- A short/medium/long term plan has been developed which refreshes the Care Home Plan. Starting with the Domiciliary Care Strategy it considers how Wakefield could commission jointly with CCG and WMDC;
- Joint Quality meetings are still being held and lots of work is taking place regarding quality monitoring and surveillance and how to strengthen

processes when Providers become inadequate;

- Third Sector Framework is progressing. There have been some challenges with the first 25 Providers not meeting the requirements onto the framework, therefore the process is being looked at to see how it can be made easier to get Third Sector Providers onto the framework so it can start to be used by the system;
- The formal My Life Framework consultations for Supported Living has been completed and the responses are being reviewed;
- Work continues to support discharges from hospital including:
  - o Paying some incentives for Providers regarding Domiciliary Care to aid patient flow
  - o Working with Kirklees and others to see how designated beds can be made available should there be an increase in Covid-19 patients. Noting Dovecote Lodge and the 6 beds for green discharges discussions are taking place regarding sharing and joint commissioning for potential Covid-19 nursing leads as no Provider came forward;
  - o Challenging behaviours unit and what that may look like should it become a WMDC operated facility noting the Providers who have come forward quoted rather expensive rates. MS advised there are examples of patients with challenging behaviours on the wards however once patients are settled in a home, they are fine. We do not want to see these patients labelled as challenging for their entire length of stay and to not have care packages in place which do not suit their needs, so steps are being taken to address this further.

MB thanked MS for his update. Noting the significance of the CHC uplift which has been agreed, MB suggested a brief assurance paper is provided for the next CCE meeting so members can see what was agreed. MB also suggested the paper includes a forward plan on what is to take place in preparation for next year's uplift conversations. MB acknowledged the work MS has done across the CCG and WMDC in agreeing the uplift, noting the challenges which have been faced and thanked MS for his work in obtaining an outcome for care homes providers and care home residents. **ACTION:** CHC Uplift Paper to be added to September 2021 CCE agenda.

9.	**FOR DISCUSSION: Update on Joint Children and Young People Commissioning:**	
	Providing a verbal update, JL advised: - Funding is being made available to look at the emotional offer for children and young people due to the Covid-19 pandemic and the impact this has had and include the introduction of 4 mental health support teams within the district. The mental health support teams will be introduced in 2 phases. The first 2 teams will commence their training in January 2022 with all 4 teams operational from January 2024; - As part of the Residential Transformation Programme, work is taking place to identify a home for children with some of the most complex needs who are on the cusp (though won't move to) of tier 4. Conversations have taken place regarding this residential provision and how the Enhanced Outreach	

	Team at SWYPFT could potentially support moving forwards. A proposal will be shared with CCE in September 2021;	
	• A Young Carers Partnership Workshop took place on 14 May 2021 with partners attending from WCCG and WMDC who identified some opportunities to link with the community navigation offer (which is part of Future in Mind) and think about the recommissioning of the 0-19 service;	
	• Joint Commissioning of SENDIAS is underway. JL asked if this was something which would be added to the CCE forward plan noting there is a £70k contribution from WCCG. This was agreed.	
	• A dynamic purchasing system has been established for the short breaks offer which will allow an increase in the number of Providers on this framework from 6 to 12. JL will be looking to see how the short break offer links with the complex care, where children with SEND overlap with short breaks and how to ensure the offer made to families feels integrated and joined up.	
10.	**FOR DISCUSSION: CCE Committee Effectiveness Survey Results:** AW advised as part of the annual governance process for all sub-committees of WCCG Governing Body, the committee effectiveness survey is circulated to members. The supporting paper reflects the results received and AW highlighted a couple of areas members may wish to consider moving forwards: • Question 6: 'At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well, etc.' Half of those who responded noted disagree; • Question 11: 'What if anything, needs to change to enable the committee to be more effective in its role?' Some comments were made regarding the future of CCE and how its role and purpose could be improved. Thanking AW for the update, MB noted a conversation regarding the future of CCE would be a good discussion to have as the new governance arrangements for the ICP are developed. MB advised Ruth Unwin (RU) is undertaking a review of the HWBB, ICP arrangements to ensure everything is aligned; adding with the NHS changes, it is hoped a joint committee ICP will be established which may mean there is no longer a requirement for a CCE from April 2022 as all of CCE functions would be part of the new joint committee arrangements moving forward.. MB confirmed whilst future arrangements are being considered, a formal committee of WMDC and WCCG needs to continue until September 2021. MB added RU will be developing a WMDC Cabinet and WCCG Governing Body paper in October/November 2021 with a proposal and suggested RU Is invited to a future CCE meeting to talk through the proposals of wider partnership arrangements before they are shared elsewhere so that the proposals can reflect the needs of the CCE.	
11.	**FOR DISCUSSION: CCE Committee Annual Report:** AW advised as part of the annual governance reporting process an annual	

report is written to ensure committees are meeting the requirements outlined in the ToR. AW confirmed the supporting paper was circulated in advance today's CCE meeting so that it could be recommended to WCCG Governing Body at their meeting on 8 June 2021.

AW confirmed WCCG Governing Body approved the annual report with a recommendation made that membership is approved for the next 12 months; aligning to the updates in the ToR.

CCE noted the annual report and WCCG Governing Body recommendation.

12.	**FOR DISCUSSION: CCE Terms of Reference (ToR):**	

MB highlighted the changes which have been made to the ToR:
- AB has been removed as a member of CCE due to AB's responsibilities now as CEO for Wakefield Council. Chair and Vice Chair arrangements have therefore changed with JoW Chair and BW as Vice Chair. MB will cover Charing duties if both are not available to attend at CCE:
- Some flexibility has been added for AH with Stephen Turnbull (Deputy Director of Public Health) added as a member and voting member;
- SCr has been removed and JL has been added as a member of CCE following her recent joint role appointment;
- Reference to the Connecting Care Health and Social Care Partnership as a sub-group of CCE has been removed.

MB asked CCE members if there were any other changes to be made. The following was advised:
- Chief of Service Delivery and Quality role to be removed and replaced with Chief Nurse.

CCE supported the changes to the ToR as described.

13.	**FOR ASSURANCE: Finance Report for Wakefield Better Care Fund aka BCF Pooled Financial Monitoring Report:**	

Providing an update EG advised:
- The main change this year is the inclusion of the hospital discharge programme as a mechanism to be able to transfer funds between partners, however confirmed all expenditure has been fully recovered from NHSE;
- Due to Covid-19 there has been some underspend in some programmes with some work not able to be carried out;
- The uplift on the social care minimum could not be invested into certain services due to Covid-19;
- The main overspend is on mental health, particularly 117 packages where patients have complex care packages in place. There was also an additional 10 patients in year accessing these services;
- The hospital discharge programme does continue from 2021/22 with scheme 3 in Quarter 1 and scheme 4 in Quarter 2.

	MB thanked EG for the update and acknowledged the amount of work undertaken at both WCCG and WMDC to close the accounts at the end of each financial year. CCE accepted the report as described.
14.	**FOR ASSURANCE: Joint Legacy Reserves:** Providing an update, AN advised: • There is £71.5k of funds available from previous legacy schemes which could be used for the Night Turn service if required; if funding from Ageing Well is not successful; • There are some new schemes for this year following the late approval of some Section 256 agreements last year. AN understands there are plans to spend all funding allocated to these additional schemes though these as with all other schemes will be monitored during the year. CCE accepted the supporting paper as described.
15.	**FOR ASSURANCE: Joint Commissioning Panel Children and Young People Update and/or Minutes from February and March**: The CCE noted the minutes from Joint Commissioning Panel for assurance.
16.	**Matters to be referred to Governing Body, Health and Wellbeing Board or other Committee:** No items were raised.
17.	**Any Other Business:** Members briefly reflected on the CCE survey results, advising: • There has been reduced attendance today; • As a new member, JL noted the culture of an integrated approach is apparent within CCE and the tone in terms of a joint approach to problem solving is very positive; • EG welcomed members using their cameras, acknowledging in larger meetings it is not always possible.
18.	**Date and Time of Next Meeting:** Thursday 9 September 2021, 11.00 to 1.00pm via Microsoft Teams. If there are any urgent items which need to be addressed before September, members were asked to let MB know so they can be progressed virtually.

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Trust Board
28 September 2021
Agenda item 10.1

Title:	**Quality Strategy Update**
Paper prepared by:	Liz Twelves, Quality Improvement Specialist Sue Barton, Deputy Director of Strategy and Change
Paper presented by:	Director of Nursing, Quality & Professions
Purpose:	This report is intended to update Trust Board with regards to the plan to develop an updated Quality Strategy for the Trust, underpinned by the principles and practices of quality improvement
Mission/values:	The strategy will be underpinned by the Trust's vision, mission and values in their entirety: **Our vision** To provide outstanding physical, mental and social care in a modern health and care system. **Our mission** We help people reach their potential and live well in their community **Our values** • We put the person first and, in the centre, • We know that families and carers matter • We are respectful, honest, open and transparent • We improve and aim to be outstanding • We are relevant today and ready for tomorrow
Any background papers/ previously considered by:	This paper was reviewed and agreed at the Clinical Governance & Clinical Safety Committee on 14 September 2021.
Executive summary:	• The previous agreement to co-produce the Quality Strategy is now underway • The work is being led by an appointed Quality Improvement Specialist, with partnership working between the Integrated Change Team and the Nursing & Quality Directorate • A timeline has been developed of how we plan to proceed
Recommendation:	**Trust Board is asked to RECEIVE the Quality Strategy Update.**

With **all of us** in mind.

Update on developing a revised Quality Strategy

Background and current workstreams

At the Clinical Governance Clinical Safety Committee in June, it was agreed that a revised Quality Strategy would be coproduced between August 2021 and September 2022. In the meantime, ongoing work means we are continuing to make progress on assuring and improving quality and changing the way we work to become more effective at how we do this. This includes work on the priority programmes, local quality improvement initiatives, the #allofusimprove action plan, and wide range of assurance and improvement activities that support our ongoing commitment to deliver outstanding care.

The last 18 months have been unprecedented in the demands and challenges that our service users and staff have experienced and adapted to. We are also working on a recovery plan that will help us reflect, recover and embed successful innovation whilst providing assurance that care is safe, effective and person-centred.

Updating the Quality Strategy

The Quality Strategy is being refreshed using QI methodology, as a way of both ensuring the final product is as helpful as it can be, but also to role model the use of improvement methodology. In practice this means that we have commenced work to:

- take stock of how we are doing, and our systems and processes for delivering quality care
- listen to as many people as we can throughout our organisation and across our wider systems to understand their perspectives on what matters to them. This will explicitly include our service users, carers, staff and communities
- co-design our vision for quality
- Map the gap between the vision and where we are, identify changes we think will help us make further progress and define how we will make progress
- Begin to get a sense of where the Trust is with regards to its improvement journey.

As always, we will look through a comprehensive quality lens to understand how we are doing. However, this year, given the way in which the COVID-19 pandemic has shone a light on the differences in outcomes and experience of different communities, we are especially mindful of examining how we are performing on equality and inclusion, and how we can contribute to addressing some of the potentially deep-rooted structural issues that mean some people in our communities and services have worse outcomes than they should.

It is expected that the strategy will:

- Hold our values at its foundation

- Be clearly aligned with the Trust's strategic priorities
- Be co-produced alongside
  o people who use our services
  o friends and family of people who use our services
  o people employed in our services
- Be ambitious and describe our quality priorities and the concrete goals we are aiming for
- Share what we have learnt
- Explain how quality is woven into all the different activities and aspects of what we do and underpinned by our values
- Explain the means by which we will make progress, and how we will know that we have delivered on our promises
- Align all our work in relation to quality across the organisation, explaining how we connect and deliver both 'bottom up' and 'top down' quality improvement
- Align to quality within our Places and integrated care systems

Timeline

The following is the proposed timeline for this work. Please note that the different aspects of this work will run concurrently. The work is being undertaken in partnership with the Integrated Change Team and the Nursing & Quality Directorate, led by an appointed Quality Improvement Specialist.

August 2021	Commence stock take of our systems and processes for delivering quality care
September 2021	Commence process of listening and exploring the evidence about what quality needs to look like in the design of services, the organisation and in our relationships with communities and partners. We will work through existing fora and networks to listen to service users, staff and partners, and reflect on what we need to pay attention to (these are already underway).
December 2021	Commence exploration of explore our progress and challenges, learning both from our strengths and areas for development, mapping where we need to go next in our continuous improvement journey and how we will do that.
April 2022	Interim document provided to EMT and Clinical Governance and Safety Committee (CGCSC) on progress to date
August 2022	Draft strategy shared with EMT and CGCSC
September 2022	Revised strategy presented to Trust Board for agreement

Conclusion

This update is presented for information

Trust Board 28 September 2021
Agenda item 10.2

Title:	**Workforce Strategy 2021-2024: Equality Impact Assessment**
Paper prepared by:	Interim Director of Human Resources and Organisational Development.
Purpose:	The purpose of this paper is to seek agreement to the Equality Impact Assessment (EIA) for the Workforce Strategy approved by the Trust Board in April 2021. The Workforce Strategy EIA has been developed by using the detailed information in the Trust's Equality Workforce Monitoring Annual Report 2021, which is available on the internet, link attached here: Equality Workforce Monitoring Annual Report 2021
Mission/values:	The Workforce Strategy is at the heart of the Trust being able to deliver its stated Mission and Strategic Objectives. The EIA is designed to not only ensure that the Workforce Strategy does not adversely impact on equality groups but more importantly to ensure it positively promotes equality, diversity and inclusion in the workplace and the communities served.
Any background papers/ previously considered by:	The Workforce and Remuneration Committee considered and discussed the Workforce Strategy EIA at its meeting on 20th July 2021. The Executive Management Team (EMT) have also considered the Workforce Strategy EIA. The Workforce and Remuneration Committee and EMT have both approved the EIA as presented to the Trust Board.
Executive summary:	The Trust has agreed a new Workforce Strategy as part of its strategic objective of Making South West Yorkshire Partnership NHS FT a Great Place to Work. The Strategy was developed through an extensive engagement exercise with staff to gain insight on what they believe to be the essential elements of a great place to work. They identified five essential elements of a great place to work: • Feeling safe. • Being part of a supportive team. • Support to keep fit and well. • Investment in their potential. • Their voice counts. These five essentials are built on a foundation of: • Our values will guide how we lead, develop, and manage staff. • Equality, Diversity, and Inclusion will be central to everything we do. The EIA has used the extensive Equality Workforce Monitoring Annual Report 2021 to not only ensure that the Workforce Strategy does not unfavourably impact on equality groups but that also it takes positive action to improve equality, diversity and inclusion in the workforce.

	Risk Appetite
	The Workforce Strategy is designed to actively respond to reducing the Workforce Risks identified in the Trust's Risk Register and is consistent with the agreed risk appetite.
Recommendation:	**The Trust Board is asked to APPROVE the Equality Impact Assessment for the 2021-2024 Workforce Strategy**.

Equality Impact Assessment template to be completed for all policies, procedures and strategies

Date of assessment: 12 May 2021

	Equality Impact Assessment Questions:	Evidence based answers & actions:
1	**Name of the document that you are Equality Impact Assessing**	**Workforce Strategy**
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**	**The Workforce strategy sets out the workforce strategic plan for the next 3 years based on the priority of Making SWYPFT a great place to work and incorporating the NHS People Plan and People Promise.** **All staff across the Trust**
3	**Who is the overall lead for this assessment?**	**Lindsay Jensen**
4	**Who else was involved in conducting this assessment?**	**Paul Brown** **Cherill Watterston** **Gill Roberts (workforce equality data)**
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**	**The Trust engaged with more than half the workforce during 2019/20, including Staff Side organisations, to gain their insight in what they believe makes a great place to work. There were 5 key themes identified from the staff engagement and listening exercise on what people believe were the essentials of a Great Place to Work:** ➢ **Staff felt it was important to Feel Safe at Work by tackling violence, preventing bullying and harassment and having enough staff.** ➢ **Staff believed that it was important to be part of a Supportive Team with compassionate team leaders, effective team working and quality appraisal and supervision.** ➢ **Staff wanted support to Keep Fit and Well including being able to work flexibly and have a manageable workload.** ➢ **Staff wanted support to Develop their Potential with flexible career pathways, investment in their training and recognition of talent.** ➢ **Staff felt it was vital their Voice Counts and wanted to be listened to, engaged and involved in change.** **These 5 essentials have been developed into a series of organisational Pledges built on a foundation of Values and Equality, Diversity and Inclusion. The pledges have been developed into strategic actions which will remain consistent over the next 3 years.**
6	**What equality data have you used to inform this equality impact assessment?**	**The annual Workforce Equality Report 2021**

7	What does this data say?		The equality report provides a comprehensive set of data on our workforce which allows us to measure changes from the previous year and describes the planned actions in 2021/22. The key headlines from the report are as follows: • **Increase in starters from 664 from 598** • **Turnover is not significantly different from the previous year at 12.25%** • **6.4% of staff declare themselves as disabled up from 6.1% previous year** • **Staff survey shows that disabled people have a worse experience than non-disabled staff in relation to bullying and harassment however, there has been an improvement on previous years.** • **Some small improvements in the data on bullying and harassment overall** • **Compared to local census demographics of the areas we cover white British representation at just over 89% is broadly similar.** • **Mixed race staff are under-represented by 0.15%, Black staff are over-represented by 2.19% and South Asian staff are under-represented by 2.49%.** • **Looking at trust demographics there is significant under-representation of South Asian staff in Kirklees/Calderdale.** • **Improvements in the number of staff reporting their religion and sexual orientation** • **Gender – stable at 21.5% male 78.5% female – which is like all NHS bodies.** • **38.7% of staff are aged 50 or over.** • **No adverse barriers to training access for any of its staff regardless of their ethnicity, disability or sexuality. The number of courses accessed exceeds the Trust population for BAME and is not significantly different for disabled and LGBT+ staff.**
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	Yes/No	The Workforce strategy is built on foundations of our Trust values and Equality, Diversity and Inclusion and therefore should not affect any of the equality groups unfavourably. The intent is to improve the experience of all staff with particular emphasis on those where our data and staff feedback is showing we need to improve. There will be an annual delivery/implementation plan for each of the three years which will have performance and outcome measures delivered through a Workforce Strategic Group. Below are the actions and plan for each of the groups:
8.1	**Race**		The aim is over the next three years to improve representation of staff from ethnic minority backgrounds and staff experience across all levels of the organisation by delivering positive programmes aligned to the Great Place to work that supports staff already working in the Trust and attracting new employees. This includes a review

			of our recruitment and retention and disciplinary policies and processes, reducing bullying and harassment, targeted health and wellbeing, development opportunities through Moving Forward programmes, career conversations, inclusive leadership and management development and supporting the BAME staff network. The Race Forward programme and the development of equity guardians. The development and launch of Civility and Respect Guardians.
8.2	Disability		The strategy supports disabled staff to have a voice and influence the organisation through the development and support of the Disability Staff network. The launch of a new Disability and reasonable adjustments policy during Q/2 of 2021. The positive programmes aligned to the Great Place to work also supports disabled colleagues in the Trust and attracting new employees. This includes a review of our recruitment and retention disciplinary policies and processes, reducing bullying and harassment, targeted health and wellbeing offers and support, career conversations, inclusive leadership and management development programmes. The development and launch of Civility and Respect Guardians
8.3	Gender		The strategy supports our staff through developing and extending flexible and agile working across the Trust building on the learning from how we have we worked during the pandemic. More generally the positive programmes described above will also apply. Additionally, the offer of enhanced health and wellbeing initiatives focussed on supporting women's and men's health.
8.4	Age		Developing and extending flexible working and the supporting the development of the Carers network. Enhanced health and wellbeing.
8.5	Sexual orientation		Developing and extending flexible working and the supporting the LGBT+ network. The offer of enhanced health and wellbeing initiatives focussed on supporting women's and men's health.
8.6	Religion or belief		Developing an open and transparent culture through creating supportive teams. Launch of civility and respect guardians.
8.7	Transgender		As described in the section above. Supporting the LGBT+ network
8.8	Maternity & Pregnancy		Developing and extending flexible and agile working and the supporting the development of the Carers network.
8.9	Marriage & civil partnerships		Developing an open and transparent culture through creating supportive teams. Launch of civility and respect guardians.
8.10	Carers (Our Trust requirement)		Developing and extending flexible working and the supporting the development of the Carers network. Working in partnership with the staff carers' network to promote and embed the staff carers' passport. Work in partnership with the equality and engagement team to appoint a Carers Project Management Officer in 2021 to further develop trust support to working carers.

9	What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-	A set of metrics and measures will be developed to support the delivery of the workforce strategy and making SWYPFT a great place to work
9a	Promotes equality of opportunity for people who share the above protected characteristics;	We produce a Workforce Equality Report annually and WRES and WDES plans that provide data to supports us to develop equality of opportunity and a Learning needs analysis by service. We also use staff feedback and insight through many forums, partnership groups, staff side, our staff networks, NHS survey and other surveys.
9b	Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;	As above and supported by the WRES OD Lead, and BAME H&WB practitioner, Carers Project Management Officer and the establishment of civility and respect guardians and equity guardians across the Trust.
9c	Promotes good relations between different equality groups;	Collaboration between staff networks. Good partnership working with TUs and Staff side.
9d	Public Sector Equality Duty – "Due Regard"	This will be achieved through the development of a series of staff pledges for a Great Place to Work built on a foundation of Values and Equality, Diversity and Inclusion
10	Have you developed an Action Plan arising from this assessment?	An annual delivery plan will be developed each year of the life of the strategy annual which will be informed by our workforce equality data, WRES and WDES requirements.
11	Assessment/Action Plan approved by (Director Lead)	Sign: Date: Title:
12	*Once approved, you __must__ forward a copy of this Assessment/Action Plan to the partnerships team:* partnerships@swyt.nhs.uk Please note that the EIA is a public document and will be published on the web. Failing to complete an EIA could expose the Trust to future legal challenge.	

Title:	**Green Plan Equality Impact Assessment**
Paper prepared by:	Interim Chief Executive
Purpose:	To recognise the impact of the Green Plan on stakeholders with protected characteristics
Mission/values:	The Equality Impact Assessment (EIA) demonstrates the Trust's commitment to putting the person first and in the centre, being honest, open and transparent.
Any background papers/ previously considered by:	Green Plan EIA reviewed and supported by the Executive Management Team (EMT). The Trust Board has approved the Green Plan and requested an updated EIA be presented back to Trust Board
Executive summary:	The Green Plan will stand as the central document to guide the Trust's carbon reduction plan over the next five years. The Trust will use the Green Plan as a guide to reduce our environmental impact, reducing our costs through energy reduction, and adding social value into our community. The Green Plan's objectives are to meet the NHS's ambitious carbon reduction targets which will ultimately benefit staff, service users, all stakeholders, and future generations to come. This can only be achieved through changes in how the Trust operates, and in staff and stakeholder behaviour. Some of these changes, whilst being nationally mandated by the NHS and through national and international legislation, may impact on equality groups disproportionately. This Equality Impact Assessment identifies which groups may be impacted by the Green Plan and why. It also explains how through effective engagement and communication these impacts can be mitigated.
Recommendation:	**The Trust Board is asked to APPROVE the Green Plan EIA.**
Private session:	N/A

With **all of us** in mind.

Appendix 2 – Equality impact assessment

Date of assessment: March 2021

	Equality Impact Assessment Questions:	Evidence based answers & actions:
1	**Name of the document that you are Equality Impact Assessing**	Trust Green Plan
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**	The Green Plan replaces the previous Sustainability Strategy. The Trust recognises the scale of the challenge that climate change presents in our region and the impact it will have on our service users, staff, and our local community. The Trust is committed to ensuring that sustainability is embedded throughout all aspects of our organisation so that we can minimise our carbon emissions, air pollution and waste. We are dedicated to adopting sustainable practices to ensure our operations and estate are as sustainable, efficient, and resilient enough to enable us to continue to deliver excellent physical, mental and social care in the future. The Green Plan will build upon our successes to date and outline our targets and ambitions for the future. The Green Plan will stand as the central document to guide the Trust's sustainable development over the next five years. We will use the Green Plan to guide us in reducing our environmental impact, reducing our costs through energy reduction, and adding social value into our community. The Green Plan addresses nationally set targets and objectives which are mandated within the NHS contract. In addition, by meeting these targets and the wider objectives the Trust, its staff, service users, carers and communities we serve will become more sustainable.
3	**Who is the overall lead for this assessment?**	• Director of HR Organisational Development and Estates
4	**Who else was involved in conducting this assessment?**	• Kevin Gelder Strategic - Planning Lead & Trust Sustainability Lead
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?**	The timescale for developing the strategy had been delayed following the COVID19 Pandemic. Every NHS organisation is required to have a Green Plan in place by April 2021 and this will set out the Trust's strategic objectives. There has been a series of engagement events to raise awareness of the Green Plan and to gauge interest from staff. These have included meetings in Wakefield, Halifax, Huddersfield and Barnsley as well as more recently open invite Teams meetings.

	What did you find out and how have you used this information?	An i-hub challenge generated over 70 suggestions and ideas around how the Trust could become more sustainable which have fed through to the proposed actions underpinning the objectives.
		In addition, conversations have taken place with heads of service across the Trust to seek their views and opinions on how they and their sphere of influence is and can work to meet the challenge.
		A meeting has also taken place with Staff Side representatives who have expressed support and agreed to nominate a lead to work on the delivery of the Green Plan.
		The Green Plan provides the strategic overview for the Trust over the next 5 years. Each of the 10 objectives will have its own workstream, actions and delivery plan prior to which the actions will be reassessed for any impacts.
6	**What equality data have you used to inform this equality impact assessment?**	<u>The communities we serve:</u>
		In all communities the 2011 census tells us there is on average across all areas there is a 1% difference in the population reported as male and female, with female reporting higher. Across all ages Calderdale has the highest 0-15 population at 19.6% and Barnsley has a higher working age population 30-44 at 26% and older population 60+ at 23.8%. Christianity and Islam respectively are both the highest reported religion and belief.
		We know that White British people make up 87% of our region's local authority population, more than the England average of 81%. The other main minority groups include Black or Black British people comprised 1%, less than the England average of 3%, while Asian or Asian British people comprised 8%, the same as the England average (2011 census). The local authorities with the largest proportions of Asian people are Kirklees (16%) and Calderdale (8%). This profile is likely to change significantly over the next 20 years with BME groups accounting for almost 80% of the UK's population growth (Policy Exchange, 2014).
		We know that those who report having a disability that impacts them a lot is higher than the census 2011 national average of just over 4% in our local areas range from 8% to over 13% in the communities the Trust cover.
		<u>Workforce data</u>
		As per Workforce Equality Report 2021
		The Trust currently employs 4,530 staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services.
		• The Trust split of 78.5% female to 21.5% male is reflected approximately across most areas, except for Medical Staff (41%/59%). As in previous years, female staff make up over three quarters of Trust staff
		• As in previous years, the highest number of Trust staff fall in the age bands 40-49 and 50-59 with over 53% of the total staff being between 40 and 59. Just over 70% of medical staff are between 40 and 59. Support Services have the highest percentage of staff in the 60-69 age

bands with 16% (118) being 60 or over, an increase on the previous year (102)

- The data shows that 6.4% of our staff consider themselves to have a disability, a slight increase on last year. The total number of staff is 292 compared to 266 last year.

- Just over 89% of all Trust staff are white, this is not significantly different from the combined local populations. The Black ethnic group is over-represented in the Trust in all areas and in total except for Support Services. In general, the other minorities are under-represented in Trust staff.

- The number of staff who have not stated their religious belief (Unknown) has decreased slightly from 2019 (21%) to just over 19% currently. Staff reported as 47% Christianity, 3% Islam, 12% other and 19% Atheism.

- There has been a consistent increase in the number of staff reporting their sexual orientation. Currently 85% of staff have provided data indicating their sexual orientation. 81.5% of staff report as heterosexual and 3.5% as LGBT.

7	**What does this data say?**	The local population we serve and the staff who work in our services represent a diverse population. The Green Plan and the subsequent delivery of the action plans must therefore reach out and provide the opportunity for involvement and engagement from a diverse population.	
8	**Taking into account the information gathered above, could this strategy affect any of the following equality group unfavourably:**		Whilst the Green Plan's objectives are to create a more sustainable Trust which will ultimately benefit staff, service users and all stakeholders and future generations, this can only be achieved through changes in how the Trust operates and in staff and stakeholders behaviours. Some of these changes, whilst being nationally mandated by the NHS and through national and international legislation may impact on equality groups disproportionately. The Green Plan proposes a Sustainable Action Plan (Section 6) covering 10 wide ranging areas which will act as a framework by which the Trust can move towards our strategic objectives. Individual actions will be identified and agreed, assigned to a relevant person or group for responsibility and given a timescale for implementation. The Sustainable Action Plan will be developed via a process of consultation and engagement with our staff and stakeholders to identify and agree relevant actions that the Trust can take to achieve our strategic objectives. This engagement will be conducted in an inclusive and collaborative manner to ensure the process identifies where protected characteristic groups may be disproportionately affected and identify actions to mitigate this.
8.1	**Race**	**Yes**	Not addressing the climate crisis and sustainability will continue to have a global impact with the most severe consequences felt in developing countries. Our staff and communities will have strong links across the world with the impact of floods and rising

temperatures reaching close to home. The Green Plan will raise awareness of the issues at a local and global level.

	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

Census 2011

The Green Plan and Sustainable Action Plan within it will need to ensure that engagement and communication is accessible to all staff and stakeholders, recognising the higher than average proportion of the population from Kirklees identifying as Asian.

We will engage and run focus groups with the Race Staff Network as future workstreams are developed to ensure action plans are co-produced.

8.2 **Disability** **Yes**

Compared to the national average all the areas covered by the Trust have a significantly higher proportion of people whose day to day activities are limited a lot by disability.

There is the possibility that any actions promoting sustainable green travel (3.4.3) and a reduction in private vehicle journeys (including the use of technology) may adversely impact those who do not have a viable alternative, such as the use of public transport or walking or who may have difficulties with using technology.

We will engage and run focus groups with the Disability Staff Network as future workstreams are developed to ensure action plans are co-produced.

	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

8.3	**Gender**	**Yes**	With over three quarters of staff being female with 40% working part time, any action within the Green Plan and Sustainable Action Plan has the potential to affect this group disproportionately. Initiatives to promote green travel and only provide initially Ultra Low Emitting Vehicles and then Zero Emitting Vehicles through the Trust car scheme (section 3.3) may reduce choice and affordability for staff to participate in such schemes.

Such awareness will need to be factored into the development and introduction of all actions within the Green Plan, notwithstanding that some are nationally mandated. Effective engagement will be key to the design and development of actions emanating from the Green Plan.

	Male	**Female**
England % av.	49.2	50.8
Kirklees		
% average	49.4	50.6
Barnsley		
% average	49.1	50.9
Calderdale		
% average	48.9	51.1
Wakefield		
% average	49	51

Taken from Census 2011 data

The Green Plan's 10 strategic objectives have been adopted to address the 17 UN Sustainable Development Goals (**Error! Reference source not found.** section 2.5) which include Gender Equality (no.5). Adopting strategic objectives aligned to the UN

			SDGs ensures that the Trust will work towards building a more sustainable organisation.
8.4	**Age**	**Yes**	The Trust provides services to children and young people through to older age adults. The table reflects the population age of the communities the Trust serve and there is increasing evidence that Barnsley represent a higher than average older population and Calderdale a higher than average age range of 0-15 age range. The Trust will ensure that information, communication, and environments support people of all ages.

Table (within 8.4):

	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

The Green Plan will ensure the Trust is a resilient organisation and adaptable to change including extreme weather events which often adversely affect the elderly.

There is the possibility that actions such as promoting alternative workstyles / use of technology may adversely impact those who are uncomfortable with such proposals.

Engagement with these groups will need to be undertaken as part of the development of any action / delivery plans

8.5	**Sexual orientation**	**No**	The Trust will improve on the recording of sexual orientation in line with the 'Sexual Orientation Monitoring standard' so the Trust can ensure that services and workforce adequately represent the population they serve. The 2020/21 census may contain further baseline information which can be used to support the Trust understanding further. A campaign to support better data collection will improve our reporting.
8.6	**Religion or belief**	**Yes**	The Trust have a spirit in mind service who play a central role in engaging faith and spiritual leaders in the communities we serve and involving them in the work of the Trust. Understanding religion and belief plays an important role in driving our offer.

The information below tell us that Calderdale and Kirklees require a focus on Muslim faith, with Christian faith representing a large proportion of people who use our services in all areas. Other faiths will be reflected in geographical areas. The Green Plan and Sustainable Action Plan within it will need to ensure that engagement and communication is accessible to all staff and stakeholders.

	Christian	Buddhist	Hindu	Jewish	Sikh	Muslim	Other	No religion
England % av.	71.8	0.3	1	0.5	0.7	10.1	0.2	15.1
Kirklees								
% average	67.2	0.2	0.3	0.1	0.7	10.1	0.2	14
Barnsley								
% average	59.4	0.5	1.5	0.5	0.8	5	0.4	24.7
Calderdale								
% average	60.6	0.3	0.3	0.1	0.2	7.8	0.4	30.2
Wakefield								
% average	66.4	0.16	0.25	0.04	0.12	2.0	0.3	24.4

Taken from 2011 Census data

8.7	**Transgender**	**Yes**	A trans equality policy aimed at workforce and people who use services will be co-designed and the approach endorsed by partner organisations. The policy and agenda for transgender people will remain a key focus and data collection will be reviewed and improved using a campaign to support improvements to disclosure and recording. The 2020/21 Census report may provide further baseline data. The Green Plan's 10 strategic objectives have been adopted to address the 17 UN Sustainable Development Goals (**Error! Reference source not found.** section 2.5) which include Gender Equality (no.5). Adopting strategic objectives aligned to the UN SDGs ensures that the Trust will work towards building a more sustainable organisation. We will engage and run focus groups with the LGBT+ Staff Network as future workstreams are developed to ensure action plans are co-produced.

8.8	Maternity & Pregnancy	Yes	There is the likelihood that actions promoting sustainable green travel and a reduction in private vehicle journeys may adversely impact those who do not have a viable alternative, such as the use of public transport or walking. Engagement with these groups will need to be undertaken as part of any Travel Plan and or proposed actions.
8.9	Marriage & civil partnerships	No	

Area	Civil Partnership	Divorced/Legally Separated	Married	Single	Widowed	Unknown	Grand Total
Barnsley	9 0.8%	109 9.8%	638 57.1%	341 30.5%	15 1.3%	5 0.4%	1,117
Calderdale and Kirklees	16 1.8%	94 10.8%	401 46.2%	337 38.8%	8 0.9%	12 1.4%	868
Wakefield	4 1.8%	38 10.8%	199 46.2%	112 38.8%	7 0.9%	4 1.4%	364
Forensic Services	9 1.4%	51 8.1%	251 40.1%	305 48.7%	5 0.8%	5 0.8%	626
CAMHS BDU		33 11.1%	137 46.3%	122 41.2%		4 1.4%	296
Inpatient Services	2 0.6%	28 7.8%	127 35.4%	200 55.7%	1 0.3%	1 0.3%	359
Support Services	9 1.2%	76 10.4%	416 56.9%	212 29.0%	9 1.2%	9 1.2%	731
Sub-total	**49** **1.1%**	**429** **9.8%**	**2,169** **49.7%**	**1,629** **37.4%**	**45** **1.0%**	**40** **0.9%**	**4,361**
Medical Staff	2 1.2%	4 2.4%	132 78.1%	29 17.2%	1 0.6%	1 0.6%	169
Grand Total	**51** **1.1%**	**433** **9.6%**	**2,301** **50.8%**	**1,658** **36.6%**	**46** **1.0%**	**41** **0.9%**	**4,530**

Trust Workforce & Equality Report 2021
It is not considered that the Green Plan will have an adverse impact on this group other than their inclusion within any of the other groups.

8.10	Carers (Our Trust requirement)	Yes	It's likely that every one of us will have caring responsibilities at some time in our lives with the challenges faced by carers taking many forms. Many carers juggle their caring responsibilities with work, study and other family commitments. Some, younger carers, are not known to be carers and this means that the sort of roles and responsibilities that carers must provide varies widely. Within the local footprint of South West Yorkshire Partnership NHS Foundation Trust, there is an estimated 160,000 unpaid carers. We need to ensure that within developing actions within the Sustainable Action Plans we recognise the role and importance of carers and assess any impacts such as reducing the affordability of vehicles through the Trust car scheme (by limiting it to electric vehicles) and promoting green travel at the expense of free parking. We will engage and run focus groups with the Carers Staff Network as future workstreams are developed to ensure action plans are co-produced. The Trust will continue to record carers as part of equality monitoring and continue to develop and deliver actions to support carers as part of the strategy action plans.
9	What monitoring arrangements are you		This strategy is subject to Trust Board approval with delivery through the Trust's Executive Management Team. The Director of Human Resources, Organisational Development and Estates will be the lead director who will be accountable for delivery of this strategy. This will be supported by all

	implementing or already have in place to ensure that this policy/procedure/strategy: -	executive directors, deputy directors, business delivery units (BDUs) championed by the Trust chair and non-executive directors.
		Implementation of the strategy and in particular the workstreams, actions and delivery plan will see involvement from staff across the organisation, in both business delivery units and in support service functions as well as creating opportunities for service users, carers, volunteers and wider communities and partner organisations to be involved. Staff side will play an active role within the implementation of the Green Plan and have a confirmed that they will have a nominated Sustainability representative.
		We will engage and run focus groups with the Trust's Staff Network as future workstreams are developed to ensure action plans are co-produced.
		Delivery will be monitored by the Sustainable Development Assessment Tool (SDAT) or replacement which will be an annual submission. In addition, the Trust reports its Carbon Footprint within the Annual Plan and will be measured against mandated targets.
		The Green Plan provides the strategic overview for the Trust over the next 5 years. Each of the 10 objectives will have its own workstream, actions and delivery plan prior to which the actions will be reassessed for any impacts. This will extend beyond the protected characteristics below and will also reflect limiting choice or additional expenditure because of any proposed actions.
9a	Promotes equality of opportunity for people who share the above protected characteristics	The Green Plan and its strategic objectives are linked to and will be measured against, the United Nations Sustainable Development Goals section 2.5). At its heart are the 17 goals, which recognise that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education and reduce inequality.
		Engagement will be a core theme throughout as workstreams / activities are designed and developed to ensure equality of opportunity.
9b	Eliminates discrimination, harassment and bullying for people who share the above protected characteristics	Being a sustainable organisation recognises the importance of staff satisfaction and wellbeing at work which are a key component of the Green Plan (section 6.8).
		The Green Plan and its strategic objectives are linked to and will be measured against, the United Nations Sustainable Development Goals (section 2.5). At its heart are the 17 goals, which recognise that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education and reduce inequality.
9c	Promotes good relations between different equality groups	The Trust values promote good relations and these form part of recruitment, training and appraisal functions. Being a sustainable organisation recognises the importance of staff satisfaction and wellbeing at work which are a key component of the Green Plan.

9d	**Public Sector Equality Duty – "Due Regard"**	Actions and delivery plans will be developed to deliver the Green Plan objectives over the life of the plan and actions will be reassessed for any impact as they develop. Engagement will be a core theme throughout as workstreams / activities are designed and developed.
10	**Have you developed an Action Plan arising from this assessment?**	Actions and delivery plans will be developed to deliver the Green Plan objectives over the life of the plan and actions will be reassessed for any impact as they develop. Where actions lead to supplementary plans or polices, for example a Travel Plan then specific EIA's will be undertaken.
11	**Assessment/ Action Plan approved by (Director Lead)**	**Sign:** **Date:** **Title:**
12		*Once approved, you <u>must</u> forward a copy of this Assessment/Action Plan to the Equality and Engagement Development Managers:* **Aboobaker.bhana@swyt.nhs.uk** **Zahida.mallard@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on the web. Failing to complete an EIA could expose the Trust to future legal challenge.**

Title:	**Quality account approval 2020/21**
Paper prepared by:	Director of Nursing & Quality
Purpose:	The quality account report is an annual report that focuses on how we perform against a set of quality priorities that we set for ourselves and a range of mandated items as identified by NHSI & DHSC. The aim is to identify how we provide safe and effective services, reflect areas that we need to improve upon and celebrate our successes.
Mission/values:	All of the quality priorities we set in the quality account process are in line with our mission and values.
Any background papers/ previously considered by:	Previous quality account update papers
Executive summary:	**Background** Each year the Trust has a responsibility to produce a quality account and a quality report as part of the annual reporting procedures. These reports are produced in a combined format. Preparation for the report is ongoing throughout the year with detailed guidance being published in early January that indicates any changes to that year's reports. Due to the pandemic, in 2020 the arrangements for the publication of the quality account/ quality report were modified to reduce the burden on provider organisations. **Production of 2021 report** *Key points to note:* • In a letter dated 15th January 2021 (from NHSE/ NHSI) - NHS accounts timetable and year-end arrangements – with provider annex, indicated that DHSC were reviewing the submission date of the Quality Account with a view of revising the date. Further publications between January & April 2021 substantiated this view. However, on 4th May 2021, DHSC brought to the Trust's attention that no changes were to be made to the Quality Account submission date of 30th June 2021. • The production of this quality report has been done in line with the 2019/20 Detailed requirement for Quality Account Production (DHSC) including adherence to the full governance requirements as outlined in the Quality Account Toolkit (DHSC, 2011). Updated

	guidance from NHSE/NHSi, in 2021, removed the requirements for a limited assurance statement from our external auditors for 2021 and in future reports.
	• Due to the ongoing pressures from the pandemic, the completion dates for quality priorities for 2020/21 have been moved to March 2022.
	• The Trust has received feedback from 7 partners – feedback will be reviewed and included in the production of future Quality Account reports where we are able.
	Risk appetite
	The trust continues to have a good governance system for monitoring and reporting against the actions that are required to support the quality account process.
	This report covers assurance for compliance risk legislation. This meets the risk appetite –low and the risk target 1-6.
Recommendation:	**Trust Board is asked to RECEIVE the Quality Account 2020/21.**
Private session:	Not applicable.

Quality

Account

Report

2020/21

Contents

Part 1:
Chief Executive and Chair's Welcome

This has been a year like no other for our organisation and the NHS as a whole. The coronavirus pandemic quickly changed the way we live and work, forcing rapid solutions to unexpected and unprecedented situations. We have had to work fast in our response whilst maintaining consistency of services.

In responding to COVID-19, we have ensured that we have considered all aspects of quality – safety, effectiveness, experience, responsiveness and leadership. What this looks like is different for the variety of teams in our organisation. A community nurse still dresses an older person's legs in her home; an occupational therapist works on the ward with people experiencing acute mental health problems; crisis teams need to be on the streets; whilst talking therapies were delivered online or on the phone, and Recovery College courses went digital.

It is a testimony to our staff and systems that services have been maintained, in some instances transformed and others curtailed and risk managed. Our strong emergency preparedness resilience response structure and governance have ensured that we have had a handle on quality throughout, backed by ethical decision-making frameworks and guidance that has often been emergent across the three waves of COVID-19.

Our Bronze (operational), Silver (tactical) and Gold (strategic) command structures ensured a representative and considered approach. Leadership at all these levels saw us navigate and communicate new guidance around Personal Protective Equipment, testing, and vaccinations – both for flu and COVID–19 and service pressures, staffing and policy changes.

Living and working in a pandemic has been incredibly difficult and we are proud that, despite the challenges, some services have substantially improved. Our teams have also been successful in becoming accredited for the quality of their care – like our adult attention deficit hyperactivity disorder (ADHD) and autism service, who received accreditation for community mental health services (ACOMHS) from the Royal College of Psychiatrists, and Kirklees memory service, who received Memory Services National Accreditation Programme (MSNAP) recognition.

Our staff survey results have improved too. Five key theme scores have been improved (by a level which is statistically significant), these are: equality, diversity and inclusion; health and wellbeing; morale; staff engagement and safety culture. Five key themes scores were unchanged from 2019, and no scores have got worse. Staff who feel supported, encouraged, respected and valued will go the extra mile to deliver outstanding care, so it's important we continue to build on these outcomes.

We are a learning organisation and admit that sometimes we get things wrong. These are always opportunities for us to recognise where we could do better. Learning is critical to the delivery of safe and effective services and to avoid repeating mistakes. Our serious incident review process has been accredited by the Royal College of Psychiatrists, demonstrating the quality of our procedures following a serious incident. A healthy incident reporting culture is indicative of an open, honest and improving organisation.

The coronavirus pandemic changed our lives and it is not over yet. As we plan for the future, we will retain quality as an organising principle as we recover, building on the work we have done so far with our valued and diverse communities to make local health and care services better for everyone.

Statement of assurance

This Quality Account has been prepared in line with the requirements of the NHS Act 2009, regulations of the Health and Social Care Bill 2012 and NHS Improvement, the independent regulator of foundation trusts.

The Board of Directors has reviewed the Quality Account and to the best of our knowledge, we confirm that the information contained in this report is an accurate account of our performance and represents a balanced view of the quality of services provided by the Trust.

Date: August 2021

Chair: Angela Monaghan

Date: August 2021

Interim Chief Executive: Mark Brookes

Part 2: Priorities for improvement and statements of assurance by the board

Part 2.1 – Priorities for improvement

In part two of our Quality Account we will outline our planned improvement priorities for 2021/22.

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has used feedback collated from a range of feedback sources, i.e. from regulators and stakeholders, staff and service user experience, to inform our quality priorities. Against each of our quality priorities we've set ourselves measures for success. The measures are reviewed and refreshed each year to make sure we're adapting to both local and national intelligence and progressing against our aim to move from '***good to outstanding'***.

Our approach to quality improvement

Our Trust-wide improvement approach is clearly reflected in our Quality Strategy, which starts with our mission and values. In 2021/22 we will be refreshing our strategy and engaging with people who use our services, carers, colleagues, and stakeholders to refresh the quality strategy, quality improvement as part of this and our quality priorities for the forthcoming years.

Our mission and values

We exist to help people reach their potential and live well in their community. To do this we have a strong set of values that mean:

- We put people first and, in the centre, and recognise that families and carers matter
- We will be respectful and honest, open, and transparent, to build trust and act with integrity
- We will constantly improve and aim to be outstanding so we can be relevant today, and ready for tomorrow.

Quality is the organising principle for our services. It is what matters most to people who use services and what motivates and unites everyone working in health and care services. The Trust's quality strategy sets out a vision for the organisation and identifies key strategic objectives and aspirations to build on our strong foundation and further improve the quality of our services on our journey to be outstanding.

We know that to provide high-quality person-centred care we must be a well-led organisation committed to delivering safe, effective, responsive and caring services.

In SWYPFT we define quality as the achievement or surpassing of best practice standards and describe this as a "*quality counts, safety first*" approach.

To us this means

Safety: people are protected from avoidable harm and abuse. When mistakes occur, lessons will be learned.

Effective: people's care and treatment achieve good outcomes, promotes a good quality of life, and is based on the best available evidence.

Caring: staff involve and treat people with compassion, dignity and respect.

Responsive: services respond to people's needs and choices and enable them to be equal partners in their care.

Well-led: an organisation that communicates well, is open and transparent, works together and in partnership with local people and communities, and is committed to learning and improvement.

In 2020/21 we have taken time to further develop alignment of our strategic objectives, priorities and programmes, with quality initiatives and we will use these as a framework to focus improvement, innovation and monitor assurance.

As part of our strategy, against each quality domain, we set out a number of objectives, some of which are aspirational, and will take several years to achieve. To realise the objectives, we have identified a number of quality improvement projects, with a specified timeframe for delivery. The progress against the projects will be revisited bi-annually, reviewed and where necessary, amended to ensure we make the required progress.

The timescales for each of the projects vary, depending on the availability and complexity of the improvement. All quality improvements have identified delivery and outcome measures so progress can be monitored. The projects that have been monitored as part of the quality account process for 2020/21 and are reported on in 'Part 3 – Our Performance in 2020/21', of this report. Performance against the measures has been delayed due to the COVID-19 pandemic, and as a direct consequence of this the completion dates for our priorities have been extended by 12 months.

Our approach to quality governance

Our executive lead for quality improvement and quality governance is the Director of Nursing, Quality and Professions. Our trust-wide improvement approach is clearly reflected in our updated Quality Strategy, which starts with our mission and values. These embed the drive to 'improve and be outstanding' enshrined in our values.

Within our Quality Strategy we describe an approach to the delivery of change based on the NHS Change Model. Through this we ensure that quality improvement occurs as near to people who use our services as possible, and we support the delivery of change initiatives to ensure quality improvements are successfully implemented.

In 2021/22 we will continue our focus on the development of skills for improvement throughout our workforce, working with our local Academic Health Science Network (AHSN), National Health Service Improvement (NHSI) and others to build capacity and capability for change.

To guide our development, we report on quality indicators in our integrated performance report (IPR), including The NHS Friends and Family Test (FFT), infection prevention and control, serious incidents, safer staffing, pressure ulcers, CQUIN performance, restrictive interventions and complaints. Each of these has a specific 'stretch' target that reflects improvement in quality, and can be viewed by team, service and Trust-

wide. The report is considered at the Executive Management Team (EMT), Trust Board and its committees. This enables us to evidence the return on our investment in quality.

We learn through a robust clinical audit programme and we participate in research and development with links to universities and AHSN. We also contribute to and learn from external benchmarking and reporting initiatives, including the National Confidential Inquiry into Suicide and Homicide (NCISH), mental health benchmarking and workforce capacity and demand. There is also an active programme of quality monitoring visits to our operational areas, from which we derive significant learning and quality assurance.

In line with the vision we set out in our Quality Strategy we are using the Model for Improvement to address themes identified in the Care Quality Commission (CQC) SWYPFT inspection report (2019). We have collaboratively developed an improvement plan to address all concerns raised from our CQC inspection. For the MUST do actions there are common themes that impact on our overall rating for the safety domain. In line with our principle of Safety First we have adapted our approach of previous years, so there is now more focus on using quality improvement methods to address these concerns.

We acknowledge that our drive for quality improvement can be put at risk if routine quality assurance measures are not in place. Therefore, we have introduced an enhanced clinical risk performance report that is presented to the Operational Management Group (OMG).

Central to our approach to governance of quality and improvement is the Clinical Governance and Clinical Safety Committee (CGCSC). This is a committee of the Trust Board. Reporting in to the CGCSC is the Trust's Clinical Governance Group. The purpose of the group is to assure safe, effective, caring, responsive, innovative and well-led practice in accordance with the Trust's Quality Strategy. The functions of the group are horizon and risk scanning; interpretation and reporting of national/local quality and safety directives; critical consideration of organisational quality and safety improvements; information sharing; planning and monitoring delivery against plan. We also have a Members' Council Quality Group to support the Trust in its approach to quality.

We believe strong clinical leadership, supported by opportunities for innovation and robust governance arrangements will help us deliver a culture where high quality services will flourish. Through our #allofusimprove campaign we aim to make quality everyone's business. We will achieve this by focusing on strong staff engagement and involvement, increasing the resources that are available to assist staff to make the improvement, creating a culture for nurture and learning, led by our trio model partnership of clinical, operational and governance roles in our leadership teams.

Our quality priorities – summary of performance in 2020/21

Throughout 2020/21 we measured activity against each of our quality priorities. Performance against the measures has been impacted due to the COVID-19 pandemic, and specific progress against each is not always what we would have hoped to report given our overwhelming focus on the pandemic response. The progress that has been made can be found in 'Part 3 – Our Performance in 2020/21. As a Trust we have decided, given the paramountcy of the pandemic response, to roll forward any quality priorities from 2020/21 to 2021/22, where we are clear that further progress is still required.

Quality priorities 2021/22

We use the 5 domains of SAFE, EFFECTIVE, CARING, RESPONSIVE & WELL LED (Care Quality Commission) as a framework to organise our quality priorities. It is important to note that some of the projects span more than one quality domain and for ease they have been placed with the 'most relevant' domain.

SAFE- people are protected from avoidable harm and abuse. When mistakes occur, lessons will be learned
- Quality domain – Safety

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Staffing initiatives Staffing establishments in mental health community teams to be reviewed and improved.	Review safer staffing in the community with a view to developing a community safer staffing tool	Trust-wide community teams	Project plan developed & progress against planned objectives to be monitored via the safer staffing group and operational management group	Staffing establishments reviewed and updated.	**Extended to March 2022**
Patient safety strategy Reduced frequency and severity of harm resulting from patient safety incidents Reduced costs, both personal and financial associated with patient safety incidents	Implement safe wards and reduce restrictive interventions We aim to reduce the total number of prone restraints across our services	Mental health and learning disability inpatient services	Sign up to safety project will be monitored in Patient Safety Group. Trajectories will be set to demonstrate progress for each year (2019-21)	**5% reduction** in prone restraints lasting more than 3 minutes by 2020 Downward trend in use of seclusion across the Trust by 2021	**Extended to March 2022**
	Expand programme of safety huddles over the next 12 months	Safety huddles targeting key risks are established in all services	Progress through will be monitored in Patient Safety Group. Trajectories will be set to demonstrate progress for each year	Increase in the number of people trained to implement safety huddles Increase in number of teams who are using safety huddles at team level Collation of information to demonstrate impact of safety huddles on patient safety incidents	**Extended to March 2022**

Suicide prevention	Implement actions from Suicide Prevention Strategy	Trust-wide services	Progress against planned objectives monitored by the suicide prevention group	Reduction in suicides by 10% across the population serviced by SWYPFT and 75% in targeted areas using a zero-suicide philosophy	**Extended to March 2022**
Improve safety in medication practice	Improve performance of missed doses of medication	Trust inpatient acute and older adult services	Quality improvement programme milestones	Reduce missed doses of medication in acute and older adults' wards	**Extended to March 2022**

EFFECTIVE: we will achieve good outcomes with people based on best available evidence. *Quality domain – clinical effectiveness*

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Outcome measures Introduction of outcomes tools to measure clinical effectiveness and improved patient experience.	Identification of outcome measures for use at both local and Trust wide level Development of systems and processes to support implementation	Trust-wide services	Project plan to be developed Monitored by EMT	Identification of outcomes measures for local and Trust wide implementation Reportable outcomes measures Ability to monitor clinical variation	**Extended to March 2022**
Clinical record keeping	Improve quality of clinical record keeping, i.e. service user voice, care plans and risk assessments Review standards for care plans and risk assessments Monitor adherence to standard s through audit and quality monitoring Improving co-production capturing service users race	All staff in clinical areas	Progress against record keeping standards Monitored by clinical governance group	95% compliance with clinical record keeping standards relating to service user voice, assessments, care planning and risk assessments.	**Extended to March 2022**

CARING: we will involve and treat people with compassion, dignity and respect - *Quality domain – Clinical experience*

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Staff experience & well being	Monitor and implement actions of staff health and well-being plan Improving staff satisfaction and wellbeing	Trust-wide services	Staff Feedback Monitored by the staff wellbeing group National survey results Internal wellbeing survey	80% of staff recommend the Trust as a place for care and treatment Improved scores in key areas on national staff survey and local well-being survey	**Extended to March 2022**
Patient experience	Implementation of new FFT model. Implementation of patient experience toolkit Use feedback from student placements to enhance patient experience	Trust-wide inpatient services	We will measure the percentage of people who are extremely likely/ likely to recommend the service to their friends and family. We will review the actions taken in response to service user experience feedback	Forensic 65% Learning disabilities 85% CHS 98% Mental health services 85% CAMHS 75% Baseline assessment of current satisfaction on inpatient wards – then set trajectory of improvement	**Extended to March 2022**
Equality, Involvement, Communication and Membership Strategy	Implement actions from the Equality, Engagement, Communication and Membership Strategy	Trust-wide services	Implementation of Equality elements of the strategy will be monitored through the Equality& Inclusion committee	Key milestone of the strategy implementation plan will be achieved within timescale	**Extended to March 2022**

RESPONSIVE: we will respond to people's needs in a timely way. *Quality domain – Clinical effectiveness*

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Improve waiting times **Learning disability service wait times** **CAMHS**	Reduce waiting times in services for people with LD Reduce waiting times in CAMHS services	Learning disability services CAMHS services	Waiting time performance is monitored via Executive Management Team (EMT), Integrated Performance Report (IPR), with a bi monthly report into CGCSC for Children & Adolescent Mental Health Services (CAMHS)	Improvement in LD waiting times in line with national referral to treatment targets Improvement in CAMHS access to treatment waiting times.	**Extended to March 2022**
Complaint closure and resolution times	Review complaint response times.	Trust wide services	Complaints performance is monitored via IPR and monthly reports to Exec Trio.	Formal complaints closed within agreed timescales, i.e.: within 40 days. Concerns are acknowledged within 48 hours.	**Extended to March 2022**

WELL LED: we will work in partnership and learn from our mistakes - *Quality domain – Safe, effective & experience*

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Implementation of a quality assurance and improvement 'self- governing' assessment and accreditation scheme	Roll out the project across the Trust	Trust-wide clinical services	Assessment against a project plan. Key milestones will be identified and monitored.	Achievement of milestones that leads to successful implementation of scheme	**Extended to March 2023**
Learning lessons from feedback and incidents	Further development of systems to improve how we learn lessons from patient experience, serious incidents, audits, safeguarding reviews and share learning	Trust-wide	Assessment against a project plan. Key milestones will be identified and monitored. Plan will be overseen by the Clinical Governance Group	Framework developed and implemented	**Extended to September 2022**

The measures identified in the Quality Priorities 2021/22 (above) will be reported and monitored in the following ways throughout the year:

1. Reporting into the Clinical Governance and Clinical Safety Committee.

2. Reporting into Clinical Governance Group (CGG)

3. To Clinical Commissioning Groups via Quality Board meetings.

Part 2.2 – Statements of assurance from the board

Review of services

During 2020/21 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provided and/or subcontracted 82 relevant health services. South West Yorkshire Partnership NHS Foundation Trust has reviewed all the data available to us on the quality of care in 82 (100%) of these services.

The income generated by the relevant health services reviewed in 2020/21 represents 100 per cent of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2020/21.

Participation in clinical audit

During 2020/21 nine (9) national clinical audits and one (1) national confidential enquiry covered relevant services that South West Yorkshire Partnership NHS Trust provides. During that period 2020/21 South West Yorkshire Partnership NHS Foundation Trust participated in 9/9 (100%) of the national clinical audits and 1/1 (100%) of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SWYPFT was *eligible to participate* in, and *did participate in* during 2020/21 are as follows:

National Clinical Audits SWYPFT was eligible to participate in during 2020/21	1. National Audit for Cardiac Rehabilitation (NAT04) 2. National Asthma and COPD Audit Programme (NACAP) (NAT06) 3. National Audit of Care at the End of Life – Round 2 (NAT02) 4. Sentinel Stroke National Audit Programme (SSNAP) (NAT10) 5. POMH 20a Improving the quality of valproate prescribing in adult mental health services (NAT07) 6. Early Intervention in Psychosis Audit (EIP) (NAT05) 7. POMH Topic 18b - Use of Clozapine (NAT09) 8. NHSE - Syringe Driver Snapshot Audit (NAT08) 9. Learning Disabilities Improvement Standards (NAT12)
National Confidential Inquiries SWYPFT was eligible to participate in 2020/21	National Confidential Inquiry into Suicide and Homicide by people with mental illness

National clinical audit programme 2020/21

The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of cases submitted to each audit or enquiry.

The percentage of registered cases required by the terms of the audit is not specified. This is because the Prescribing Observatory for Mental Health (POMH) audits does not specify a minimum number in their sampling framework criteria.

National Clinical Audits 2020/21	Cases submitted *(If applicable)*
1	National Audit for Cardiac Rehabilitation (NAT04)	Continuous clinical audit. Data collection commenced March 2020, **217** during 2020/21. **(In total 634 cases submitted as at 31st March 2021 based on eligible criteria).**
2	National Asthma and COPD Audit Programme (NACAP) (NAT06)	Continuous clinical audit, data collection commenced March 2020. Data collection was put on hold due to COVID-19. Plans to restart September 2020 but majority of the patient's not seen face to face therefore the pulmonary audit wasn't completed. Minimal submissions from April 2020 – March 2021.
3	National Audit of Care at the End of Life – Round 2 (NAT02)	**NACEL round three (2020) was cancelled due to the impact of COVID-19. NACEL round three will now be completed in 2021.**
4	Sentinel Stroke National Audit Programme (SSNAP) (NAT10)	Continuous clinical audit Annual Report 2020 now publicly available
5	POMH 20a Improving the quality of valproate prescribing in adult mental health services (NAT07)	**87** cases submitted to POMH based on eligible patients.
6	Early Intervention in Psychosis Audit (EIP) (NAT05)	National and local reporting summer 2021, **224** cases submitted based on eligible criteria. Contextual data submitted for each team
7	POMH Topic 18b - Use of Clozapine (NAT09)	Due to the ongoing impact of COVID-19, the data collection and entry period was extended to 30th April 2021. **189** cases submitted to POMH based on eligible patients
8	NHSE - Syringe Driver Snapshot Audit (NAT08)	Data submitted to NHS England and NHS Improvement the NHS Benchmarking Network
9	Learning Disabilities Improvement Standards (NAT12)	Report due to be published July 2021

The reports of nine (9) national clinical audits were reviewed by the provider in 2018/19 and South West Yorkshire NHS Foundation Trust intends to take the following actions to improve the quality of health care provided.

- Each clinical audit has a project lead that is responsible for presenting the audit results to their business delivery unit (BDU). Areas of concern or high risk are escalated to the deputy district director for immediate action.
- The members of the governance group or another lead will action the plan against the audit recommendations.
- Implementation of the action plan is monitored by the BDU as part of their governance systems

National confidential inquiry (NCI) 2020/21

The national confidential inquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of

cases submitted to each inquiry as a percentage of the number of registered cases required by the terms of that inquiry.

Title	Number of cases submitted	Number of cases completed	Commentary
National Confidential Inquiry into Suicide and Homicide by people with mental illness	6	4 (80%)	2 questionnaires continue to be processed

Local clinical audit

During 2020/21 the Clinical Audit and Service Evaluation (CASE) prioritised plan had a total of 58 clinical audit projects listed. The reports of 24 local clinical audits were reviewed by the provider in 2020/21. There are 24 projects completed, 28 projects in progress and 6 have either been deferred into 2021/22 or removed from the programme.

South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Each clinical audit has a project lead that is responsible for presenting the audit results to their business delivery unit. Areas of concern or high risk are escalated to the deputy district director for immediate action.
- The members of the governance group or another lead will action the plan against the audit recommendations.
- Implementation of the action plan is monitored by the BDU as part of their governance systems

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by South West Yorkshire Partnership NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee is185.

Goals we agreed with our commissioners

Commissioning for Quality and Innovation Payment Framework (CQUIN)

South West Yorkshire Partnership NHS Foundation Trust income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because of the COVID-19 pandemic. All CQUIN payments were suspended throughout the year with all main contracts paid on a set block basis.

Care Quality Commission (CQC)

The CQC last inspected the Trust in May 2019. The outcome of this inspection was that our overall rating improved from Requires Improvement to Good. The CQC highlighted areas of strength and improvement, as well as areas of real challenge.

- 12 of 14 core services were rated Good

- 2 of 14 core services were rated as Requires Improvement

- More than 85% of individual domains rated Good or Outstanding (60 out of 70)

- Overall were rated Good for the Well -Led, Caring, Effective and Responsive domains and Requires Improvement for the Safe domain.

South West Yorkshire Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is registered in respect of the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and Screening Procedures
- Treatment of disease, disorder or injury

There are no conditions attached to the registration other than the specified locations from which the regulated activities may be carried on at or from.

South West Yorkshire Partnership NHS Foundation Trusts conditions of registration state that the three regulated activities listed above can only be carried out at the following locations:

- Fieldhead Hospital (Wakefield)

- The Dales (Calderdale Royal Hospital)

- Kendray Hospital (Barnsley)

- The Priestley Unit (Dewsbury District Hospital)

- Lyndhurst (Halifax)

- Enfield Down (Huddersfield)

- The Poplars (Hemsworth)

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2020/21.

South West Yorkshire Partnership NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

During 2020 The CQC reviewed our progress against the Infection, Prevention & Control Board Assurance Framework and they found '***that the board is assured that the trust has effective infection prevention and control measures in place'.*** (15ᵗʰ July 2020)

NHS Number and General Medical Practice Code Validity

South West Yorkshire Partnership NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 100% for outpatient care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:
- 100% for admitted patient care
- 100% for outpatient care

Data security and protection toolkit (previously Information Governance Toolkit attainment)

South West Yorkshire Partnership NHS Foundation Trust achieved a status of 'Standards Exceeded' for the 2020/ 21 toolkit assessment.

Clinical Coding accuracy

South West Yorkshire Partnership NHS Foundation Trust has not been subject to the Payment by Results clinical coding audit during the reporting period.

Quality of data

Improving data quality remains one of South West Yorkshire Partnership NHS Foundation Trust's key strategic priorities. There was continued focus in 2020-21 on improving the quality of clinical record keeping. With a number of areas routinely reported and monitored to the Trust's Improving Clinical Information Group. This underpins the delivery of safe effective care and assures the Executive Management Team (EMT) and the Trust Board that data taken from the clinical record and used for activity and performance monitoring and improvement is robust.

South West Yorkshire Partnership NHS Trust will be taking the following action to further improve data quality:

Bringing Clarity to Quality	We will continue to improve the training, guidance and support available to help staff and services understand and improve data quality.
Measuring Quality	We will continue to develop a wide range of team, service line, BDU and Trust level operational and performance reports. Service line reporting and electronic dashboards will include key performance indicators and will enable users to look at performance at team, service line, BDU and Trust levels. Team dashboard are available via the Trust intranet and will continue to be developed and further rolled out across all services areas. Internal and external benchmarking will be incorporated, the Trust has established a benchmarking group to review benchmarking

	data and identify areas for opportunity to further increase quality and effectiveness and make comparisons with peers.
Publishing Quality	The Trust will continue to publish its data to the Secondary Uses Service, NHS England Improvement, the CQC, the Department of Health, Commissioners and Partners and to the Members Council.
Partnership for Quality	We will continue to work with partner organisations to ensure that all our respective quality and performance requirements are met and that duplication of data collection and inputting is minimised.
Leadership for Quality	The improving clinical information group will oversee the development and delivery of the data quality improvement programme and will provide a quarterly progress update to EMT. BDUs will ensure the development and delivery of the individual BDU level improvement plans.
Innovation for Quality	Following the Trust's implementation of SystmOne for Mental Health, the Trust continues to work to ensure innovation for quality is embedded within this as part of the continued development of the system and the Trust continues to exploit new technology to make these systems easy to access and use. Particular use of digital solutions for non-face-to-face activity was implemented during the COVID-19 pandemic which allowed continued service delivery in a challenging environment and this is being evaluated as part of the Trusts restoration and recovery programme alongside new ways of working.
Safeguarding Quality	The Trust's Executive Management Team will ensure essential standards of safety and quality are maintained and monitored and will take action where data quality issues arise.

Part 2.3 – Reporting against core indicators

2.3.1 Patients on Care Programme Approach who were followed up within seven days

Indicator	NHS Outcomes Framework Domain	Health and Social Care Information Centre SWYPFT performance data Goal = 95%				
			Q1	Q2	Q3	Q4	TOTAL
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period. **Performance indicator is 95%**	1: Preventing people from dying prematurely 2: Enhancing quality of life for people with long-term conditions	SWYPFT 2020/21	99.3%	99.3%	99.7%	98.6%	99.2%
		SWYPFT 2019/20	97.7%	97.2%	97.6%	96.4% *(local data)*	97.2% *(Local data)*
		SWYPFT 2018/19	97.7%	96.2%	97.3%	99.6%*	97.5%
		SWYPFT 2017/18	97.7%	95.5%	96.9%	97.2%	
		SWYPFT 2016/17	96.9%	97.8%	97.4%	97.5%	
		SWYPFT 2015/16	98.66%	97.98%	95.64%	97.44%	

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

This information is taken from the electronic clinical record system.

Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training.

Data is clinically validated before it is submitted to NHS Digital.

Performance data is reviewed monthly by the Executive Management Team and the Trust Board.

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage and therefore the quality of its services:

The Trust has an established Improving Clinical Information Group sponsored and chaired by the Director of Nursing & Quality, that meets quarterly to focus on the quality of clinical data. Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data.

Each Business Delivery Unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

2.3.2 Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper

Indicator	NHS Outcomes Framework Domain	Health and Social Care Information Centre SWYPFT performance data					
			Q1	Q2	Q3	Q4	TOTAL
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period **Performance target is 95%**	2: Enhancing quality of life for people with long-term conditions	SWYPFT 2020/21	100%	96.1%	98.7%	99.4%	98.9%
		SWYPFT 2019/20	99.7%	100%	99.7%	97.9% *(local data)*	98.4% *(local data)*
		SWYPFT 2018/19	97.6%	97.9%	98.9%	96.5%*	97.7%
		SWYPFT 2017/18	98.4%	96.9%	96.9%	99.6%	98%
		SWYPFT 2016/17	96.9%	99.3%	99.3%	99.3%	
		SWYPFT 2015/16	95.81%	97.29%	96.04%	98.32%	

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

This information is taken from the electronic clinical record system.

Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training.

We have two specific gatekeeping activity codes that are used for all gate kept admissions - this information can be extracted directly from the electronic record system.

Data is clinically validated before it is submitted to NHS Digital.

Performance data is reviewed monthly by the Executive Management team and the Trust Board.

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and therefore the quality of its services:

The Trust has an established Improving Clinical Information Group, sponsored and chaired by the Director of Nursing, Quality and Professions, which meets quarterly to ensure a focus on the quality of clinical data. Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data.

We undertake a weekly audit of our gate kept admissions to validate the gate keeping function.

Each Business Delivery Unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

2.3.4 Readmission rates

Indicator	NHS Outcomes Framework Domain	SWYPFT data								
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2020/21	2020/21
The data made available to the National Health Service trust or NHS foundation trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	3: Helping people to recover from episodes of ill health or following injury	6.86%	7.02%	8.7%	9.7%	9.8%	9.8%	9.1%	5.8%	5.2%

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

94.8% of people were not readmitted in 2020/2021.

This information is taken from the electronic clinical record system.

Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training.

Data is clinically validated before it is submitted to NHS Digital.

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

An Improving Clinical Information Group sponsored and chaired by the Director of Nursing, Quality and Professions, that meets quarterly to ensure a focus on the quality of clinical data. Each Business Delivery Unit has developed a robust process to improve the quality of their clinical data.

Each business delivery unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

2.3.5 Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

Indicator	NHS Outcomes Framework Domain	SWYPFT 2019 Score	National 2019 score	
			National comparison	
		7.0	About the same as other trusts nationally (CQC website)	
		SWYPFT 2018 Score	National 2018 score	
			National comparison	
		6.7	About the same as other trusts nationally (CQC website)	
		SWYPFT 2017 Score	National 2017 score	
			National comparison	
Indicator		7.9	About the same as other trusts nationally (CQC website)	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	2: Enhancing quality of life for people with long-term conditions 4: Ensuring that people have a positive experience of care	SWYPFT 2016 score	National 2016 score	
			Highest trust score	Lowest trust score
		7.5	8.5	6.8
		SWYPFT 2015 score	National 2015 score	
			Highest trust score	Lowest trust score
		8.00	8.2	6.8
		SWYPFT 2014 score	National 2014 score	
			Highest trust score	Lowest trust score
		7.9	8.4	7.3
		SWYPFT 2013 score	National 2013 score	
			Highest trust score	Lowest trust score
		8.6	9.0	8.0

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons: it was taken from the national CQC community patient survey, which uses approved survey contractors, external to the organisation and the information is provided anonymously.

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this percentage and therefore the quality of its services:

triangulating this information with other sources of patient and staff experience feedback in order that we can successfully focus our action.

2.3.6 The number and percentage of such patient safety incidents that resulted in severe harm or death

The number and, where available, rate of patient safety incidents reported within the trust during the reporting period (2020/21), and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Period	Number of patient safety incidents uploaded (by incident date) (at 17/05/21)	Severe harm	% severe	Death	% death
2020/21	6252	28	0.45	29	0.46

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 accuracy of data. 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. This data has been prepared on 17 May 2021.

In 2020/21 the Trust uploaded a total of 6252 patient safety incidents to the NRLS, compared with 6278 reported in 2020/21 Quality Accounts. 94% of the 6252 incidents resulted in no harm or low harm.

The Trust reported a total of 57 severe harm and patient safety related death incidents in 2020/21, compared to 53 incidents in 2020/21 (as at 17 May 2021).

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 2020/21. The percentage number of patient safety related deaths (uploaded to NRLS) is the same percentage as last year which was 0.46%.

It is difficult to make comparisons in annual figures, because not all incidents reported up to 31 March 2021 will have been reviewed and uploaded to the NRLS at the date of the report.

Nationally, it is believed that organisations that report more incidents usually have a better and more effective safety culture, with which we agree. If we understand what our incidents are, we can learn and improve our services. Each of our BDUs have a systematic way for reviewing learning from their incidents.

2.3.7 Learning from deaths

NOTE: This data has been prepared from information on Datix and business intelligence dashboards. The table contains the prescribed information and reference number with the updated text/data below

27.1. The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

During 2020/21 (at 11 May 2021), 4085 of South West Yorkshire Partnership NHS Foundation Trust patients died. 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. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number, the Trust was not the main provider of care at the time of death. This comprised the following number of deaths which occurred in each quarter of that reporting period:

1190 in the first quarter;
784 in the second quarter;
1174 in the third quarter;
937 in the fourth quarter.

27.2. The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure

By 11 May 2021, 89 case record reviews and 22 investigations have been carried out in relation to 111 of the deaths included in item 27.1.
In 22 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

35 in the first quarter;
25 in the second quarter;
24 in the third quarter;
27 in the fourth quarter.

27.3. An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

0 representing 0% for the first quarter;
0 representing 0% for the second quarter;
0 representing 0% for the third quarter;
0 representing 0% for the fourth quarter.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the North of England Alliance, we have jointly developed a policy and use a common reporting dashboard that brings together important information. The Alliance are unable to report on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there is currently no research base on this for mental health services, no satisfactory definition of 'avoidable' and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. As an Alliance, we continue to review this decision and develop our data and general understanding of the issues.

These numbers have been estimated using the methodology below:

Our Structured Judgement Reviews are conducted by trained reviewers from a clinical background (e.g. medicine, nursing, physio) who work outside the clinical area. The reviewer scrutinises the clinical records to review the care and treatment the induvial received leading up to their death. They record their findings in a template under specific phases of care. Each phase of care is rated with supporting narrative. The reviewer also makes a judgement about if the death was due to problems in care that resulted in harm. All completed reviews are discussed at Business Delivery Unit governance groups to agree next steps, which may include areas for improvement or further investigation.

Our investigations range from local level investigations to serious incident investigations. Investigators will review the care and treatment of the individual who died to identify any care and service delivery issues in the care received over a period of time. The focus is on human factors, systems and processes. They will also examine if any issue led to the death occurring. Most care and service delivery issues identified are not contributory to the death occurring.

27.4. A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.

Not applicable

27.5 A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).

Not applicable

27.6 An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

Not applicable

27.7
The number of case record reviews or investigations finished in the reporting period (2020/21) which related to deaths during the previous reporting period (2020/21) but <u>were not included in item 27.2 in the relevant document for that previous reporting period</u>.

16 case record reviews and 24 investigations completed after 31/3/2020 which related to deaths which took place before the start of the reporting period.

27.8 An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Trust mortality review processes described above in 27.3.

27.9 A revised estimate of the number of deaths during the previous reporting period (19/20) stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.

0 representing 0% of the patient deaths during 2020/21 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3.8 Guardian of safe working hours

The 2016 junior doctors' contract introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is a paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. In this respect, the new contract introduced the role of Guardian of Safe Working Hours. The Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian ensures that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and provides assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The introduction of a new contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point.

The Trust appointed a senior medical representative as the Guardian of Safe Working and his 2020/21 Annual Report highlighted the following:

- The number of exception reports has remained low during this period (11 in total), which is in line with the majority of Trusts providing mental health care. The two most common issues are (a) pressure of work on in-patient areas, especially during colleagues' absence, and (b) higher trainees acting-down to cover gaps on the 1st on-call rota.

- The pandemic clearly created significant challenges, not least with the cover of rotas where a number of staff were shielding, self-isolating or off-sick (nearly 70% increase in gaps and nearly 50% increase in hours to be covered / costs overall). There were 13 shifts where it was not possible to obtain junior doctor cover, a small reduction on the previous year. Where there is a rota gap, the rota co-ordinators will seek to find someone to cover via the Medical Bank resource. If this is not possible, senior doctors act down to cover.

- Rota coordinators managing the Trust Medical Bank, with the support of the trainees have done fantastic work to maintain the service despite these challenges.

- Improved recruitment to core training in Psychiatry has led to a significant reduction in vacancies across the trust. Therefore, once we emerge from the pandemic, it is hoped that there will be fewer gaps on the rotas (and initial data would suggest that this is the case).

- The Guardian of Safe Working Hours continues to have sessions with all new trainees at induction to offer support and encourage trainees to raise any concerns that they may have. The Guardian of Safe Working Hours also meets trainees at the quarterly Junior Doctors' Forum.

2.3.10 Performance against indicators set out in Single Oversight framework

The table below shows our performance against the indicators which are monitored by NHS Improvement, as required for our regulation process and set out in the Single Oversight Framework (SOF)

Indicator		SWYPFT data
	Target	**2020/21**
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	60%	89.5%
Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset)	50%	52.2%
b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral	75%	94.0%
ii. within 18 weeks of referral	95%	99.4%
Admissions to adult facilities of patients under 16 years old	0	1
Inappropriate out-of-area placements for adult mental health services	494	1691 bed days

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Section 3:
Our performance in 2020/21

In this section you'll find more information about the initiatives we have undertaken to improve the quality of our services and build a culture for improvement. For 2020/21 we set ourselves a set of challenging goals, which were in line with our quality strategy priorities. However, in March 2020, the NHS faced one of the biggest challenges in its history. The COVID-19 pandemic spread across the world impacting on the health and social care sector, the economy, and on everyone's daily lives. This response to the pandemic has continued throughout 2020/21 and the Trust has adapted to meet the challenges posed, continuing to meet the needs of the communities we serve, supporting our staff and carers and maintaining business continuity.

Faced with an unprecedented situation, our Trust responded with kindness, compassion, and in line with our values. Throughout 2020/21, we have seen many examples of our staff demonstrating just what the NHS is about.

In challenging times, it's reassuring when you have values which guide you, inform your response, and influence your reaction. In our Trust, we are proud to have a strong vision, mission and values which unite us and remind us why we are here.

The coronavirus pandemic hit the NHS quickly and unexpectedly and we found ourselves in situations we had never experienced before. Thanks to our values, we have been able to expertly navigate our way through the year, not only maintaining our core services but in many cases improving them too.

Our need to respond to the pandemic meant that many of our development projects were put on hold, some reinstated after the first wave of the pandemic, only having to be paused again until after the second wave, and restarted in March 2021.

In this section we will report on the progress that was made in 2020/21 and identify projects that have had completion dates extended.

We use the 5 domains of SAFE, EFFECTIVE, CARING, RESPONSIVE & WELL-LED (Care Quality Commission) as a framework to organise our quality improvement priorities.

The quality initiatives we undertake against our quality priorities change from year to year, which means we are not always able to make a direct comparison of our performance against each priority each year, as we are not comparing 'like for like' and comparable data is not available. Where we can make comparisons across the years we have done so. We make these changes to continually strive to improve the quality of our care.

Our Trust provides a wide range of services across several communities. These services are commissioned by separate commissioning groups, which are:

1. Barnsley CCG
2. Calderdale CCG
3. Kirklees CCG
4. Wakefield CCG

The CCG's in Calderdale, Kirklees and Wakefield work in partnership to commission services. Some of the Trust's specialist services such as the Forensic Mental Health services are commissioned by NHS England.

As commissioners work for different communities the goals for each area can differ. However, as an organisation, the Trust ensures that a consistent quality threshold is applied across all services

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Quality priority improvements: 2020/21.

Below is a list of quality priorities that the Trust identified for improvement in 2020/21. Each of these will subsequently be expanded on in the narrative, to explain what has been possible during the pandemic period, and what remains as further areas of work and focus for 2021-22.

SAFE		Goal	Timeframe for achievement	Status
S1	Staffing initiatives	Staffing establishments reviewed and updated. Implementation of new professional roles	March 2022	Plans extended into 2021/22
S2	Patient safety strategy	5% reduction in prone restraints lasting 3 minutes or less.	March 2021	Plans extended into 2021/22
S3	Suicide prevention plan	Implement actions from suicide prevention strategy	March 2022	Plans extended into 2021/22
S4	Medication safety	Improve performance of missed dose medications in acute, forensic, LD and older adult wards	March 2022	Plans extended into 2021/22

EFFECTIVE		Goal	Timeframe for achievement	Status
E1	Outcome measures	Identification of outcome measures for use in clinical practice	March 2020	Plans extended into 2021/22
E2	Clinical record keeping	95% compliance with evidence of service user voice, quality of care plans and risk assessment completion and quality	March 2021	Plans extended into 2021/22

CARING		Goal	Timeframe for achievement	Status
C1	Staff well- being	Improved scores on national staff survey	March 2020	Plans extended into 2021/22

		Forensic (Target 65%) Learning disabilities (Target 85%) CHS (Target 98%) Mental health services (Target 85%) CAMHS (Target 75%) Trustwide (Target 90%)		
C2	Patient experience: Friends & Family Test		March 2020	Plans extended into 2021/22
C3	Equality, improvement, communication, and membership strategy	Implementation of Equality Strategy objectives	March 2023	Plans extended into 2021/22

RESPONSIVE		Goal	Timeframe for achievement	Status
R1	Learning Disability waiting times	Improvement in LD waiting times	March 2020	Plans extended into 2021/22
R2	Improve access to CAMHS	Improvement in waiting times	March 2020	Plans extended into 2021/22
R3	Complaint resolution times	Improve performance against complaint resolution times	March 2022	Plans extended into 2021/22

WELL LED		Goal	Timeframe for achievement	Status
W1	Accreditation scheme	Achievement of project plan milestones	March 2023	Plans extended into 2022/23
W2	Quality dashboard	Dashboard availability	October 2021	Plans extended to October 2021
W3	Learning lessons from feedback	Further development of systems to improve how we learn lessons from patient experience, serious incidents, audits, safeguarding reviews	October 2022	Plans extended into 2021/22

Priority 1: SAFE

Why did we focus on this?

By safe, we mean that people are protected from abuse and avoidable harm. When mistakes occur, lessons will be learned.

'SAFE' quality initiatives in 2020/21

The following quality initiatives were prioritised for action in 2020/21 as part of the quality account process.

S1. Staffing initiatives:

Our vision is to continue to create a sustainable workforce to meet the demands of inpatient mental health wards and community teams within our Trust.

The focus of our work on staffing initiatives during 2020/21 was to maintain safety on the inpatient units during the pandemic. Despite the challenges of the pandemic we have implemented '*SafeCare*' on some of our wards which has allowed us to move away from the traditional view of having an established "number" of staff on inpatient areas and utilise the acuity and demand to flex the staffing resources appropriately. This now allows us to ensure our skill mix within the teams is optimised and should lead to a reduction of the dependency on our flexible staffing resource. Initial learning from early adopter wards is being used to inform our approach to its broader roll out.

In order to support the understanding of staffing needs and acuity within our community teams, we plan to review the establishment templates to support the delivery of a safe and effective service offer in our community teams. Due to the COVID-19 pandemic this has delayed several initiatives which would support this project. However, we have started the migration of community teams onto a health roster (Allocate) system which aids in the understanding of current requirements, vacancies and other comparable measures required when looking at staffing modelling. The work has recommenced.

Below is a summary of the initiatives we are progressing to ensure that the Trust is doing everything it can to improve safer staffing and the management of resources. The focus is always to improve quality and drive up safety for service users, carers and staff.

In 2020/21 we have continued our work to ensure we have a workforce to support the clinical need of the people who are in our services. Actions we have taken:
- Work has commenced on safer staffing within the community, several work streams have been developed
- Increased our use of social media and digital platforms to support recruitment
- Recruitment of bank only staff continues to be grown covering all disciplines within our trust
- Increased fill rates and fewer vacancies. Improved and sustained quality of new employees, both on bank and agency through the establishment of the values-based assessment centre. Our safer staffing figures are published on our website
- Continue to work closely with wards where there is pressure on meeting staffing numbers
- Continue to review the medical bank capability and explore their migration onto the e-rostering system
- Continue expanding the bank to support other areas including Allied Health Professionals (AHPs) and community teams

- Trustwide 'internal' transfer window has been in place since January 2020 following initial marketing campaign with communications on the intranet and headlines to pique interest. We have had a successful start to the campaign
- A new retirement interview procedure is now in place to focus on furthering employment within the Trust. Greater focus on opportunity to work flexibly in the Trust post retirement etc
- Recruitment of Trainee Nursing Associates (TNAs) and nursing apprenticeships is a constant process across the Trust
- New roles - development roles in teams for wider workforce, for example, Trainee Nurse Associates, Nurse Associates, Advanced Clinical Practitioner (ACP) roles, Physician Associates & non-medical Approved Clinician

Development of career pathways in professions:
- Nursing, AHP and Psychology leads developing career structure pathways. Plan to develop more visible progress opportunities for staff both within intranet and at job application, job advert/NHS Jobs   E.g. Advanced Clinical Practitioners (ACP) developments
- The development of the Trainee Nurse Associate (TNA) has provided opportunities to bridge the role between Health Care Support Workers and Graduate Nurses, supporting career progression, increasing the supply of Nurses and enabled Nurses to take on more advanced roles
- The introduction into our workforce planning of Advanced Clinical Practitioners will ensure a clearer focus on clinical practice, clinical leadership and high-quality patient care.

Next steps are to:

- Complete the migration of all community teams onto the health roster (completion date Oct. 2021)
- First meeting to establish membership and terms of reference for the Safer Staffing group in community to be held in August 2021
- Decide pilot areas/teams for model testing in that meeting whilst completing a timeline for analysis and roll out of results in line with completion of migration of teams onto health roster.

S2. Patient safety strategy

Through the implementation of the Patient Safety Strategy the Trust's aim is to reduce frequency and severity of harm resulting from patient safety incidents. This will in turn reduce associated costs, both personal and financial.

Objectives from the strategy are:

1) Reduce restrictive interventions to improve care and treatment of service users and reduce the frequency of harm to staff and patients from violence and aggression incidents

2) Human Factors training to improve staff knowledge of systems analysis and associated human factors

3) Safety huddles implementation to encourage teams to use this approach to enhance learning and improve the quality of clinical care, with the aim of reducing harm to patients

The Patient Safety Strategy development work has been paused or significantly interrupted during the pandemic. The timeframe for priority achievement has been extended until 2022 by our Trust Board.

1. Reducing restrictive interventions

Reducing restrictive interventions has formed part of our harm reduction plans for the last 4 years and progress has been made against it, for example with prone restraints.

A prone restraint is a physical restraint holding a person chest down to the floor. This restraint position is controversial due to significant research that associates this position with an increased risk of death through positional asphyxia. Hence the shorter period a person stays in prone restraint the less risk of asphyxia.

One of our quality aims in 2020/21 was to reduce the amount of time a person stays in prone restraint for three mins or less by 5%.

As the table below demonstrates between April 2019 and March 2020, we consistently improved our performance against this indicator and achieved a 19-percentage point improvement.

Month	April 2019	May 2019	June 2019	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
% of prone restraints- 3 mins or less	76%	88%	91%	94%	92%	85%	90%	98%	97%	96%	95%	95%

In 2020/21 our performance in 202/21 fluctuated across the year.

Month	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
% of prone restraints - 3 mins or less	93%	91.5%	90%	80%	94.5%	94%	87.5%	100%	90.2%	100%	90%	79%

There are three months of 2020/21 when the percentage of prone restraints lasting three minutes or less were under the 90% target. In each case a small number of service users, in specific services, accounted for many of the prone restraints, for example,

- a person who had complex challenging behaviours which has resulted in several prolonged restraints within seclusion to facilitate emergency medical treatment
- a person who required several interventions to prevent self-harming behaviours
- a person who required intervention due to violence and aggression which resulted in others being harmed.

The Reducing Restrictive Practice Team are actively involved in people's care and treatment and work alongside the clinical staff teams to ensure care and treatment is provided as safely as possible.

During 2020/21 we maintained the development activity that was already established, i.e. reducing restrictive practice, however the focus of our safety activity was on keeping our service users/ patients and staff safe during the pandemic. Therefore, work on human factors training and safety huddles was paused.

S3. Suicide prevention
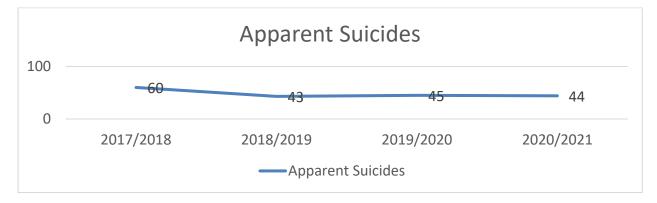
In 2017 at the initial launch of the regional suicide prevention strategic ambition the Trust supported the regional ambition of an overall reduction in suicides with a focussed reduction on targeted areas.

Targeted areas were considered in line with the National Confidential Inquiry to be in-patients, crisis teams, and those individual in the post-discharge period following admission.

Over the last 2 years the Trust has revised the Suicide Prevention Strategy and created a Zero Suicide Ambition, this is in support of the belief that suicide is not inevitable and many can be prevented.

In 2020 a focussed 7-point plan for Suicide Prevention was created and was presented at the Extended Management Team in September and further reviewed in December 2020. The Trust are currently re-assessing the 7-point plan to ensure Quality Improvement and Assurance measures are evidenced within the actions identified.

In respect to reductions of suicides the below chart demonstrates a reduction over the period of time 2017/18 to 2020/2021.

The above chart demonstrates the numbers of suicides of individuals that have been recorded within the Trust over a period of time and have been identified as being in receipt of care or treatment or have recently been discharged.

The Table demonstrates an initial significant reduction and more recently stable numbers of suicides recorded. The organisation has utilised the National Confidential Inquiry self-assessment tool as part of the overall aims/ambitions and improvements in reductions of suicides. A report prepared for the West Yorkshire and Harrogate ICS (Integrated Care System) identified that of all suicides across the general population of the West Yorkshire and Harrogate region 27% of these people have been identified as in receipt of health care in some form.

The Trust will continue to utilise national data in order to further analyse the understanding of the numbers of individuals who die by apparent suicide who have contact with our organisation.

The use of data is designed to complement the deeper and more personal analysis and understanding sought through our organisational learning from lessons all of which aims to reducing the loss of life to suicide for those individuals who have been or are in receipt of SWYPFT care.

Progress we have made:

Trust Wide:

- Developed suicide prevention improvement plans across our whole organisation and signed up to reduce our organisational suicides by 10% across all our services
- Suicide prevention champions have been recruited and will continue to grow across the organisation; trust wide meetings have been held and further arranged
- We continue our work within our inpatient units with a renewed emphasis on suicide prevention in line with the NCISH guidance: removal of ligature points, ensuring care plans are in place during agreed leave; measures to reduce leaving the ward without agreement, e.g. improvements to ward milieu, better monitoring of ward access and exit points, and observation protocols
- Training on risk formulation has been delivered throughout the organisation. This includes safety plans, positive risk taking, service user and carer involvement in managing risk
- We continue to review any themes from our incident investigations in order to increase our understanding on suicides across the organisation in order to share learning and advocate best practice.

S4. Safe medicines management
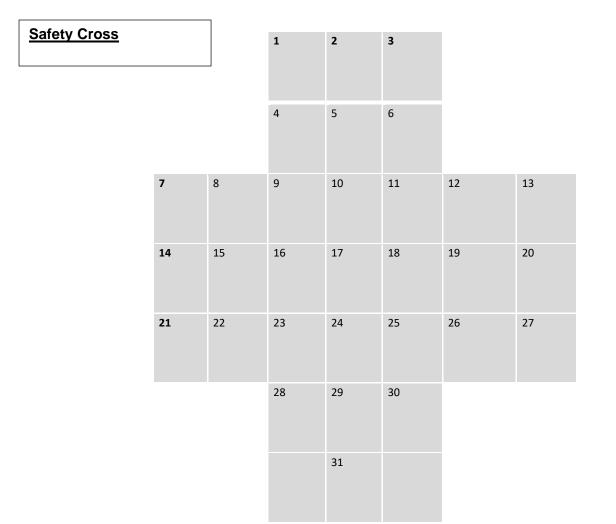
Medicine Omissions

An area of concern was identified in the management of medication in the form of 'missed doses' or omissions of medication. The number of omissions was considered to be high across the mental health wards in the Trust. It appeared that when medications were not given as prescribed, people were not receiving the treatment that they required.

A medication omission is when prescribed medication is not administered within the timescale it needs to be given, and the medication card is left blank with no reason given as to why the medication had not been administered.

A quality improvement group was established and developed a project plan for improvement. Inpatient teams from acute wards and Psychiatric Intensive Care Units (PICUs), older adults, learning disability and forensic services were involved in the project.

To collect the data a safety cross was used, which is a visual data collection tool that we can use to identify areas for improvement. A safety cross (below) is a calendar in the shape of a cross in which we can record a metric and the number of occurrences

Safety Cross

			1	2	3		
			4	5	6		
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
			28	29	30		
				31			

Staff complete the safety cross using the following key:

Colour code each box as follows**:**

Red-Medication omission occurred (if more than 1 omission occurred on this day, enter the number in the box

Green- No medication omission occurred

The Quality Improvement and Assurance Team (QIAT) collate the information for teams and reports performance into the safe medicines group.

Performance key =

- 82% and above is green:
- Below 82% amber:
- Below 75% red

Below is a table the demonstrates the **averages** over the last year

Ward	June 20- Average	Nov 20- Average	March 21- Average
Appleton	82%	Achieved performance	Achieved performance
Bronte	72%		82%
Chippendale	79%	78%	93%
Hepworth	75%	77%	64%
Johnson	78%	82%	86%
Priestley	78%	80%	78%
Waterton	63%	64%	89%
Sandal	83%	76%	66%
Thornhill	72%	68%	66%
Newhaven	75%	72%	82%
Beechdale	50%	53%	63%
Ashdale	72%	66%	66%
Elmdale	68%	71%	86%
Ward 18	68%	70%	93%
Clarke	71%	70%	68%
Beamshaw	70%	67%	58%
Poplars	78%	No longer completing	No longer completing
Crofton	90%	No longer completing	No longer completing
Willow	82%	No longer completing	No longer completing

The safe medicines group oversees the performance of missed doses of medicines and share change ideas that wards have implemented for others to adopt and adapt if appropriate.

Medicine Omissions improvement ideas that are being progressed are:

- Session with registered staff to go through areas of the medicines code – used a quiz to make the session fun but informative.
- At tea-time medicine round, nurses check medication charts for omissions and where there are gaps, these are identified, and action is taken before the end of the shift.
- Staff are completing e-learning and competency training on medicines management.
- Medication cards are taken into handover and both nurses check though them as part of the handover

In addition to medication omissions we also worked on a quality improvement project on short shelf life medication. Information on this is on a project on a page template below.

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NHS
South West
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NHS Foundation Trust

Change idea

Medicine with a short shelf life always has the date of opening listed

Issue

CQC inspection report identified practice issues which may cause harm. All short life medications did not have an opening date to make it clear how long the medications had been in use for.

Prediction

All short life medications to have an opening date to make it clear how long the medications had been in use for.

Plan

- Pharmacy will introduce labels with use by dates when items are dispensed
- Nursing staff will add date and check label when administering medication
- A poster will be designed and placed on each ward clinic to ensure staff know which medications are short life
- Pharmacy will check as part of medicine assurance

Do

Reduced expiry dates on medicines

Some medicines have a reduced expiry once the original pack has been opened. These include:

Liquids/ syrups
Discard 3 months after opening unless another date is stated by the manufacturer.

Eye/ear/nose drops, sprays or ointments
Discard 14 days after opening. For antibiotic preparations discard 7 days after opening. by the manufacturer.

Insulin
Insulin pens have a 28 day expiry if removed from the fridge and stored at room temperature

Topical creams/ ointments/gels
Insulin pens have a 28 day expiry if removed from the fridge and stored at room temperature

Any medication that contains a desiccant
To be stored as per advice from manufacturer

All items received from pharmacy should include the prefix label:

Study

- ☐ Poster developed by pharmacy student and supported by communications team
- ☐ Labels were updated and put out in circulation
- ☐ Medicine assurance monthly checks
- ☐ Jan 20 – Jun 20 all wards graded green with no issues identified

Act

- The process has been embedded across inpatient wards with sustainable improvement
- Assurance checks to continue

Act | Plan
Study | Do

With **all of us** in mind.

What we can all learn – What learning can you share about this test of change?

- We had the answer when we worked together
- We asked staff what the issues were that stopped best practice happening

- We did not do a baseline because we had evidence it was an issue, it would have been useful to do so

- We were able to roll out across the inpatient wards by adopting the practice
- To ensure it is sustainable takes time to assess

What next?

The quality initiatives in the SAFE domain which we will continue into 2021/22 are:
- Continuing our work to maintain the safety of service users, carers and colleagues with regards to COVID-19
- Implementation of patient safety initiatives as outlined in our Patient Safety Strategy (e.g. prone restraint reduction, reduction of avoidable and attributable pressure ulcers)
- Implementation of suicide prevention strategy with a zero-suicide philosophy
- Implement safer staffing establishment review of community mental health teams
- Improve performance of missed doses of medication

Priority 2: EFFECTIVE

Why did we focus on this?

By effective, we mean that people's care, treatment and support achieve good outcomes, promotes a good quality of life and is based on the best available evidence.

'EFFECTIVE' quality initiatives in 2020/21

The following quality initiatives were prioritised for action in 2020/21 as part of the quality account process.

E1 Outcome measures

Our work on the development of outcome measures reduced during 2020/21 as a direct result of the pandemic.

Although the national CQUIN scheme was paused for 2020/21 we took the opportunity to start considering the requirements of Routine Outcome Monitoring in Mental Health Services standard.

Clearly defined outcomes that are collected routinely are an essential part of measuring and monitoring the effectiveness of a service. If clinicians make treatment decisions based on outcomes, patients are more likely to receive high quality care. To effectively use outcome measures in the Trust will help promote more consistent and effective use in practice.

We made the following progress:

Preparation work for commencing the CQUIN has been commenced.

- 7a & 7b CQUIN group has met initially monthly to understand the requirements of the CQUIN (CQUIN 7a: Routine outcome monitoring in CYP and perinatal mental health services, CQUIN 7b: Routine outcome monitoring in community mental health services)
- Representation achieved from all applicable service areas and relevant support services
- Understand current good practice and performance
- Devise guidance for clinicians on scope, recommended outcome tools, recording
- Promoted the reason and purpose of using outcome measures

- Completed a small start and finish task group to look at developing an outcome pathway to record Mental Health Cluster Tool outcomes, currently being piloted.
- Developed Trust / BDU / Team dashboards to monitor performance
- Agreed BDU Governance monitoring of performance
- Reviewed the need for improving digital solutions to improve completion and efficiency and options available.

The CQUIN improvement initiative hasn't commenced yet but the requirement will be to achieve 40% of service users accessing community mental health services, having the same outcome measure used at least twice during the team referral.

In 2021/22 we plan to:

- Continue to meet as a task group on a regular basis to review preparation and implementation of the approach (Quarter 3).
- Continue to promote communication strategy ensuring clinicians understand the benefits and the process.
- BDUs to monitor performance through current governance structures and review any clinical variation.
- Overall monitoring by CQUIN Trust Leads Meeting feeding back into OMG / EMT
- Further development of digital solutions with a Digital Outcomes Project Action Plan developed for a pilot commencing in August 2021. This will facilitate sending out outcome measures electronically for completion by service users and present data in an easier format for review to support treatment decisions. Update Clinical Safety Design Group (SystmOne) and Digital Strategy Group of progress and agree next steps.
- Review pilot of outcome pathway and agree next steps through Clinical Safety Design Group (SystmOne) as part of optimisation agenda.

E2. Clinical record keeping

Good record-keeping helps to maintain best practice, aiding clear communication between professionals, and demonstrates that best practice has been followed. In order to ensure that staff provide a contemporaneous and complete record of care; the Trust has adopted basic record keeping standards that apply to all healthcare records in accordance with local and professionally recognised standards.

When the CQC inspected the Trust in 2019 they identified that the Trust was not meeting the required regulatory standards in relation to acceptable record keeping in a number of areas, i.e**. risk assessment and care planning.**

To address these issues, we adopted a quality improvement (QI) approach and established a project structure to support work across the Trust.

Information from both external and internal sources assisted us to identify 2 key areas for improvement:

1. Risk assessment

2. Care planning

Following the model for improvement framework the project group,

- scoped out the issue
- determined an aim
- clarified what we wanted to achieve and how we would measure improvement

- identified changes that we could make that would result in improvement and sustainable change.

This QI project was put on hold in March 2020, restarted in September 2020, paused October 2020 and restarted February 2021 due to the pandemic. Work has progressed at a steady rate, however the timeframe for completion has been rest for March 2022 by our Trust Board.

The following 'QI plan on a page' capture the progress we have made to date with this area of work.

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NHS
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NHS Foundation Trust

Change idea

Improve record keeping (risk assessment & care planning) across the Acute Wards and PICU's

Issue

The CQC inspection report identified practice issues which may cause harm. The Trust were asked to ensure that staff maintain an accurate, complete and contemporaneous care record in respect of each service user

Plan

We talked to staff from across the organisation, to understand the issue and form a Quality Improvement Plan

Do

- We introduced ward manager and matron checklists to ensure records are of a high quality
- We introduced new care plan and risk assessment tools on SystmOne, which are more relevant, user friendly and person centred
- We launched revised care planning and risk assessment training
- We revised and launched the Clinical Risk Assessment, Management and Training Policy
- We introduced leads in the Trust for care planning and risk assessments
- We revised and piloted the clinical record keeping audit
- We created and launched a 'good practice in care planning guide' for staff

Study

Preliminary information from Quality Monitoring Visits and feedback from staff indicate an improvement in records keeping standards across our inpatient ward

Act

To continue implementing the QI plan, ensuring we are keeping people safe, with high quality, accurate, complete and contemporaneous care records

With **all of us** in mind.

What next?

The quality initiatives in the EFFECTIVE domain which we will undertake in 2021/22 are:

- Improve quality of clinical record keeping (ongoing)
    - Improve quality of care planning
    - Risk assessment & management – set standards of practice and monitor clinical outcomes and performance
- Development and implementation of outcome measures

Priority 3: CARING

Why did we focus on this?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
We believe that individualised personal care is essential to enable a person's recovery. Everybody should have an appropriate assessment of their needs and an individualised care plan that supports them in achieving their goals.

'CARING' quality initiatives in 2020/21

The following quality initiatives were prioritised for action in 2020/21 as part of the quality account process.

C1. Staff Friends and Family Test (Staff FFT) - staff recommend the Trust as a place of care and treatment

Making the Trust a Great Place to Work is a key strategic priority for the Trust.

A key element of our workforce strategy is improving levels of workplace wellbeing, resilience and staff engagement. We know through research that wellbeing, resilience and engagement is essential to the provision of high quality care and to the quality of our service.

Significant activity was undertaken in 20/21 to support colleagues though the COVID-19 pandemic including formal risk assessment processes and enhanced wellbeing support services.

The Trust conducted a Workplace Wellbeing Survey in July 2020 with over 2000 responses. Results showed that the 6 essentials of wellbeing in the survey remained the same or improved on the previous results in 2019. The health scores worsened but this is likely to be due to the pandemic rather than specific work factors.

The Trust's 2020 NHS Staff Survey results showed significant improvement in 5 of the 10 key theme scores. The Trust understands that the pandemic has affected many colleagues in a number of ways and we want to continue our focus on improving workplace wellbeing moving forward.

The Trust has agreed a revised Workforce Strategy for 2021-24. This includes the key staff pledge of 'We will provide support to keep staff physically and psychologically well, enabling them to work flexibly and ensure they have manageable workloads'.

The Workforce strategy includes several strategic actions including enhancing our Occupational Health offer, improving flexible working, reducing levels of violence and a focus on the prevention of ill health.

C2. Patient experience: Friends and Family Test

Patient experience is one of the three key components of quality and needs to be given equal emphasis along with safety and effectiveness. Evidence illustrates the link between experience and health outcomes i.e. service users who have a better experience of care generally have better health outcomes. There is also a link between experience and cost of care i.e. poor experiences generally lead to higher costs as service users may have poorer outcomes, require longer stays or be admitted for further treatment. To improve the quality and experience of all that we do effective measurement is required.   The national reporting requirements of the FFT were stood down between April – November 2020**.** However, the Trust continued to collect Friends and Family Test feedback.

In 2020/21 we focussed on:

- Expanding the text message collection service in line with the implementation of SystmOne. The text messaging service provided the largest contribution of responses to the Friends and Family Test during the pandemic, and continues to be the primary method of Friends and Family Test feedback collection methodology for community mental health services.
- Focussed on the Trustwide Carers Survey which has been built into work the Trust is doing on the Carers Charter.
- The new Friends and Family Test question and promotional materials were launched across the Trust is April 2020. However, the launch was affected by the pandemic. The Trust has been working with services to adapt and gather feedback using alternative methods, such as electronic surveys.

Work that has been delayed by the pandemic and not progressed as much as we would have liked is:

- The Trust was unable to trial text messaging in Community Health Services due to the pandemic and redeployment of staff. This work is being picked up in 2021/22.
- The Quality Improvement and Assurance Team work with operational teams to ensure they are collecting, reviewing and acting upon service user and carer feedback. This continues to be a development for 2021/22.
- Continue to work with teams to develop a practical way to collate actions being taken across the Trust to demonstrate the changes that are being made as a result of feedback. This continues to be a development for 2021/22.

New developments for 2021/22 are:
- Development of Patient Experience representatives across the Trust to support the Patient Experience agenda. This continues to be a development in 2021/22
- Review of the Patient Experience Framework This continues to be a development in 2021/22
- Review text messaging collection service to improve data quality
- Expanding the text messaging service across Barnsley Community Health
- Review and complete the Patient Experience Improvement Framework

Friends & Family Test

The NHS Friends and Family Test (FFT) is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This feedback should be used to improve services for service users. The FFT question asks overall, how their experience of our service was and offers a range of responses from 'very good' to 'very poor', including a 'don't know' option. When combined with supplementary follow-up questions, the FFT question provides a mechanism to highlight both good and poor service user experience.

The free text comments are a rich source of information, which provide staff with a greater depth of understanding about the experiences of their service users. The results are available more quickly than traditional survey methods, enabling providers to take swift action when required. The FFT results are also a

useful source of information which can help to inform choice for service users and the public. The results are available on the NHS England website and the NHS Choices website.

The FFT was implemented in the Trust in 2015. The Trust is on a progressive journey of continually refining and improving systems and processes for the collection of service user feedback and uses this to improve quality. In 2020/21, the Trust received 4808 individual pieces of feedback, an average of 400 responses per month, compared to 8173 individual pieces of feedback, an average of 681 responses per month in 2019/20
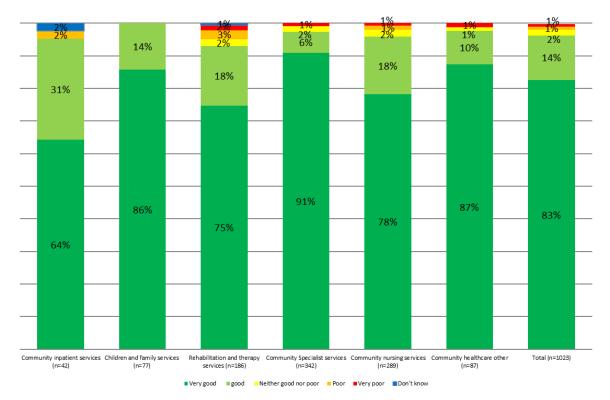
Friends & Family Test	Target	Reporting Period	Q1			Q2			Q3			Q4		
			A	M	J	J	A	S	O	N	D	J	F	M
Mental health	85%	Monthly	86%	86%	85%	88%	79%	80%	84%	88%	90%	81%	81%	80%
Community health services	98%	Monthly	97%	100%	100%	95%	95%	100%	97%	96%	96%	100%	95%	98%
Trust wide	90%	Quarterly	86%			87%			90%			81%		
CAMHS	75%	Quarterly	89%			81%			78%			76%		
Forensics	60%	Annually	72%											
Learning Disability	85%	Quarterly	96%			95%			83%			88%		

*Community Health services generally achieve a higher satisfaction rate than Mental Health. Due to this Community Health services have a satisfaction rate target of 98%

Themes from mental health services feedback include staff attitude, access to CAMHS, and food and activities on inpatient areas.

The dissatisfaction of access to CAMHS has an impact on the overall MH score.

Community Service Friends and Family Test Results 2020/21

97% of respondents rated the service they received as either 'very good' or 'good. 2 % rated the service as 'very poor' or 'poor'. The percentages for those who would rate the service as 'very good' or 'good' fell below the 98% target by 1%. On review of the data we were unable to identify a single service that this could be attributed to. The free text comments did not indicate any themes or trends. Reporting is provided to services to regularly review and act upon comments.

C3. Equality, involvement, and communication

Equality is about creating a fairer organisation in which everyone can fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense and treating everyone with fairness and understanding, not necessarily treating everyone the same. The Trust is committed to being responsive and supporting the needs of the diverse population it serves, reflected in the Trust's values. Equality and Diversity is not an 'add on', it is central to all we do as a provider of services, as an employer and as part of the public sector. People who use the Trust's services are all different - in terms of social circumstances.

To ensure we comply with our statutory responsibilities under the Equality Act 2010 especially the Public Sector Equality Duty, (PSED) and the Health and Social Care Act 2014 we must consider equality and involvement at each stage of service delivery including as part of any decision-making process.

The Trust believes that an integrated approach to equality, involvement, communication, and membership will ensure we deliver on our inclusion agenda.   We know that each of these areas has its own drivers and legal obligations which we will need to adhere to and deliver on. Our approach to equality will be driven by involving people and will ensure our methods and approaches are reflective of the audience we are aiming to reach. This means that a one size fits all or single approach will not provide the right conditions. Our commitment will be to always understand our audience before we start any activity.

The Trust has an Equality, Involvement, Communication and Membership strategy and supporting annual action plans to ensure an integrated approach to delivering on the strategic objectives. The approach is insight driven and offers a joined-up approach to delivering equality and involvement in its broadest sense. The strategy identifies the processes already in place to support equality and inclusion and the breadth of insight and intelligence that already exists.

Using the principle of involvement to underpin everything we do; we will drive the equality and inclusion agenda. This strategy sets out the core components that will enable us to deliver a clear and comprehensive approach to meaningful involvement and inclusion. Underpinned by communication and supported and driven by our members. This will ensure our ambition which is to ensure:

- Every person living in the communities we serve will know our services are appropriate and reflect the population we serve.
- That our workforce reflects communities, ensuring our services are culturally appropriate and fit for purpose.
- Service users, carers and families receive timely and accessible information and communication, ensuring a person-centred approach to care.
- That our services are co-created and designed with our staff and communities

The Equality and Inclusion (E&I) Committee oversees the agenda and has delegated responsibility for signing off annual action plans. The Equality and Inclusion Committee was established to act on behalf of the Board and to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does.

The Committee oversees the implementation of the Equality, Involvement, Communication and Membership Strategy (reviewed and approved by Trust Board September 2020) 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.

This year the Trust response to the pandemic was to set up an Equality and Inclusion Sub- Committee to address and understand wider health inequalities and a specific task force to address the inequalities that were highlighted during the pandemic for people from a BAME background in the form of a BAME Workforce Task Force.

The trust has made the following progress in 2020/21:

- The Trust has co-created with people who use services, staff, and communities a new strategy. The Equality, Involvement, Communication and Membership Strategy pulls together previous strategies into one approach. The strategy is available in easy read and an animation with the option for translated versions as requested.
- The Equality, Involvement, Communication and Membership Strategy is supported by annual equality and involvement action plans. These plans set out our Trust wide approach to delivering strategic objectives and describe the Trust actions for the forthcoming year. The plans align existing internal resources, data, and insight frameworks to ensure a systematic and integrated Trust wide approach.
- Underpinning our integrated approach is the effective use of insight and data, this includes robust equality monitoring. Without good quality data, the Trust will not be able to identify if services or workforce are reflective of the population the Trust serve. Data is used to identify who uses and works in services, highlighting areas of inequality that can be addressed through insight work and action planning.
- Equality Impact Assessments (EIA) are in place for all services, strategies, and policies. This ensures that equality; diversity and human rights impacts are considered, recorded and action taken for every service. Action to mitigate impacts are taken through service level actions plans which are used to implement service improvements.
- A short form EIA has been introduced to support quick decisions. This form has been used to support a response to the COVID-19 pandemic ensuring that equality and diversity are considered and any impacts identified, and action taken.
- A Trust wide equality impact assessment and approach was developed in direct response to the pandemic. This approach includes a Trust wide EIA that has regularly been updated and reviewed and signed off by E&I Committee and Trust Board and the development of a resource and research bank which is an internal resource of all literature published during this time. These tools have ensured that our public sector equality duty to advance equality of opportunity and consider impacts has been a core focus in response to the pandemic.
- Several involvement resources such as plans and reporting templates to record activity ensure that our approach is audited and in line with our legal obligations.
- The Trust have a clearly articulated approach to formal consultation, this includes a training pack, plan on a page and governance through EMT and E&I Committee who will sign off the approach.
- The Trust wide change framework includes the process for involving people at each stage and a 'checklist' approach and dedicated inbox for involvement ensures that a systematic and considered approach to engagement, co-production and consultation is considered at the start of any new project or programme of work
- All involvement plans are driven by the local Joint Needs Assessment (JNA) and service level Equality Impact Assessment (EIA) data which describe the reach so that approaches consider equality and diversity by including a range of methods and approaches to support an inclusive involvement approach.

- A process is in place for working with our communities using stakeholder mapping to identify key stakeholders and contacts. Whilst working with community groups the routine collection of feedback and equality monitoring will ensure we are listening to, recording, and reporting on the voice and views of a representative sample of the local population. Quarterly insight reports support this approach.

- A Trust wide survey toolkit to support the collection of patient experience and engagement intelligence ensures that the Trust have a clear approach for capturing views. The central collection of data provides an opportunity to use the feedback at both a service and Trust wide level to inform.

- The Department of Health's Friends and Family Test in every service setting now has a short equality monitoring form. This ensures feedback is representative and that the information can be broken down by protected group to identify and address inequalities.

- Using what we already know including the data we hold and insight and intelligence from local and national surveys, including partners such as Healthwatch will be used as a baseline to inform Trust developments. Using existing insight is a process we are undertaking in the form of a composite report prior to planned involvement.

- The Trust publish report of findings from all our involvement activity to demonstrate the insight we are using to inform service improvements. The reports include an equality section, which includes who we have reached and how reflective the voice is of the local population. This will ensure the representation of voice is in line with and reflective of the population we serve.

- The principle of co-production is a Trust wide approach evident in our Recovery Colleges who co-create learning and development opportunities.

- A dedicated programme of work to roll out of Peer Support Workers and ensure lived experience is part of our approach has resulted in the development of a dedicated training programme and increase in internal posts.

- Staff networks are a significant part of our approach. The black, Asian and minority ethnic (BAME) staff network was established to empower and support staff to achieve their potential and maximise their contribution in delivering the Trust's Mission, Values and Strategic Objectives. The Trust has an established disability staff equality network, Lesbian, Gay, Bisexual, Transgender (LGBT+) and Carers network using the same principles of self-determination and support. This year we have established a staff carers network to support any staff in their caring role outside of work. The networks play an active role in several elements of Trust business, including recruitment to senior positions and the development of Freedom to Speak Up Guardians.

- The Trust has also established a clinical network, called Race Forward, to reduce bullying and harassment from service users and carers on staff from BAME backgrounds. The clinically managed network meets bi-monthly to support staff and liaises with the Police and other Trusts to tackle the issue and create positive change.

- The Board and Governors believe they should be reflective of communities and represent the workforce and population it serves. Over the last year a good level of diversity has been retained across the Board with a good balance of gender, age, and ethnicity. Governors use a targeted approach to support recruitment from local communities.

- The Trust has developed an experience and engagement tool which includes a mandatory equality monitoring form so data can be disaggregated and interrogated by diversity and ethnicity. This has been used to capture insight during the pandemic at a service level. With the findings supporting our recovery approach.

- The Trust has a value led recruitment approach and has over the past year recruited to public panels. This has resulted in a diverse range of service users, carers and volunteers who are now able to attend recruitment of senior roles (band 7 and above). This means that there is BAME representation on all senior appointments which will be extended to all key appointments

- Our commitment to Carers has resulted in a co-designed Carers passport and funding which has resulted in a dedicated post to act on these commitments. We continue to work closely with West Yorkshire and Harrogate ICS.

- Our 'Choose well for mental' health guide was co-designed with staff, service users, carers and families and is available on our website to download. This includes and easy read and Urdu version Choose well for mental health | South West Yorkshire Partnership NHS Foundation Trust.

- We continue to support people's religious and spiritual needs by providing a multi-faith room in our inpatient settings

- 'Virtual Visitor' was developed during the pandemic using feedback from staff, carers and families.

- The Trust digital strategy used existing insight and captured wider views to inform the approach, with a report of findings available on the insight which had supported development

- Work with Governors has taken place to ensure that they are supported to work with communities. This includes capturing and feeding in people's feedback and the development of an insight report.

- We work closely with our Advocacy partner organisations to gain insight about the experience of those who access our services. The Acute Care Forums in Barnsley and Wakefield have representatives from the Advocacy Services in attendance.

- We have been fully accredited under the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loops receive information in a way they can access and understand, and any communication support that they need is identified and provided whilst continuing to work in partnership with Language Empire, our interpreting, translation and transcribing provider.

- We have reviewed our communications request form to include the 10 most common translation requests and request this at the design stage so JPEGS and a large print statement can guide people to accessible versions.

- As part of Active Calderdale, we have employed a change and innovation facilitator to work alongside our community teams to get physical activity embedded into care plans. This post is a new role and the postholder has developed a collaborative plan for this work. Work has started with Calderdale staff to develop innovative approaches to supporting people to be more active. The project manager is linking with someone who is undertaking a similar role in Calderdale and Huddersfield NHS Foundation Trust. This role is starting to make an impact.

- The Calderdale Creativity and Cultural programme has been developed over several years, following the approval of the living a larger life creativity arts and culture strategy that was supported by the Calderdale Health and Wellbeing Board.

- Recovery colleges have invested in a dedicated website – the website went live in July 2020 and continues to ensure courses are available as a part of a digital offer.

- The programme has secured funding from partners including the CCG, Local Authority and North Halifax Primary Care Network. This is primarily to fund the role of the programme manager over 12 months and is hosted by SWYPFT/Creative Minds.

- We publish our Equality Workforce Monitoring Report on our website at: https://www.southwestyorkshire.nhs.uk/about-us/performance/workforce-equality/. The report covers a range of information about staff, mapped to protected characteristics, and a range of indicators including starters, leavers, promotions, pay bandings and update of training. The report concludes that the workforce is broadly representative of the communities it serves, with the exception of South Asian, particularly in Kirklees. Targeted recruitment is being explored to address this, including through an apprenticeship scheme for young people and working with schools and colleges to promote Trust services as a career option. We also consider workforce diversity issues as part of our workforce planning processes.

- We were successfully accredited against national standards for both investing in Volunteers and Customer Service Excellence.

- The Trust has established a 'Race Forward' group specifically to look at the NHS Workforce Race Equality Standard (WRES) indicator 5 (staff experiencing harassment, bullying or abuse from patients, relatives, or the public). SWYPFT has also linked with other trusts to work on a cross-organisational approach to improving staff experience in this area.

- Workplace health and wellbeing has been a key priority for 2020/21. Actions included a dedicated BAME staff members and intranet support.

- The Trust has a nationally accredited volunteer service with over 244 registered. The service continues to offer several roles across the Trust which provides a diverse service offer to service users, staff, and the public. Examples of roles include: smoke free champions in wellbeing services, light touch volunteers in service improvement groups and staff recruitment processes, K9 Befrienders and Chaplain service for our services, student volunteers in our Improving Access to Psychological Therapies (IAPT) team, catering assistants in our catering departments, Recovery colleges providing community support, Befrienders on wards and communities, Expert Patient Programme provides support and courses in the communities, Admin volunteer supporting the mental health museum, befriender volunteers, activity volunteers within Forensic services, Pat Dog volunteers, Library service and Speech therapy buddies for our Aphasia café.

- The Trust has now incorporated the Edward Jenner programme NHS Leadership Academy e-learning on-line modules into our Introduction to Leading & Managing' and 'Moving Forward' programmes.

- The Trust has continued to embed the values-based leadership framework launched in 2018, also used in our appraisal process and moving towards an E-System using 'WorkPal'.

- The Trust has further developed a coaching and mentoring framework. This includes the provision of coaching via 'Crucial Conversations', 360-feedback, peer coaching and executive coaching programmes to which we have added medical mentoring and reciprocal mentoring for our BAME colleagues.

The next steps for this programme for 2021/22 will be:

- To deliver the actions set out in the Equality action plan which include:

- Improve baseline equality data

- Improve data collection using a campaign and training

- Improve the resources to support the development and completion of Equality Impact Assessments

- Demonstrate compliance with our Public Sector Equality Duty (PSED)

- Review our offer and continue to deliver mandatory and focussed training

- Continue to deliver and report on the WRES and NHS Workforce Disability Equality Standard (WDES) including action planning and improvements

- Continue to deliver and report on Equality Delivery System (EDS2)

- Ensure services remain accessible and inclusive with a focus on information and communication

- Reducing health inequalities: Using the super output data available in each Place monitor and respond to the use of services from these areas using targeted approaches to reduce inequality of access to mental health services

- Build relationships and sustain our work with Healthwatch, the third sector and faith groups and other partners

- Establish a robust approach to identifying and supporting carers

- Ensure we continue to provide opportunities which will result in diverse leadership

- Continue to support and develop staff networks

- Reduce disparity in disciplinary and complaints processes: By ensuring all staff subject to these processes are offered support through advocacy and support

- Eradicate discrimination and prevent bullying across all protected groups

- Increase the diversity of volunteers with a focus this year on BAME, Learning Disability/Autistic Spectrum Disorder, LGBTQ+, young people and carers in this period

- Increase Peer support offer: Identify vacancy opportunities and accelerate the peer support worker offer in all Trust services

- Capture insight from all Trust wide data sources: Use the information we already hold as a baseline prior to delivering any engagement activity

- Trust wide use of the checklist to ensure there is a consistent approach to involving people. Use service line and staff equality data to identify the target audience to ensure involvement methods and approaches meet the needs of those audiences

- Introduce a training package for staff and governors to support the involvement approach

- Identify and invest in existing asset-based approaches and identify new opportunities

- Identify a feedback mechanism which will support Governors to capture community voice to support Trust wide approach to capturing insight and intelligence

- Develop and agree a reimbursement of expenses policy

- Refresh the get involved section of the website to support the Equality, Involvement, communication and membership strategy

- Develop a pilot toolkit to capture patient stories and test out using the Hope Project

C4. Dignity and Respect

At South West Yorkshire Partnership NHS Foundation Trust we put the person first and in the centre. This includes treating all service users, carers and staff with respect and dignity at all times. We receive positive feedback on our staff on a daily basis.

In 2019, the Trust was inspected by the CQC. The core service 'acute wards for adults of working age and psychiatric intensive care units' received the following 'Must Do' action:

AMD6: The Trust MUST ensure that patients are always treated with dignity and respect and staff are not abrupt in their approach

This was issued due to the following findings:

Nine patients described staff as being 'not respectful' or 'short tempered.' Four patients stated that staff were 'rude.' One patient said they had observed staff acting in a racist manner and verbally abusing a patient who was under 18 years of age. Another patient said that a staff member had shouted at another patient in their presence.

The Trust intended to conduct an 'Always Event' with service users and staff to further explore views regarding dignity and respect, and if necessary, co-produce QI work. However, due to the COVID-19 pandemic this was not possible, and an alternative plan was created. A survey was designed and distributed across the core service.

Results

Responses were received from 7/9 wards. 66 responses were received in total.

Did staff treat you with dignity:	Total % 'Yes all the time' / 'Yes to some extent'
By involving you in decisions about your care	94%
By addressing you by your preferred name	100%
By respecting your personal space and possessions	92%
By talking to you about your treatment in private	97%
By knocking on your bedroom door before entering	95%

Did staff treat you with respect:	Total % 'Yes all the time' / 'Yes to some extent'
By introducing themselves to you with 'Hello, my name is'	97%
By making you feel welcome when you were admitted onto the ward	91%
By valuing you as an individual, your values, beliefs and personal relationships	94%
By being polite to you	95%
By listening to you and communicating with you in a way that is easy for you to understand	95%
By supporting you to make decisions about your care	91%
By maintaining your confidentiality always	95%

Below is a selection of free text comments received:
- "The quality of care and genuine love shown to each and every individual is truly outstanding to all the patients" – Ashdale
- "Once I got better, I realised just how helpful and caring the staff are" – Elmdale
- "The staff are approachable and always willing to help" – Ward 18
- "Staff are professionals in what they do" – Stanley
- "Staff uniformly excellent, whether housekeeping, TNA or consultant" – Nostell
- "Beamshaw Ward is a superior quality facility. All staff are friendly yet firm and fair. Quality starts at the top and has kept going. Clean and tidy. Great" – Beamshaw
- "Staff are amazing, and they treat you with dignity and respect" – Melton

Conclusions

There is a high level of satisfaction across all questions asked, and several very positive free text responses regarding staff across the core service.

What next?

The quality initiatives, in the CARING domain, we will undertake in 2021/22 to help us achieve our aim 'to improve and be outstanding' are:

- Staff health and well-being- make the Trust a great place to work

- Patient experience – implementation of the updated friends and family guidance
- Complaint response times.

Priority 4: RESPONSIVE

Why did we focus on this?

By responsive, we mean that services are organised so that they meet people's needs.

'RESPONSIVE' quality initiatives in 2020/21

The following quality initiatives were prioritised for action in 2020/21 as part of the quality account process.

R1 Learning Disability Wait Times

The focus continues to be the reduction of waiting times for people with a learning disability who require treatment from a specialist LD Community Team, that they receive an assessment and treatment in a timely manner. The monitoring of the key performance measures (waiting times) shall improve the management and understanding of who is waiting for a service and how needs can be met within the shortest timeframe.

Following is an overview of actions that have been taken/put in place to assist with the management of the teams waiting lists.

- A range of access key performance measures are monitored on a month by month basis.

- We receive monthly detailed management information that tells us

  - Who is awaiting a specific discipline provision and not open to the team

  - Who is awaiting a specific discipline provision but is open to another discipline in the team dependent on need, these can be prioritised lower as they are being seen which allows the team to prioritise those that are not being seen at all given that the risks are more unknown.

- Waiting lists are reviewed in weekly multi-disciplinary team meetings

- Weekly multi-disciplinary referral and allocation meetings are in place

- A duty provision and process are in place that screens/triages all new referrals and undertakes an assessment of clinical risk

- Work is progressing to develop a clear pathway with Kirklees mental health services for people who have both learning disability and mental health services involved in their care. An effective pathway will assist with creating capacity on caseloads. When this pathway has been finalised, it will be adopted across all localities.

- Dementia Pathway for people with a learning disability has been devised in Kirklees in partnership with the Community Dementia Service.

- Transition Pathway being redeveloped.

- Greenlight Tool kit and Care Programme Approach (principles) to be re-established.

- Strategic Health Facilitator posts to commence in the Community Teams.

The current national waiting time key performance indicator for referral to treatment is eighteen weeks for people who are screened as requiring routine care. People who require urgent access to care are responded to within 24 hours.

The data below shows our performance against three of our access measures:

1. Percentage of referrals that are screened within 2 weeks – Target 90%:

Locality	Year to date 2019/20	Q1	Q2	Q3	Q4	Year to date 2020/21
Barnsley	89%	91.7%	95.9%	100%	85.71%	93.32%
Calderdale	69%	57.9%	72.7%	82.14%	85.71%	74.61%
Kirklees	87%	93.30%	94.30%	94.23%	91.53%	93.34%
Wakefield	76%	92.30%	90.74%	97.37%	85.71%	91.53%

Improvement was made in each service; however, the 90% target was not achieved in all the localities across the year. Three out of the four teams across the year did attain the target percentage in each quarter, however Calderdale did not achieve the required performance measure in any of the quarters. This was due to new members of staff starting through the pandemic and taking more time than usual to be inducted. This has now been addressed.

2. Percentage of referrals that have commenced treatment within 18 weeks – Target 90%:

Locality	Year to date 2019/20	Q1	Q2	Q3	Q4	Year to date
Barnsley	94%	82.60%	85.19%	100%	100%	91.95%
Calderdale	92%	95.50%	84.20%	87.50%	81.25%	87.11%
Kirklees	87%	60.30%	87.50%	100%	68.97%	79.19%
Wakefield	80%	88.20%	88.90%	90.00%	85.19%	88.07%
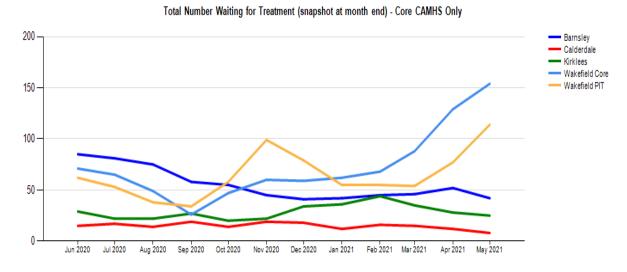
The 90% target was not achieved consistently in any of the localities across the year. The impact of the various COVID-19 lockdowns had an untoward influence on the statistics. The service average for this measure is 86.58%

R2. Improve access to Child and Adolescent Mental Health Services (CAMHS)

Our aim is to ensure that children and young people experiencing emotional and mental health wellbeing difficulties have early access to the right support, at the right time and in the right place.

Improving waiting times from referral to treatment in CAMHS remains a Trust (and national) priority programme - supported by a CAMHS Improvement Steering Group - and routine progress updates continue to be provided to CGCS Committee. Previous CQC inspection had identified waits to be a concern, specifically in relation to the risk of escalation in acuity whilst children/young people were waiting.

Significant progress has been made in waiting times for treatment over the past 2/3 years across CAMHS – though this position has been somewhat undermined by the impact of the pandemic on referral rates and service capacity. As part of service continuity plans a significant proportion of assessment and treatment has continued to be delivered by telephone/video-link. Face to face support has been provided where a clear clinical need has been identified and has increased incrementally as the service has started to experience demand and acuity pressures. Referral levels (including crisis referral) have generally increased since March 2021. A CAMHS Bronze-level control group has continued to meet weekly.

The current positions (May 2021) are identified below.

Total Number Waiting for Treatment (snapshot at month end) - Core CAMHS Only

	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021
Barnsley	85	81	75	58	55	45	41	42	45	46	52	42
Calderdale	15	17	14	19	14	19	18	12	16	15	12	8
Kirklees	29	22	22	27	20	22	34	36	44	35	28	25
Wake Core	71	65	49	26	47	60	59	62	68	88	129	154
Wake PIT	62	53	38	34	58	99	79	55	55	54	77	114

Significant progress has been made in waiting times for treatment over the past 2/3 years across CAMHS – though this position has been somewhat undermined by the impact of the pandemic on referral rates and service capacity.

A service-wide evaluation of the new ways of working i.e. 'Changing the Ways We Work' has been undertaken. The evaluation highlighted the positivity of most children/families toward the new technology

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balanced by the risk of digital exclusion with respect to some children and families - with potential for a disproportionate impact on the most vulnerable

Important developments include:

Waiting list initiatives. In all areas, capacity has been temporarily increased through additional investment. This capacity has largely been maintained through the period of the pandemic. This work has been complemented with ongoing review of demand/capacity models to ensure pathways are efficient and effective. As an example in Wakefield an assessment team pilot has been implemented to strengthen 'front-end' decision-making.

Community Mental Support Team (MHST). The roll out of the national MHST programme has strengthened the school-based support available in each area. The expectation is the focus on mild/moderate mental health needs will reduce referrals to specialist CAMHS.

Neurodevelopmental pathways

The position in respect of waiting times for diagnostic assessment has continued to deteriorate - with non-recurrent waiting list investment insufficient to bridge the gap between demand and assessment capacity. In Kirklees a revised business case will be submitted by end June 2021 aimed at establishing capacity to meet ongoing demand. A separate procurement will shortly be completed in relation to a further short-term waiting list initiative. We are working with commissioners on developing solutions to address waiting times and completing business cases to this effect. Current waits are detailed below:

	May 20	Sep 20	May 21	Longest wait (months)
Calderdale	251	342	340	24
Kirklees	573	701	778	20

Development in CAMHS in 2021/22 will include:

- Ongoing review of business continuity plans and agreement of a re-set position

- Optimising level of recurrent investment in strengthening CAMHS capacity (within developing ICS-level arrangements)

- Agreement and implementation of business cases regarding neurodevelopmental pathways
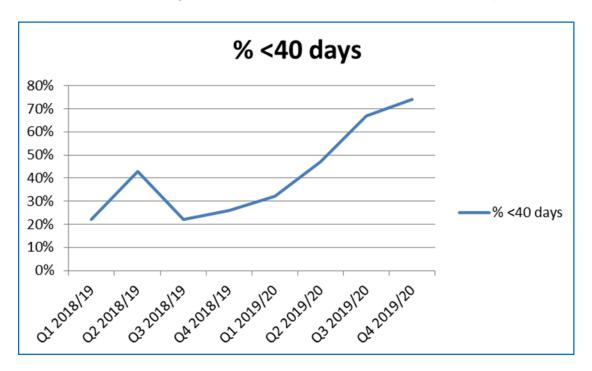
R3. Complaint resolution times

Efficient and effective handling of complaints ensures that NHS organisations continuously review and improve the quality and safety of care they deliver.

Ensuring good handling of complaints is one way in which healthcare providers can help to improve quality for their patients. Monitoring trends and patterns in complaints and concerns raised by patients about organisations facilitates early detection of systemic problems. Learning from complaints helps organisations to continually improve the services they provide and the experience for all their patients.

Extensive development work on the complaints pathway was undertaken in 2019/20 to improve the complaints pathway, process and data quality. We have adopted a continuous quality improvement approach to our complaints process to ensure we have a contemporary service that is fit for purpose and can respond efficiently & effectively to issues people raise.

The previous work we undertook resulted in a steady improvement of response times to complainants. In February 2020 we achieved the key performance indicator of 80% and in March achieved 71%. Although we didn't quite reach our target, our performance is much improved from the position of 20% in April 2018.

The pandemic had an impact on our complaints process. On 26 March 2020 NHS Improvement wrote to NHS organisations explaining that, subject to local determination, we could pause the complaints process. During this time the Trust did respond to complaints, however as our model relies on frontline clinical staff to investigate complaints we had to adapt to the situation and utilise staff who were not working in frontline roles. This meant that where we did not have clinical expertise available to respond to complex complaints, these complaints were paused or took longer to investigate.

Nationally the complaint process was fully reinstated on 1st July 2020 with no further changes during the second wave of the pandemic.

The performance of our response to complaints within 40 days fluctuated throughout the period August 2020-March 2021 as frontline staff maintained their priority focus of working to maintain safety for people who used our services in responses to the changing landscape of the pandemic.

Month	Percentage of complaints closed within 40 days
August 2020	62%
September 2020	30%
October 2020	60%
November 2020	73%
December 2020	11%
January 2021	50%
February 2021	100%
March 2021	42%

Areas for development focus in 2020/21 which were achieved are:

- Review of processes to support complex complaints – see below – **Response times.**

- Review of processes to manage persistent complainants – process available in the updated complaints policy
- Continue focussed work on response times – see below **Response times**

Response times

National guidance stipulates a complaint investigation must be proportionate to the concerns raised and the deadline in which a complainant can expect to receive a formal response should be agreed between the customer services officer and the complainant. The national timescale for resolving a complaint is 6 months.

The Trust currently aspires to respond to all complaints within 40 working days, however given the challenging circumstances that COVID-19 pandemic has posed and against a backdrop of the current national guidance the following timescales (working days) were agreed as a pilot between May 2021 and July 2021.

	Acknowledgement (working days)	Timeframe Response (working days)
Level 1 (PALS / Informal concerns / service issues)	1-3	3-5
MP responses	1-5	10
Level 2 (minor)	3	25
Level 3 (moderate)	3	40
Level 4 Complex)	3	60

Several areas of learning were started in 2020/21, however these are being carried forward into 2021/22 for completion:

- Learning lessons from complaints (triangulating feedback from other sources of patients and staff experience)
- Review of process for reopened complaints
- Update the Customer Services Policy

R4. Care closer to home

Aim of the work:

The reduction of inappropriate out of area beds to zero by April 2021. We set out to achieve this by:

- Setting out and delivering the operational model which promotes providing care as close to home as possible.
- Establishing performance management systems including performance dashboards that support delivery of the model, so it is easy to manage services in line with expectations.
- Working with teams to deliver a series of quality improvement projects which will impact on admissions, discharges and length of stay.

Why is it important to the quality of clinical care?

Over recent years we have been admitting more people to beds than we have available in the Trust. People therefore have to be placed outside the Trust bed base and this impacts on them and their

family/carers/friends. In both 2017/18 and 2018/19 there were about 5000 bed days spent out of area. The factors which are contributing to this situation are many and complex.

In 19/20 the Trust reduced the number of Out of Area bed days by about 50% to approximately 2600 and reduced placements further in 20/21 to under 2300 bed days. The information below sets out the work we've been being doing to reduce to the levels and continue to do now.
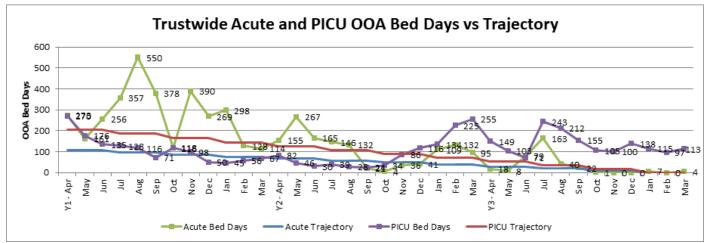
The work is focused on providing all care as close to home as possible for people. This will improve the quality of care and the aim of this work is to reduce the number of admissions for people in our care so that we not only reduce the number of people going out of area but we also reduce the occupancy on our wards. This thereby leads to better quality care and an improved working environment for staff. Ultimately, we wish to reduce the size of our wards.

Significant work has been undertaken to understand and manage the bed pressures. The situation is still challenging although a large programme of work has been undertaken to address it, with some elements ongoing.

What have we done so far?

- Criteria Led Discharge has now been fully rolled out and refreshed across all wards to support timely and appropriate inpatient stays.
- Patient flow has become a Trust Wide service and now operates a 7 day extended service. This support more effective access to beds across the Trust footprint.
- In Kirklees changes have been made to community systems that now support the Intensive Home Based Treatment (IHBT) to put their focus into supporting people with the highest needs.
- The PICU service has developed a new standard operating procedure.
- The Calderdale and Kirklees Single Point of Access (SPA) has taken forward a number of initiatives. In particular, it has implemented a new triage scale which helps to get people assessed in a timely way but also reduces burden on IHBT.
- Work has also taken place with commissioner to focus on referrals into the service.
- The programme has overseen delivery of new trauma informed pathways, designed to improve outcomes for patient with a personality disorder. This work has now been operationalised.
- A review of gatekeeping has recently taken place. Recommendations from this exercise will be considered and it could lead to further priorities being identified.

We set out to achieve zero out of area admissions to acute wards by 2021. The graph below demonstrates our progress:

We achieved our target for acute wards, however more work is required on PICU, especially gender specific placements.

PICU work will now focus on operationalising the Standard Operating Procedure (SOP) and activity is due to resume across the West Yorkshire and Harrogate ICS looking at PICU opportunities. This could help address some of the issues with gender specificity as we will not be able to cease all out of area placements until a solution is found to this.

It is important to note that since lockdown easing there has been new pressures placed on the acute inpatient pathway. We are taking action to resolve this pressure and assessing whether it is likely to be short term pressures caused by pent up demand or longer-term issues that need further change and programme activity.

The Trust has identified the acute inpatient pathway as a strategic priority and a team have been established to review ongoing improvement work and reconsider what is required to improve services for people who are acutely mentally unwell and improve the working environment for staff on our wards. We are considering how the work of the out of area programme can integrate with this into a new joint plan.

What next?

The quality initiatives in the RESPONSIVE domain which we will undertake in 2021/22 to help us achieve our aim 'to improve and be outstanding' are:

- Complaint closure and resolution times

- Improve waiting times in Learning Disability and CAMHS services

- Implement objectives from the Equality, Engagement, Communication and Membership Strategy

Priority 5: WELL LED

Why did we focus on this?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

'WELL- LED' quality initiatives in 2020/21

The following quality initiatives were prioritised for action in 2020/21 as part of the quality account process.

W1. Quality assurance and improvement accreditation scheme

In previous quality reports we have detailed how we have developed a quality assurance and improvement 'self- governing' assessment model, which provides a philosophy, process, and a set of tools for improving results for clinical teams. As a philosophy and process, the model provides a context for a dialogue on self-governance and self-evaluation. As a series of methods and tools, it will help map the relationships between

quality assurance and quality improvement and be a continual source of evidence for teams to inform them how well they are performing (in relation to quality).

An implementation plan for the full roll out of the quality assurance and improvement accreditation scheme was developed in February 2020 and presented to our clinical governance and clinical safety committee for approval. The schedule was due to commence in April 2020, which was delayed by COVID-19, however one of our wards for older adults commenced the scheme in July 2020 and the full implementation plan is being revised. It is anticipated that this scheme will be able to be rolled out during 2021/22.

W2. Quality dashboard development

Good quality information is a driver of performance for clinical teams and helps ensure the right services and best possible care is provided to service users.

A 'quality dashboard' is a toolset developed to provide clinicians with the relevant and timely information they need to support daily decision making that improves quality of service user care. A dashboard gives our clinicians easy access to the wealth of data that is being captured locally, in a visual and usable format, whenever they need it. In SWYPFT we have developed a range of dashboards that assist staff the monitor and improve quality.

The first step we took in the development of the quality dashboard was to identify metrics that we already collected, that could be reported monthly in the quality section of our integrated quality report. We aligned the metrics to the Trust objectives and CQC domains and allocated each metric a director level 'owner'. This ensures there is appropriate accountability for the delivery of all our metrics and helps identify how achievement of our objectives is being measured. A copy of our Trust board quality dashboard can be found at https://www.southwestyorkshire.nhs.uk/about-us/performance/performance-reports/.

Over the past three years we have developed a range of business intelligence dashboards for our clinical teams to track and improve their performance. To complement these dashboards, we have developed a quality dashboard that will be populated from a range of data sources and will provide a body of impartial evidence for teams to review when they undertake their quality scheme self – assessment.

W3. Learning lessons from feedback

The work we had planned to do to triangulate feedback from a range of sources was put on hold as part of the pandemic. This work has recommended in 2021.

What next?

The quality initiatives in the WELL- LED domain which we will undertake in 2021/22 to help us achieve our aim 'to improve and be outstanding' are:

- Continue with implementation of quality assurance and improvement 'self-governing' assessment and accreditation model.
- Learning lessons- further development of systems to improve how we learn lessons from patient experience feedback, serious incidents, audits, safeguarding reviews and share the learning.

Annex 1 Glossary

AHSN	**Academic Health Science Networks** are membership organisations within the NHS in England. They were created in May 2013 with the aim of bringing together health services, and academic and industry members
BDU	**Business Delivery Unit:** The Trust runs services on a district by district basis with support from a central core of support services. These district management units are called Business Delivery Units (BDUs). We have six BDUs; Barnsley, Calderdale, Kirklees, Wakefield and Forensics and Specialist Services.
CAMHS	**Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.
CMHT	**Community mental health team:** A community based multi-disciplinary team who aim to help people with mental health problems receive an appropriate community environment for as long as possible, and in many cases preventing hospital admission.
CQC	**Care Quality Commission** The Care Quality Commission is the health and social care regulator for England. Their aim is to ensure better care for everyone in hospital, in a care home and at home
CQUIN	**Commissioning for Quality and Innovation.** A payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All (the NHS next stage review report) of an NHS where quality is the organizing principle.
DATIX	**Datixweb** is the web based version of the Trust's risk management system. It enables staff to report incidents that happen at the Trust, electronically
EMT	Our **Executive Management Team** (EMT) put into action the strategic direction and priorities set by the Trust Board. They are responsible for the day to day running of the Trust, making sure that resources are in the right place to provide high quality care and achieve our mission and objectives. They are held to account by our Trust Board.
FFT	**Friends and Family Test:** a service user experience and quality improvement tool used across the NHS
IAPT	**Improving Access to Psychological Therapies** is a National Health Service initiative to provide more psychotherapy to the general population
Key performance indicator	A performance indicator or **key performance indicator** is a type of performance measurement. KPIs evaluate the success of an organization or of a particular activity in which it engages.
NCISH	The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is an internationally unique project. The study has collected in-depth information on all suicides in the UK since 1996. Their recommendations have improved patient safety in mental health settings and reduced patient suicide rates, contributing to an overall reduction in suicide in the UK. Their evidence is cited in national policies and clinical guidance and regulation in all UK countries.
NHSI	**NHS Improvement** is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NICE	**National Institute for Clinical Excellence:** a national group that works with the NHS to provide guidance to support healthcare professionals make sure that the care they provide is of the best possible quality and value for money
SafeCare	A daily staffing software tool that matches staffing levels to patient acuity, providing control and assurance from bedside to board. The tool allows Trusts to compare staff numbers and skill mix alongside actual patient demand in real time, allowing us to make informed decisions and create acuity driven staffing.
Safety Huddles	A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.
SystmOne	The electronic service user record system that is used in within our Trust.

Annex 2: Statements from our stakeholders

1. Barnsley Clinical Commissioning Group

NHS
Barnsley
Clinical Commissioning Group

17 August 2021

Mr Darryl Thompson

Director of Nursing & Quality

South West Yorkshire Partnership NHS Foundation Trust c/o Darryl.Thompson@swyt.nhs.uk

Dear Darryl

Re: SWYPFT Draft Quality Account Report 2020/21

Thank you for sending through the South West Yorkshire Partnership NHS

Foundation Trust's (SWYPFT) Quality Account Report 2020/21 for our comments. Please see below the CCG's feedback which I hope you will find useful. Comments on the format or wording of the Report can be found in Appendix A.

General Comments

The CCG welcomes this report which demonstrates South West Yorkshire Partnership NHS Foundation Trust's ongoing commitment to quality improvement and addressing key issues. The Quality Account has been shared with the members of the CCG's Quality and Patient Safety Committee prior to providing you with this feedback. Comments received have been incorporated into this statement.

First we would like to express our appreciation for the way that SWYPFT staff have maintained quality and patient systems during an extremely challenging year for the Trust, due to the demands placed on them during the Covid19 pandemic. It is clear that staff wellbeing has been a key priority for the Trust in 2020/21 and it has pledged to maintain this focus on supporting staff in 2021/22.

The Report provides a detailed account of SWYPFT's activities in 2020/21. Overall, the document provides a fair reflection of the quality of services provided by SWYPFT and clearly demonstrates the Trust's commitment to quality and patient safety.

The contents of the report align with information we have received at the joint

Barnsley Clinical Commissioning Group/ SWYPFT Clinical Quality Board during 2020/21. At these meetings, the Trust has demonstrated that it is committed to being open and transparent in relation to the quality and safety of the care it provides.

The Quality Report is presented in a clear and easy to read format and appears to include all essential elements and covers the formal requirements for quality accounts. To the best of my knowledge, the report is factually correct.

It would be useful for readers if the report included more detail about how SWYPFT works with its membership council in relation to the Trust's quality agenda.

Performance 2020/21

We acknowledge that the Covid pandemic has impacted on your Trust being able to achieve as much progress as it would have liked for its 2020-21 Priorities for Improvement. We commend that you have been able to make progress in the following areas:

- Increased the % of patients not readmitted to the Trust within 28 days of being discharged from a hospital.

- In relation to staffing, the Trust's 2020 NHS Staff Survey results showed significant improvement.

- The establishment of an Equality and Inclusion Sub-Committee to address wider health inequalities and the creation of a BAME Workforce Task Force.

- It was encouraging to see the results of the survey undertaken in response to an action relating to dignity and respect that arose from the CQC inspection in 2019. These demonstrated that service user satisfaction had improved.

We also commend the Trust for continuing to participate in all national confidential enquiries and national clinical audits, which were accepting data. However, it is not clear how the actions listed on page 10 of the report will in improve patient care, rather they appear to relate to improving the clinical audit process.

Whilst the Trust has reduced the level of 'missed doses' or omissions of medication in some of its wards, performance declined in 2020/21 for two Barnsley wards. We recognise that staff shortages due to the Covid pandemic may have hampered efforts to improve performance.

The CCG shares the Trust's concerns about the level of inappropriate out-of-area placements for adult patients who need a PICU bed and discussions have been held in the joint Clinical Quality Board around how the CCG can support the Trust to address this issue.

In relation to quality of data, whilst not mentioned in the report, we expect the Trust to continue its work in relation to improving community services waiting list data so that it provides clear information on waiting times.

Priorities for 2021/2022

As required by the Department of Health, the Accounts set out the Trust's priorities for 2021/22.

The CCG is supportive of the priorities, whilst noting that these have been rolled forward from 2020/21 due the impact of the Covid19 pandemic. We consider that this is a reasonable approach.

We are pleased to see the sustained focus in 2021/22 on reducing restrictive physical interventions after performance fluctuated in 2020/21.

We would have liked the Trust's community services to have featured more strongly in the 2021/22 priorities, as currently they appear to focus more on the Trust's mental health and learning disability services.

We welcome the Trust's inclusion of a priority for patient experience but would like to see carers' experiences also included within the Caring priorities for 2021/22.

The Trust intends to implement its patient experience toolkit and we expect this will be aligned with the Parliamentary Health Service Ombudsman's Model Complaints Handling Toolkit which is currently being piloted.

Overall, we welcome the Trust's 2020/21 Quality Report and look forward to another year of working together to improve the quality of services provided to Barnsley patients.

Yours sincerely

Jayne Sivakumar Chief Nurse

Appendix A

General - could more of the data be shown in graph format instead to make it easy to see changes

Page 3 - A diagram illustrating your quality governance reporting rather than text would aid understanding of the reporting structure

Page 3 – not clear what is meant by the word paramountcy.

Page 10 – *The reports of nine (9) national clinical audits were reviewed by the provider in 2018/19* - is this a typo? Should it read 20

Pages 10 & 11 - repetition of text. Is this necessary?

Page 12 – A link to the CQC report would be helpful to the reader so that they can see in detail the areas you refer to.

Page 20 – Where it states *In 22 cases a death was subjected to both a case record review and an investigation.* It would be helpful to the public to know who undertakes this process and what it involves.

Multiple references to ICS in the document but no definition of ICS in your glossary.

Quality Priorities 2021/22

For some of the quality priority targets, It would be useful for the reader to know what the baselines are that the Trust is starting from so that it can see what level of improvement the Trust is aiming for.

2. **Barnsley Healthwatch**

15th August 2021

Darryl Thompson

Karen Batty

Cc Sarah Harrison

(all by Email)

South West Yorkshire Partnership NHS Foundation Trust

QUALITY REPORT 2020-2021

Thank you for giving us the opportunity to comment on your quality report for 2020 – 2021. There is nothing within this report that is contradicted by any intelligence that we have received.

It is difficult when reviewing a report from an organisation covering more than one Healthwatch area, to objectively comment on issues related to that place, when the data is aggregated at an organisational level.

It is very pleasing to see the improvements the trust has been able to make in the quality it provides to patients, even during the exceptional circumstances of the SAR-CoV-2 pandemic this year. This has understandably resulted in some milestones being extended to this year.

We will be keen to work with the trust in the implementation of the new zero suicide ambition within Barnsley and look forward to that being reflected in next year's report.

We must praise the reduction in waiting times for children and young people accessing your Children and Adolescent Mental Health Services (CAMHS) within the borough during this reporting year.

It is disappointing to see that the performance relating to average medication omissions decreased for the two Barnsley adult inpatient wards and we hope to see an improvement this year. We note the work the trust is undertaking to improve patient safety and hope progress is made with the human factors training, which had to be postponed. We also hope next year's report will include details of how the Trust has implemented any National Patient Safety Alerts that the organisation receives and if it is meeting the required implementation timescales.

Finally, we must note the work the trust is contributing to the new Barnsley Mental Health Partnership as well as the South Yorkshire and Bassetlaw Integrated Care System and expect to see the progress reported in next year's report. Healthwatch Barnsley will continue to support the Trust and look forward to seeing continuing improvement in the quality of the services it provides for the people of Barnsley.

Mark Smith

Vice Chair

Healthwatch Barnsley

3. Barnsley Hospitals Foundation Trust

28 July 2021

Darryl Thompson
Deputy Director of Nursing & Quality
South West Yorkshire Partnership NHS Foundation Trust

BY EMAIL: Darryl.Thompson@swyt.nhs.uk

Dear Darryl

Thank you for offering us the opportunity to review South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) draft Quality Account Report 2020/21.

Despite the challenges faced by healthcare organisations over the past 18 months SWYPFT clearly have remained focussed on their commitment to provide high-quality person-centred care.

SWYPFTs approach of, "quality counts, safety first" is clearly reflected in the progress made on the 2020/21 quality priorities however it is also understood that some progress on achievement was affected by the COVID-19 pandemic resulting in a number of priorities being taken forward into 2021/22.

Barnsley Hospital NHS Foundation Trust (BHNFT) values the relationship it has with SWYPFT and we wish you every success in delivering your framework of quality priorities over the coming 12 months.

Yours sincerely

Jackie Murphy
Director of Nursing & Quality

4. Barnsley Metropolitan District Council - Overview & Scrutiny Committee

BMBC Overview & Scrutiny Committee (OSC)

Comments on SWYPFT Quality Account 2020-21

The Overview & Scrutiny Committee would like to thank the South West Yorkshire Partnership Foundation Trust (SWYPFT) for sharing their Quality Account with us, and to thank all the staff at the Trust for their hard work in delivering vital services to the people of Barnsley, particularly given the challenges the last 12 months have presented.

It is clear from the report that the Covid 19 pandemic has had a significant impact upon the organisation and the committee supports the Trust's decision to extend the 2020-21 quality priorities into the following year and will look forward to an update on these in the next Quality Account, particularly those developed in response to the CQCs judgement around patient safety.

Despite the challenges brought by the pandemic, the report shows that the findings of the staff survey have improved since it was last carried out, and performance of many of the core services has either been sustained or improved. This is a significant achievement for the Trust given the circumstances and should be celebrated.

Wait times for people with learning disabilities in Barnsley have fluctuated throughout the year, presumably as a result of Covid, with some areas of good performance and some under-performance. The committee would expect to see performance stabilise at above target levels for all quarters during 2021-22.

Although steps have been taken to reduce the number of children and young people waiting for help with their emotional wellbeing, without recurrent investment in this work, it is difficult to see how this progress can be sustained. The Overview & Scrutiny Committee are scheduled to look at Children & Young People's Mental Health Services (CYPMHS) in March 2022 and expect that performance will have improved further by then, including the wait for assessment on the Neurodevelopmental pathways.

It is encouraging to see that the Trust has plans to expand the use of systems for capturing patient feedback across Barnsley Community Health and has implemented several initiatives to increase participation in the 'friends and family' test. The committee are also pleased to see that much work has been done to address equality and diversity, both in supporting the workforce and the communities that the Trust serves.

The committee is supportive of the priorities for 2021-22 and the aims that the Trust has identified for the coming year. To support this the OSC expect the Trust to continue to learn from audits, inquiries and reviews, and to use robust and timely data, so that the Trust and partners can continue to measure and improve the quality of its services in Barnsley.

We look forward to continuing to engage with the Trust over the coming year, and to seeing the results of the quality improvement work in the journey to becoming 'outstanding'.

5. Calderdale, Kirklees and Wakefield Clinical Commissioning Group

02.08.2021

Darryl Thompson

Director of Nursing and Quality

South West Yorkshire Partnership NHS Foundation Trust

Fieldhead

Ouchthorpe Lane

Wakefield

WF1 3SP

Dear Darryl

Thank you for providing the opportunity for us to comment on the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Quality Account 2020/21. This response has been collated by NHS Calderdale Clinical Commissioning Group (CCG) as lead commissioner in conjunction with associated commissioners from NHS Kirklees CCG and NHS Wakefield CCG.

The quality account provides a comprehensive and transparent assessment of existing levels of quality and acknowledges areas requiring improvement in the future. The account demonstrates the Trust's commitment and focus on the quality of patient care, safety, experience, responsiveness, and leadership as well as highlighting achievements and successes throughout an incredibly challenging year. It highlights the escalation in pressure due to increased demand for the services, patient acuity and managing workforce capacity, as well as illustrating how the services have adapted in response to the coronavirus pandemic and managed to maintain consistency of services.

The commissioners acknowledge the challenges faced by the Trust throughout this year, those posed by the Covid-19 pandemic, and would like to take this opportunity to thank all staff across the organisation for their continued commitment and diligence. We would also like to re-iterate the statements of SWYPFT's Chief Executive and Chair that it is testimony to the staff and systems that services have been maintained, in some instances transformed and others adapted and risk managed. Living and working in a pandemic has been incredibly difficult, however it is important to note that despite the challenges, some services have substantially improved.

It should also be recognised and commended that despite the pandemic and the demand this has had on all colleagues the SWYPFT staff survey results have improved. The Trust acknowledge that staff who feel supported, encouraged, respected, and valued in their roles will go the extra mile to deliver outstanding care and the quality account explains that SWYPFT understand it is important to continue to build on these outcomes.

The organisations commitment to quality improvement is clear throughout the account and we value and appreciate the openness and transparency of the Trust, further evidenced through invites for the CCG to attend Clinical Governance & Clinical Safety Committee and Serious Incident Panel. Our attendance provides great insight into the safety culture and approach to learning from when things go wrong, including embedding change and improvements.

It is noted that 2021/22 the Trust will be refreshing their Quality Strategy and will be engaging with people who use their services, carers, colleagues, and stakeholders to refresh the quality strategy, quality improvement as part of this and our quality priorities for the forthcoming years. The CCG look forward to being involved with this co-production.

The commissioners are aware of the Trust's enthusiasm for quality improvement and we look forward to learning more about the implementation of a quality assurance and improvement 'self-governing' assessment and accreditation scheme as identified in their well led domain of quality improvement.

We acknowledge that given the significant response required by the pandemic and the impact this has had on progress of quality priorities, the Trust have decided to roll forward the quality priorities from 2020/21 to 2021/22.

It is recognised that the Trust are using the Model for Improvement to address themes identified in the Care Quality Commission (CQC) SWYPFT inspection report (2019). It is good to see the areas for improvement in the safety domain for CQC reflected in the Trust priorities and quality improvement is action planning.

We welcome the introduction of outcome tools to measure clinical effectiveness and improved patient experience and would be keen to know more about how the data will be used to improve services and share learning.

The pandemic has had a substantial impact on all aspects of the healthcare system and on individuals physical and mental health. It has affected all ages and further amplified health inequalities. This has inevitability led to increase demand for mental health services. The commissioners recognise the Trusts commitment to reduce waiting times in services for people with a learning disability and those requiring CAMHS services. We look forward to receiving updates and improvements to waiting times from the initiatives implemented.

It is commendable that the Trust has continued to participate in all national clinical audits and national confidential inquiries as this allows benchmarking and sharing of best practice. The commissioners are encouraged by the actions taken by South West Yorkshire Partnership NHS Trust to further improve data quality. For example the Trust has established a benchmarking group to review benchmarking data and identify areas for opportunity to further increase quality and effectiveness and make comparisons with peers.

The commissioners would have welcomed more information on the findings of the audits and how this has influenced effectiveness of actions, practice and service delivery. We would welcome further detail in this area in future Quality Accounts.

The commissioners recognise the previous work undertaken by the Trust to improve complaint resolution time and the improvements this had made prior to the pandemic. Since the pandemic

response time has increased as frontline duties and care was prioritised. We welcome the Trust introduction of a pilot to improve complaint response times between May 2021 – July 2021 and look forward to receiving feedback from this pilot and other initiatives to improve complaint management process and outcomes.

The commissioners would like to congratulate the Trust on their achievement of becoming accredited for the quality of their care – such as the adult attention deficit hyperactivity disorder (ADHD) and autism service, who received accreditation for community mental health services (ACOMHS) from the Royal College of Psychiatrists, and Kirklees memory service, recognised by Memory Services National Accreditation Programme (MSNAP) recognition.

In conclusion, the commissioners value the Trust's approach to quality and the trio model partnership of clinical, operational and governance within their leadership teams. This quality account contains inspiring examples of partnership working across the sector and quality improvement initiatives to improve patient safety, effectiveness and experience with a focus on the health and well-being of staff. Key areas for improvement have been identified and we look forward to working closely with the Trust to support in the priorities identified and the journey from being Good to Outstanding in the Care Quality Commission (CQC) ratings.

Yours Sincerely

Penny Woodhead.

Penny Woodhead

Chief Quality and Nursing Officer

NHS Calderdale Clinical Commissioning Group

NHS Kirklees Clinical Commissioning Group

6. Mid Yorkshire Hospitals

INVESTORS IN PEOPLE | Accredited Until 2022

NHS
The Mid Yorkshire Hospitals
NHS Trust

Sent via email   Aberford Road

Tim Breedon Wakefield

Director of Nursing and Quality   WF1 4DG

Deputy Chief Executive

South West Yorkshire Partnership NHS david.melia3@nhs.net Foundation Trust   PA: Vicki Jones 01924 543745 tim.breedon@swyt.nhs.uk vicki.jones8@nhs.net

Dear Tim

Re Response to Quality Account

Thank you for sharing the Quality Account with the Mid Yorkshire Hospitals Trust and I note the request for the Trust to review and comment on this document. I am aware that it is not mandated to ask partners to comment on the Quality Account but recognise that it is good practice to share Quality Accounts with our local partners.

Personally, I found this Quality Account to be an interesting read from two perspectives; one being the quality focus of a mental health provider and two, the commonalities that span the quality agendas of across health providers.

 I note that you report that your Quality Strategy is due for review next year and our Trusts is also due at that time too and I wonder whether there are opportunities for us to work together on articulating some joint working on mental health within our strategies . We already have the Inter Trust Partnership Forum and the Mental Health Alliance work but we could supplement and interface this work with some joint improvement work in how we improve the experience of patients with mental illness who access services at both our Trusts.

  One of your quality areas reported on is the missed medication doses and I can see that you have done some considerable work in this and again this could be an area that we could share some learning. We reach out to other acute Trusts all the time to share learning but less so to mental health Trusts and I think this is an opportunity that we could do this more regularly about quality areas which are similar.

 With particular regards to sections in the Account, I applaud the work on the Learning from Deaths section and the work with the North of England Alliance. I recognise that the reporting on this area for mental health services is a considerable challenge in the absence of greater guidance and definitions

The section on equality and involvement and communication section is interesting and very strong and I think the patient experience lead who is new to our Trust could link with your lead person to share some of your creative approaches.

You report that you are starting the Quality Governance approach building in self-governance and accreditation. We have a quality governance framework in place that includes accreditations, audits and heat maps and we have not built in self-governance so this is an area that we learn from each other going forward

Finally, I think this is a very good document, assuring and enlightening to read and I know that you also will have this document in an easy to read version prior to publication so this will meets the needs of the local community

Yours sincerely

David Melia Director of Nursing & Quality/Deputy Chief Executive

7. Wakefield Healthwatch

Healthwatch Wakefield on the Quality Account Report 2020-21 of South West Yorkshire Partnership NHS Foundation Trust.

Once again, Healthwatch Wakefield was pleased to be involved with giving feedback on this latest quality account report. This year the Trust is to be congratulated for the improvements in quality attained during the Coronavirus pandemic. It is understandable and acceptable that completion of many of the quality priorities has been extended until 2021-22.
This year this feedback has been written jointly by myself and Julia Brook, an active volunteer and member of our Quality Accounts Task and Finish Group. She has held senior roles in the NHS.

General Comments
Healthwatch Wakefield has statutory functions which include the obtaining of views of people about their needs and experience of local health and social care services. These views are made known to us by various means including from our excellent Engagement Officer who visits people whose views are seldom heard such as refugees and asylum seekers. Views of services are given to us by phone, letters, emails and using our website.

During the 2020/21 period there were 21 submissions of feedback from people about provision for mental health care, not all concerning the Trust. The Young Healthwatch survey brought up criticism of CAMHS which included the long waiting times which are addressed in the report. There were also negative comments about the quality of care by CAMHS by one or two. There were a couple of negative comments about the Drury Lane Health and Wellbeing Centre.

It is appreciated that people are more likely to make negative comments than positive. There were only two positive comments out of 21. One was about Turning Point and the other, iSpace.
Patient experience with CAMHS was not reported this year and was deferred to 2021/22. Healthwatch suggests that there should be quotations of both positive and negative experiences with CAMHS. Although waiting time reduction should be a top priority, the quality of care should also be reported.
"CAMHS wasn't very helpful when I went to them. They just tried to shove me in a group with people where I wouldn't be able to talk about my problems just listen to stuff I already knew." (Young Healthwatch survey).
One example of the many positive actions within report was the use of digital solutions for non-face-to-face activity during the pandemic.

Quality Priorities
Safe
The number of suicides of people receiving care or treatment by the Trust has not altered in the last three years. Much work, some of which is innovative, has been undertaken to try and address the difficult area of suicide prevention. The evidence-based relationship of reduction in actual suicide levels with prevention of

suicides could be explained. It is difficult to understand how it is known a suicide is prevented. Many laudable approaches have been developed or introduced to try and address the suicide situation.
One challenging performance was in the area of medicine omissions were just under half the wards were graded 'red'.

Effective
When the Care Quality Commission inspected last it was found that the Trust was not meeting the standards of acceptable record keeping and the areas of risk assessment and care planning. The report demonstrates that a lot of work has already been done on this area and a new date to make headway and provide a full report has been moved to March 2022. It is often heard that clinicians and others are not at all familiar with the patient's past history despite having the records in front of them. An excellent level of quality of record keeping is pointless if there is not time/expectation that staff will familiarise themselves with the history. It will be interesting to know of the relationship of complaints with degrees of quality of the record keeping including excellent records.

Like much of the quality improvement work, the patient experience work will continue until March 2022 because of the pandemic, and this includes the review of complaint response times etc. It is possible that the complaint is closed down after an acceptable response time and yet the complainant remains unhappy about how the complaint was handled. We were reassured at the presentation session that this concern would be addressed by surveying complainants after closure. Some complainants could be worn down by the procedure and give up.

Caring
The Trust was involved in a piece of work undertaken by Healthwatch Wakefield in 2017 on compassion in care. This involvement is recognised in the report. The friends and family test resulted in 97% of respondents writing the service they received is either 'very good' or 'good'. This is a fantastic achievement in the middle of a pandemic and everyone concerned is to be congratulated. It is mentioned that free text is a rich source of information. Examples of positive as well as negative contributions would be of interest to readers of this report.
Involving the general public has been admirable. The easy read version of the "choose well for mental health" guide is superb. Perhaps this Quality Account Report should have an easy read version.
Some staff were described by patients as being not respectful or rude and one acting in a racist manner accompanied by verbal abuse. The outcome of investigating these instances is not reported.

Responsive
It is interesting that Wakefield achieves the 90% target for screening learning disability cases within the two-week period. None of the areas consistently achieved the 90% target for treatment to start within 18 weeks. For example, access to CAMHS as mentioned in the introduction to this feedback. However, there is a slow improvement and the rate of this might have been influenced by the pandemic. Healthwatch Wakefield continues to survey young people about mental health provision.
Discussing complaints in protected time is a valuable educational tool that should lead to improvements in care. This is recognised by the Trust. Response times are important but, as discussed at the presentation, it might be of value to undertake a complainant satisfaction survey after a complaint has been closed. Complainants are sometimes worn down by the process and give up remaining dissatisfied.
The high number of bed days for an appropriate out of area placements for adult mental health services is concerning as this affects the patient and their families who will need to travel distances and will also incur higher costs. It is suggested that any actions agreed to address this should be part of the narrative.

Well led
Delivery of high-quality person-centred care is an admirable objective of the leadership and management of the Trust. A report on the appraisal scheme of leaders and managers might be illuminating especially if it is 360° including some staff. The dashboard is impressive.

Conclusion
Who is expected to read this report? Is it written for people living in the Trust's catchment area? Is it written for the government? Is it written for the staff, management and leadership? It is a good thing that there is a glossary and most of the of the acronyms in the report are immediately explained. However, it is a difficult

read for most lay people which might explains why very few of our volunteers who have had the report made any comments.

However, the people we have met who are intimately involved with the creation of this report are to be highly commended and have been only too willing to answer questions on the zoom presentation and by email.

The report illustrates the high quality of healthcare services given to the population of Wakefield District and wider. The philosophy of caring and compassion not only embraces the patients but all those who work for this Trust.

Dr Richard Sloan, Healthwatch Wakefield Trustee and Lead for Quality Accounts Task and Finish Group
Julia Brook, Healthwatch Wakefield Volunteer

Trust Board
Agenda item 11.2

Title:	**Medical Appraisal / Revalidation Annual Board Report 2020-21**
Paper prepared by:	Responsible Officer
Purpose:	The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the NHSE Designated Body Annual Board Report Statement of Compliance (Annex D), as required by NHS England.
Mission/values:	Ensuring that all medical staff are fit to practice and up to date supports the Trust's mission to enable people to reach their potential and live well in the community and demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	Not applicable
Executive summary:	151 doctors had a prescribed connection with the Trust as at 31st March 2021. 68.2% successfully completed the appraisal process during 2020/21, which is a decrease of 20.8%; however this can be explained by the impact of Covid-19. 31.8% 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. 1 revalidation recommendation made between 1st April 2020 and 31st March 2021. 1 doctor had positive recommendation made. - This recommendation was upheld by the General Medical Council (GMC). - Covid-19 significantly impacted on medical appraisal and revalidation, with all activity pausing between 31st March and 30th September 2020. Appraisal restarted in October 2020 and the GMC extended the revalidation cycle of doctors due to revalidate in 20/21 year by 12 months. **Next steps** - A key process for 2021/22 is to review the wellbeing data provide in appraisals, looking at key themes and highlights to ensure that this data can be used in a meaningful way, to help improve doctors' wellbeing. - There is also a requirement for more appraiser trainers to be recruited, to ensure that there is a diverse range of experiences amongst trainers and that the workload remains sustainable.

With **all of us** in mind.

	Expressions of interest requests will be sent to all appraisers, as well as targeted recruitment campaigns of experience appraisers.
	• There will be an evaluation of online feedback, to understand the update and whether this should be continued in future years. As well as an exploration of alternative forms of feedback for different service users' population, to ensure that all service users are able to provide feedback for their clinicians.
	Risk appetite
	Risk identified – the trust continues to have a good governance system of reporting and investigating incidents including serious incidents.
	The following are areas of potential difficulty for the Trust:
	• The voluntary status of the appraisers and their importance to the system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.
	• Covid-19 is expected to have a significant impact on appraisal and revalidation activities for at least the next two years. Due to a marked reduction in face-to-face contact with patients, it is anticipated that some doctors will struggle to collect the minimum number of patient feedback responses; doctors are expected to continue to try, and this will be assessed on an individual basis.
Recommendation:	• **The Board is asked to RECIEVE this report noting that it will be shared with NHSE/I and to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.**
	• **The Board is asked to APPROVE the NHSE Designated Body Annual Board Report Statement of Compliance, attached as Annex D of this report, confirming that the Trust, as a Designated Body, is in compliance with the regulations.**
Private session:	Not applicable.

With **all of us** in mind.

MEDICAL APPRAISAL / REVALIDATION
ANNUAL BOARD REPORT 2020-21

1.   Executive Summary

1.1   151 doctors had a prescribed connection with the Trust as at 31st March
2021.
   - 68.2% successfully completed the appraisal process during 2020/21,
     which is a decrease of 20.8%, however this can be explained by the
     impact of Covid-19.
   - 31.8% 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.

1.2   1 revalidation recommendation was made between 1st April 2020 and 31st
March 2021.
   - 1 doctor had positive recommendations made.
   - This recommendation was upheld by the General Medical Council
     (GMC)

1.3   Covid-19 significantly impacted on medical appraisal and revalidation,
with all activity pausing between 31 March 2020 and 30 September 2020.
Appraisal restarted in October 2020 and the GMC extended the
revalidation cycle of doctors due to revalidate in 20/21 year by 12 months.

2.   Purpose of Paper

This report is presented to the Board:

2.1   For assurance that the statutory functions of the RO role are being
appropriately and adequately discharged.
2.2   To inform of progress in medical appraisal and revalidation during
2020/21.

3.   Background

3.1   2020/21 was the ninth year of medical revalidation. Launched in 2012 to
strengthen the way that doctors are regulated, the aim is to improve the
quality of care provided to patients, improving patient safety and
increasing public trust and confidence in the medical profession. As this
is the ninth year, a number of doctors in the Trust are now in their second
5-year revalidation cycle.

With **all of us** in mind.

3.2 L2P, the e-appraisal web-based system that the Trust utilises is based on NHS England's medical appraisal guide (MAG) model appraisal form.

3.3 Each doctor must have a RO, who must oversee a range of processes including annual appraisal, and who will at five-yearly intervals make a recommendation to the GMC in respect of the doctor's revalidation.

3.4 The RO is appointed by the Board of the organisation, termed a Designated Body, to which the doctor is linked by a Prescribed Connection.

3.5 Provider organisations have a statutory duty to support their RO in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards/executive teams will oversee compliance by:

3.5.1 Monitoring the frequency and quality of medical appraisals in their organisation.

3.5.2 Checking there are effective systems in place for monitoring the conduct and performance of their doctors.

3.5.3 Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.

3.5.4 Ensuring that appropriate pre-employment background checks (including pre-employment for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3.5 Compliance with the Responsible Officer Regulations forms part of the Care Quality Commission inspection.

4. Governance

4.1 Trust's Revalidation Team
- Responsible Officer – Dr Adrian Berry (until November 2020.) and Dr Subha Thiyagesh (from November 2020).
- Associate Medical Director for Revalidation – Dr Mike Ventress
- Business Manager, Medical Directorate –Catherine Lothian
- Medical Directorate Administrator – Charlotte Lyons
- HR Business Partner with responsibility to support Revalidation – Diane Townsend

4.2 Main Tools Utilised Centrally
- L2P (web based) – e-appraisal system
- Datix (Trust system) – provision of incident, complaints and compliments data
- HR Online (Trust system) – provision of sickness data and mandatory training
- GMC Connect (web based) – designated body list

With **all of us** in mind.

4.3 Designated Body List

The Business Manager and Administrator ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed connections is recorded on the GMC Connect portal. As individual doctors are able to add themselves to this list, it is regularly checked to ensure that all the prescribed connections are appropriate. To facilitate this, a regular starters and leavers report is run from the Electronic Staff Record.

4.4 External Oversight

The Trust is subject to the oversight of the NHS England Revalidation Team. During 2020/21, NHS England did not require the usual quarterly reporting, instead encouraging Trusts to focus on their response to the pandemic.

4.5 Internal Oversight

4.5.1 The AMD, Business Manager and Administrator meet fortnightly to oversee the day-to-day running of the appraisal and revalidation processes.

4.5.2 The RO, AMD and Business Manager meet monthly to ensure that there is regular communication with the RO and that any issues are highlighted and acted upon. Where a meeting is not possible, email and telephone conversations take place to ensure matters are dealt with in a timely manner.

4.5.3 The Revalidation Team have Revalidation Review meetings to formally consider those doctors with a revalidation recommendation required within the following 12 months.

4.5.4 The Revalidation Oversight Group has the aims of:
- To advise the Responsible Officer of delivery of appraisal and revalidation processes and overall direction in terms of strategic, policy and performance.
- To advise the Responsible Officer of delivery of the improvements to revalidation based on the recommendations from Sir Keith Pearson's Taking Revalidation Forward [TRF] report.

The group has a volunteer lay member to provide independent scrutiny and service user input.

4.6 Independent Verification

4.6.1 Independent verification is required to be undertaken every 5 years. In November 2017 a Revalidation Peer to Peer Review was undertaken with Leeds and York Partnerships NHS Foundation Trust and the resulting report shared with NHS England.

With **all of us** in mind.

5.   Medical Appraisal

5.1 Covid-19 and Medical Appraisal and Revalidation

5.1.1 In March 2020 the GMC announced, in conjunction with NHS England that all medical appraisal and revalidation activity was to cease for six months, to enable doctors to focus on Covid-19. For all doctors who were due to be appraised between April 2020 and September 2020, appraisal was be postponed by 12 months, therefore appraisal numbers are not as high as previous years, due to having only 6 months of data.

5.1.2 For doctors who were due to revalidate from April 2020 until March 2021, this was postponed for 12 months.

5.1   Appraisal and Revalidation Data

	Consultant		SAS* & Trust Grade		Fixed Term	
Number of doctors as at 31st March 2021 who have a prescribed connection to the Trust	90		48		13	
Number of completed appraisals during 2020/21:	59 appraisals	65.5%	35 appraisals	72.9%	13 fixed term doctors completed 9 appraisals	69%
Number of missed/ incomplete appraisals during 2020/21(see reasons in appendix 1):	31	34.5%	13	27.1%	4	31%
Number of doctors in remediation:	0	0%	0	0%	0	0%
Number of doctors in disciplinary processes	1	1.11%	0	0%	0	0%

y and * Specialty Doctors and Associate Specialist doctors

5.2 Appraisers as at 31st March 2021

5.2.1 Number of appraisers – 32 (24 consultants, 8 SAS doctors)

5.2.2 Support activities undertaken:

- A half day refresher training session was provided on 09.9.20. for 10appraisers.
- New appraiser sessions were facilitated on 15.07.20,12.08.20,11.11.20,11.02.21 and 25.03.21
  - Training sessions are facilitated by experienced Trust appraisers, currently Dr Mike Ventress and Dr Khaled Mostafa.
- Appraiser forums were held on 08.07.20 and 08.12.20. The forums continue to provide an opportunity for appraisers to share ideas about good practice and discuss areas of concern/difficulty.
- Continuous improvement of the appraisal process in the Trust is also an important topic for discussion in the forums, and areas of good practice and reasons for appraisals being referred back for further work are highlighted by the AMD.
- There was a Trust-wide presentation by the AMD to all doctors on 30 September 2020 about changes to medical appraisal in light of the pandemic.

5.3 Quality Assurance Processes

5.3.1 There is a portfolio minimum data set required for appraisal and the appraisers are required to check that this is uploaded or an adequate reason provided for non-inclusion.

5.3.2 The Trust utilises the multisource feedback tool embedded within L2P. This automatically flags with the doctors when they are required to undertake the colleague and patient feedback (required to be undertaken every 3 years, unless new to the Trust then required within first year). The reports are only released to the doctor if they have gained the minimum number of responses (and undertaken their self-assessments) or a request for release to the Revalidation Team is agreed.

5.3.3 The Revalidation Team inform the doctor if they are required to change their appraiser for their next appraisal (change is required after three consecutive appraisals with same appraiser).

5.3.4 The AMD reviews all submitted appraisals (excluding those where he was the appraiser). Checks are made on appraisal inputs (appraisal portfolio), appraisal outputs (Personal Development Plan (PDP), appraisal summary and sign-off) and where appropriate, the AMD will request further work be undertaken prior to him recommending to the RO that annual appraisal is satisfactory. Those appraisals where the AMD was appraiser are similarly reviewed by the RO.

With **all of us** in mind.

5.3.5 The RO subsequently reviews completed appraisals on receiving the AMD's recommendation and either concurs or requests further clarification.

5.3.6 Each doctor is asked to provide feedback about the system and appraiser after their appraisal has been submitted (see section 5.6). This process is embedded in the L2P system. This feedback is combined with other objective measures and observations of the AMD who provides feedback in writing to appraisers on an annual basis. If any issues arise in the course of the year, the AMD will liaise with individual appraisers.

5.3.7 The reviews undertaken by the AMD and RO also often raise agenda items for the Appraiser Forums, where, for example, inconsistencies are identified.

5.3.8 The appraisers receive further group feedback during Appraiser Forum meetings.

5.3.9 Such issues are also discussed at the refresher training, which appraisers are required to attend every 2 years.

5.4 Access, security and confidentiality

5.4.1 The e-appraisal system (L2P) is required to be used by all doctors. No breaches to the system or individual portfolios were recorded during 2020/21.

5.4.2 Access to individual appraisals on L2P is restricted by login to the doctor, their appraiser, RO, Medical Director (MD), AMD and the Revalidation Team and any other person to whom the doctor provides access (via their own login).

5.4.3 Doctors are made aware via the L2P system that no patient identifiable information should be included in their appraisals. This is also stated in the Trust 's Medical Appraisal Policy.

5.5 Clinical Governance

5.5.1 All doctors are provided with a PDF formatted record (including a nil response if appropriate) of incidents, complaints and sickness for their appraisal year from the Revalidation Team. This data is directly uploaded to the doctor's appraisal record on L2P. Doctors are required to reflect on their involvement in incidents and complaints included in the reports and any others of which they are aware but which may not have been linked to them via Datix.

5.5.2 The minimum requirement for the appraisal portfolio is provided in a Portfolio Minimum Data Set, which is reviewed every year.

5.5.3 Doctors are required to complete a checklist prior to submitting their appraisal to their appraiser and where key information (predominately the minimum data set) is missing, they are required to provide a reason for its absence.

5.6 Appraisal feedback

Of the 88 feedback questionnaires completed by doctors after their appraisal, the following is a selection of the feedback given:

Was your appraisal useful for:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Your personal development	49% (51%)	42% (41%)	7% (8%)	2% (0%)	0% (0%)
Your professional development	56% (59%)	39% (39%)	2% (2%)	3% (0%)	0% (0%)
Your preparation for revalidation	56% (64%)	41% (33%)	2% (2%)	1% (0%)	0% (0%)
Promoting quality improvements in your work	45% (54%)	48% (40%)	5% (5%)	2% (1%)	0% (0%)
Improving patient care	49% (55%)	42% (36%)	7% (9%)	2% (0%)	0% (0%)

Number of hours	<1	1-2	2-3	3-4	>4
Duration of appraisal discussion	3% (4%)	67% (56%)	15% (30%)	8% (5%)	7% (5%)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The appraisal was satisfactory	69% (76%)	30% (23%)	1% (0%)	0% (1%)	0% (0%)
I was able to collect all the necessary supporting information from the organisation	57% (63%)	36% (33%)	6% (2%)	0% (2%)	1% (0%)

*() are the 2019/20 results.

100% of the doctors either agreed or strongly agreed that they would be happy to have the same appraiser again.

With **all of us** in mind.

5.6.1 After each appraisal, appraisees provide feedback on their appraiser, which forms part of the annual review the AMD undertakes of appraisers. There is a process which highlights if any appraisers have negative feedback and the AMD will discuss this with the appraiser, to provide any support or training as required.

6. Revalidation Recommendations (1.4.20 to 31.3.21)

Number of recommendations	1
Recommendations completed on time	1
Positive recommendations	1
Deferral requests	0
Non engagement notifications	0

6.1 The Revalidation Review Group meet monthly and consider those revalidation recommendations due to be made in the following 12 months. This allows time for any further requirements to be actioned to enable a positive revalidation recommendation to be made.

6.2 As an outcome of this process, 100% of recommendations due in 2020/21 were submitted on time.

6.3 All positive recommendations were approved by the GMC and the doctors subsequently revalidated.

6.4 No recommendations were made late (within GMC category of late 7 days and under).

See Appendix 3; Audit of revalidation recommendations

7. Recruitment and engagement background checks

7.1 Substantive and Fixed Term appointments
During 2020/21, 11 substantive doctors were employed and 18 doctors were employed on temporary contracts.

7.1.1 During the application and interview process, doctors are assessed to ensure they have the qualifications and experience in order to fulfil the duties of the post.

7.1.2 For consultants, all interviewees are required to complete a 16PF (16 personality factors) questionnaire and the resulting assessment report is considered by the Advisory Appointment Committee.

7.1.3 For consultants, an assessment centre is held if more than 1 candidate for the role is to be interviewed.

With **all of us** in mind.

7.1.4 Where appropriate, Medical HR checks the national database for Approved Clinician and Section 12 status. GMC registration is also checked.

7.1.5 Reference checks from the previous 3 years of employment are undertaken by Medical HR and the Appointing Officer confirms that they are satisfied with the references. The references will be checked for the correct dates and that the person giving them is the relevant person to provide.

7.1.6 Medical HR would normally meet with the doctor to verify their ID using the acceptable documents list. However due to the pandemic, they have requested that copies are sent and the original documents are checked, copied, signed and scanned by the clinical lead on the doctors first day.

7.1.7 The Medical Directorate requests information from the doctor's current/last RO, where the doctor has had one. This includes information about 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 RO, prior to a 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.

7.1.8 The MD checks and approves the final offer letter prior to sending.

7.1.9 If a doctor is recruited with GMC conditions, further information from the GMC is requested.

* if requests for RO information have not been responded to after 4 weeks, the Trust's RO will contact the GMC Employment Liaison Advisor to flag but recruitment will continue to ensure posts are filled as soon as possible.

7.2 Agency Locum appointments

7.2.1 Agency locum doctors do not have a prescribed connection to the Trust. Their connection is with their locum agency. It is the agency's responsibility to ensure their doctors are appraised and revalidated. However, the Trust's processes to engage locums do include appraisal and revalidation checks.

7.2.2 The Trust has a neutral vender, PlusUs that is also a direct engagement portal.

7.2.3 The Medical Clinical Lead/Medical Manager usually leads on the securing of locum doctors for their areas.

7.2.4 PlusUs provides suitable CVs and references through an online portal.

7.2.5 If a locum doctor's appraisal is over 24 months overdue, then it is recommended the doctor is not engaged.

7.2.6 If a booking is taken forward, a checklist is sent via email confirming the doctor has a DBS, Occupational Health clearance, Right To Work etc.

7.2.7 In line with the Trust guidance on booking locum doctors, the internal lead is then required to undertake a telephone interview prior to commencement.

7.2.8 In line with Trust guidance on booking locum doctors, on their first day a locum doctor's identification should be verified through the checking of their passport or photo-card driving licence by the medical clinical lead or nominated person.

8. Monitoring Performance

8.1 Doctors are generally monitored through their team management structures.

8.2 In addition, a doctor's performance is monitored via the appraisal system, which includes a requirement for feedback from service users and 360° feedback from colleagues on a three-yearly basis.

8.3 Information in relation to whether a doctor is involved in serious incidents or subject to complaints is also included in the appraisal system.

8.4 Serious incidents are investigated using the Trust investigation procedures, carried out by trained investigators.

8.5 In the event that any concerns are raised, these are referred to the MD who can instigate various levels of investigation and take to the Responding to Concerns Advisory Group as appropriate.

9. Responding to Concerns and Remediation

9.1. The Trust has a Responding to Concerns and Remediation Policy which was approved in June 2018.

9.2. As at 31.3.21 the Trust had 2 trained Case Managers and 3 trained Case Investigators, all of whom are medical consultants.

9.3. A Responding to Concerns Advisory Group meets monthly wherever possible/required. It is chaired by the RO and is also attended by the Medical Director, Director of Human Resources, Organisational Development and Estates, the AMD for Revalidation, Director of Nursing and Quality and Medical Directorate Business Manager. Relevant general management representatives may attend as and when required. This approach ensures a consistent and open approach is taken across the Trust in the investigation of concerns in relation to doctors. The group's terms of reference are included in the Responding to Concerns and Remediation Policy.

With **all of us** in mind.

9.4. Remediation, when identified, is carried out on an individual basis, being tailored to the individual's needs.

10. Risk and Issues

The following are areas of potential difficulty for the Trust:

10.1 The voluntary status of the appraisers and their importance to our system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.
Mitigating factors:

- Appraisers have time allocated in their job plans for the role.
- The workload of appraisers is regularly reviewed in the Appraiser Forum and the Revalidation Oversight Group.
- Ensuring the Trust has sufficient appraisers to enable the maximum number of 7 appraisals for each appraiser per year to be maintained.

10.2 Covid-19 is expected to have a significant impact on appraisal and revalidation activities for at least the next two years. Due to a marked reduction in face to face contact with patients, it is anticipated that some doctors will struggle to collect the minimum number of patient feedback responses; doctors are expected to continue to try and this will be assessed on an individual basis.

11. Actions, Improvements and Next Steps

An action plan for medical appraisal/revalidation is regularly reviewed and updated by the AMD and Business Manager and periodically reviewed with the RO.

11.1 Improvements Implemented 2020-2

11.1.1 Ensuring the quality of appraiser training is maintained with the introduction of new trainers, the AMD has been leading on training in 2020/21 and has recruited an appraiser trainer. In the 2021/22 year it is expected that there will be more appraisers trained as trainers.

11.1.2 The process for patient feedback was reviewed in light of GMC consultation/updated guidance, leading to online feedback being launched in 2021/22.

11.1.3 The appraisal process has been continually reviewed in light of Covid-19 and the implications this has had. Nationally, this has led to an increased focus on wellbeing, with doctors being asked to rate their wellbeing and this being a particular focus of the appraisal meeting. Appraisers have signposted doctors to appropriate

services, when required. An audit is being undertaken of the wellbeing section of appraisals, so that this can be fed into the appraiser forum.

11.2 Next Steps (2021-22 Actions)

11.2.1 A key process for 21/22 is to review the wellbeing data provided in appraisals, looking at key themes and highlights to ensure that this data can be used in a meaningful way, to help improve doctors' wellbeing.

11.2.2 There is also a requirement for more appraiser trainers to be recruited, to ensure that there is a diverse range of experiences amongst trainers and that the workload remains sustainable. Expressions of interest requests will be sent to all appraisers, as well as targeted recruitment campaigns of experienced appraisers.

11.2.3 There will be an evaluation of online feedback, to understand the uptake and whether this should be continued in future years. As well as an exploration of alternative forms of feedback for different services user populations, to ensure that all services users are able to provide feedback for their clinicians.

12. Recommendations

12.1 The Board is asked to receive this report, noting that it will be shared with NHSEI.

12.2 The Board is further asked to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.

With **all of us** in mind.

APPENDIX 1
AUDIT OF MISSED / INCOMPLETE APPRAISALS DURING 2020/21

DOCTOR FACTORS	CONSULTANT	SAS/TRUST GRADE
Maternity Leave during the majority of the appraisal period	0	0
Sickness Absence during the majority of the appraisal period	0	0
Prolonged Leave during the majority of the appraisal period	0	0
Suspension during the majority of the appraisal period	0	0
New starter	0	0
Postponed due to incomplete portfolio / insufficient supporting information	0	0
Lack of time of doctor	0	0
Lack of engagement of doctor	0	0
Other doctor factor (describe)	0	0
APPRAISER FACTORS	**NUMBER**	
Unplanned absence of appraiser	0	0
Lack of time of appraiser	0	0
Other appraiser factor (describe)	0	0
ORGANISATION FACTORS	**NUMBER**	
Administration or management factors	0	0
Failure of electronic information systems	0	0
Insufficient numbers of trained appraisers	0	0
Other organisational factors (describe) – suspension of appraisal due to Covid-19	31	15

With all of us in mind.

APPENDIX 2
QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS

TOTAL NUMBER OF APPRAISALS COMPLETED – 103		
	NUMBER OF APPRAISAL PORTFOLIOS AUDITED (1.4.20-31.3.21)	**NUMBER OF APPRAISAL PORTFOLIOS DEEMED TO BE ACCEPTABLE AGAINST THE STANDARDS**
APPRAISAL INPUTS		
Scope of work	103	103
Is continuing professional development compliant with GMC requirements?	103	103
Is quality improvement activity compliant with GMC requirements?	103	103
Has a patient feedback exercise been completed?	103	103
Has a colleague feedback exercise been completed?	103	103
Have all complaints been included and appropriately reflected on?	103	103
Have all significant events been included and appropriately reflected on?	103	103
Is there sufficient supporting information from all the doctor's roles and places of work?	103	103
Is the portfolio sufficiently complete for the stage of the revalidation cycle?	103	103
Other reason	103	103
APPRAISAL OUTPUTS		
Appraisal summary	103	103
Appraiser statement	103	103
PDP	103	103

All deficits were either addressed satisfactorily after the appraisal had been referred back.

With **all of us** in mind.

APPENDIX 3
AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2020 to 31 March 2021)

Recommendations completed on time (within GMC recommendation window)	1
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	1
PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe)	0
TOTAL (sum of late and missed)	0

APPENDIX 4
AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTICE

CONCERNS	HIGH LEVEL	MEDIUM LEVEL	LOW LEVEL	TOTAL
NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTICE IN THE LAST 12 MONTHS				
Capability concerns (as primary category)	0	0	0	0
Conduct concerns (as primary category)	0	1	0	1
Health concerns (as primary category)	0	0	0	0
REMEDIATION/RESKILLING/RETRAINING/REHABILITATION				
Number of doctors who have undergone formal remediation				0
Consultants (permanent, employed staff)				0
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				0
Temporary or short term contract holders				0
OTHER ACTIONS / INTERVENTIONS				
LOCAL ACTIONS				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.20 and 31.3.21)				1
Number of doctors who have had local restrictions placed on their practice in the last 12 months				1
GMC ACTIONS				
Number of doctors referred to the GMC between 1.4.20 and 31.3.22				0
Number of doctors who underwent or undergoing GMC Fitness to Practice procedures between 1.4.20 and 31.3.21				0
Number of doctors who had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1.4.20 and 31.3.21				0
Number of doctors who had their registration / licence suspended by the GMC between 1.4.20 and 31.3.21				0
Number of doctors who were erased from the GMC register between 1.4.20 and 31.3.21				0
NHS Resolution ACTIONS				
Number of doctors about whom NHS Resolution has been contacted between 1.4.20 and 31.3.21				1
Reason for contacts:				
For advice				1
For investigation				0
For assessment				0
Number of NCAS investigations performed				0
Number of NCAS assessments performed				0

Where 5 or more doctors have concerns about their practice in the year, a breakdown of appropriate protected characteristics will be provided

With **all of us** in mind.

NHSE Designated Body Annual Board Report

Section 1 – General:

The board of South West Yorkshire Partnership NHS FT can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

   > Date of AOA submission:
   >
   > Action from last year: N/A
   >
   > Comments: Nil
   >
   > Action for next year: N/A

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   > Action from last year: N/A
   >
   > Comments: Dr Subha Thiyagesh is appointed as RO
   >
   > Action for next year: N/A

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   > Yes
   >
   > Action from last year: N/A
   >
   > Comments: There is a continuing expectation that there will be further development demands on the revalidation process which will place increasing demands on resources. If it transpires that additional resources are required, the RO will present this to the appropriate forum in the Trust.
   >
   > Action for next year: Monitor demand on current resources

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   > Action from last year: N/A
   >
   > Comments: The Revalidation Team ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed connections is recorded on the GMC

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Connect portal. As individual doctors are able to add themselves to this list, it is regularly checked to ensure that all the prescribed connections are appropriate. To facilitate this, a regular starters and leavers report is run from Electronic Staff Record.

Action for next year: N/A

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A

Comments: Medical Appraisal Policy approved May 2021 and Responding to Concerns & Remediation Policy approved Jun 18. These policies will be routinely reviewed in 2024 unless local or national changes need addressing earlier.

Action for next year: N/A

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: N/A

Comments: In November 2017 a Revalidation Peer to Peer Review was undertaken with Leeds and York Partnerships NHS Foundation Trust and the resulting report shared with NHSE.

Action for next year: A peer review is due to take place in 2022.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A

Comments: All doctors working in the Trust, work under the Trust's governance processes.

The Trust's processes to engage agency locums includes appraisal and revalidation checks.

Doctors on short-term contracts within the Trust undertake appraisal within the Trust's processes and have access to study leave as per substantive doctors.

Action for next year: N/A

With **all of us** in mind.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

   Action from last year: N/A

   Comments: All doctors are provided with a PDF formatted record (including a nil response if appropriate) of their Incidents, Complaints and Sickness for their appraisal year from the Revalidation Team. This data is directly uploaded to the doctor's electronic appraisal record. Those doctors who also undertake work outside of the Trust are required to provide supporting information from their other places of work.

   Action for next year: N/A

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

   Action from last year: N/A

   Comments: Where this supporting information is missing, this is picked up in the review process (all appraisals are reviewed by the AMD for revalidation and the RO) and the doctor would be asked to provide the information or explain the reason for its absence.

   Action for next year: N/A

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

   Action from last year: N/A

   Comments: Approved by Executive Management Team, May 2021.

   Action for next year: N/A

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

   Action from last year: Undertake appraiser recruitment process

   Comments: In anticipation of some appraisers retiring, a recruitment round was undertaken to ensure the Trust has the appropriate number of appraisers to undertake a maximum of 7 appraisals per year each. The figures are regularly monitored.

With all of us in mind.

> Action for next year: Further appraiser recruitment to be undertaken.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

> Action from last year: N/A
>
> Comments: Appraiser forums are held 3 times a year. All appraisers have to undergo refresher training every 2 years. The AMD for revalidation provides individual annual feedback to each appraiser.
>
> Action for next year: N/A

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

> Action from last year: N/A
>
> Comments: A comprehensive annual appraisal/revalidation report is submitted to Board. The report details the QA processes in place. There is also a revalidation oversight group, with lay representation, to monitor performance and quality.
>
> Action for next year: N/A

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

> Action from last year: N/A
>
> Comments: A process is in place within the Revalidation Team to ensure timely recommendations are made. No late recommendations were made in 2020/21.
>
> Action for next year: N/A

---

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

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2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

> Action from last year: N/A
>
> Comments: The RO confirms with the doctor if a deferral is to be recommended, providing the reasons for this decision – in most cases discussions will have already been taking place with the doctor around a possible deferral. The same would occur if a non-engagement recommendation was required.
>
> Action for next year: N/A

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

> Action from last year: N/A
>
> Comments: Clinical governance for doctors is overseen by the Trust's Clinical Governance and Safety Committee. Its remit is to provide assurance to Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation through receipt of exception reports from relevant Directors to demonstrate that they have discharged their accountability for parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical education, safeguarding children, research and development, compliance, and health and safety.
>
> Action for next year: N/A

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> Action from last year: N/A
>
> Comments: The medical directorate collate information from reporting systems for complaints and significant incidents relating to doctors. This together with sickness data is uploaded to the doctor's appraisal document. Other relevant information, such as involvement with Coroners inquests, is also noted on the document.   Doctors are also

With **all of us** in mind.

required to upload their mandatory training matrix to their appraisal document. Job planning is now completed on the same electronic system to allow easier sharing of information across the two processes. Colleague and patient feedback occurs at least every 3 years and is automatically uploaded to the appraisal form. Triangulation of all above data and review of content of appraisal occurs before sign off by the RO.

Action for next year: N/A

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: N/A

Comments: The Trust has a Responding to Concerns and Remediation Policy.A Responding to Concerns Advisory Group meets monthly wherever possible/required. It is chaired by the RO/Medical Director, Director of Human Resources, Organisational Development and Estates, the AMD for Revalidation, Director of Nursing and Quality and Medical Directorate Business Manager. Relevant general management representatives attend as and when required. This approach ensures there is a consistent and open approach taken across the Trust in the investigation of concerns in relation to doctors. The group's terms of reference are included in the Responding to Concerns and Remediation policy.

Action for next year: N/A

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.   Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: N/A

Comments: There was one formal concern received in 20/21. There is a pathway to receive concerns which includes the Medical Director and RO. The Responding to Concerns Advisory Group ensures there is consistency in the investigations and management of concerns across the Trust. The annual appraisal/revalidation report is submitted to Board and includes a table detailing numbers, types and outcomes of concerns

Action for next year: N/A

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[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

With all of us in mind.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: N/A

Comments: A new form has been developed for the transfer of information and this would be used where concerns needed to be transferred.

Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: N/A

Comments: Equality Impact Assessment was undertaken in developing the Responding to Concerns & Remediation Policy. The Responding to Concerns Group monitors all processes relating to concerns about doctors' practice however the low numbers involved precludes meaningful analysis

Action for next year: N/A

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N/A

Comments: Medical staffing undertake pre-employment checks for all employed doctors in line with Trust agreed procedures. CVs and references are required for agency locum staff, together with a telephone interview.

Action for next year: N/A

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[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

With all of us in mind.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions; N/A**
- **Actions still outstanding: N/A**
- **Current Issues**
- **New Actions:**
  - **Monitor resource demand on resources**
  - **Undertake appraiser recruitment**

Overall conclusion: This has been a very positive year both in terms of performance of the appraisal and revalidation system and the incremental development of the process. Appraisee feedback continues to remain positive and as does the Associate Medical Directors feedback to appraisers. Anticipated changes to the guidance for patient feedback may play a significant role in future improvements to the appraisal process and personal development of the medical workforce.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of South West Yorkshire Partnership NHS FT has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chair(or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _   Signed: _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

With **all of us** in mind.

![NHS logo]

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

    a) help the designated body in its pursuit of quality improvement,

    b) provide the necessary assurance to the higher-level responsible officer, and

    c) act as evidence for CQC inspections.

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[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of South West Yorkshire Partnership NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   > Action from last year: N/A
   >
   > Comments: Dr Subha Thiyagesh is appointed as responsible officer and is suitably trained to undertake this role.
   >
   > Action for next year: N/A

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   > Yes
   >
   > Action from last year: N/A
   >
   > Comments: The Responsible Officer is supported by an Associate Medical Director for revalidation and dedicated administrative support to ensure that she can fulfil the responsibilities.
   >
   > Action for next year: N/A

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   > Action from last year: N/A
   >
   > Comments: The list of medical practitioners is checked on a weekly basis to ensure it is reflective of the medical staff working within the organisation. There is a robust process in place to remover medical staff on the day that they leave and to connect them on the day that they join.
   >
   > Action for next year: N/A

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

> Action from last year: N/A
>
> Comments: All policies are reviewed 3 yearly, or sooner if there is a significant change. The covid-19 pandemic has meant that some policies have been extended beyond the 3-year period, however the risks have been highlighted and agreed with the trusts executive management team.
>
> Action for next year: N/A

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

> Actions from last year: N/A
>
> Comments: The trust has undertaken a peer review process previously in 2019.
>
> Action for next year: The trust is expecting a peer review to take place in 2022 but is awaiting details from NHS England.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

> Action from last year: N/A
>
> Comments: All doctors with a prescribed connection to the trust, regardless of contract length are supported with appraisal and revalidation matters, including an induction appraisal with the AMD for revalidation, as well as having access to the trusts electronic appraisal and revalidation system. They are also allocated a study leave budget pro rata to contract length and expected to attend local and trust wide teaching and governance events.
>
> Action for next year: To review the GMC fair to refer document and implement any changes as required.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model,

there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

> Action from last year: Adopting appraisal 2020 model.
>
> Comments: The new appraisal model, that focused on wellbeing has been adopted and reviewed as positive. Quality has remained within appraisal, as the highly trained appraiser have been documenting and encouraging reflection across the doctors' whole scope of practice, regardless of documentation provided.
>
> Action for next year: To consider if the trust wishes to keep the appraisal 2020 model.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

> Action from last year:
> Comments:
> Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

> Action from last year: To review the medical appraisal policy.
> Comments: The medical appraisal policy has been reviewed and approved by the Executive management team until 2024.
> Action for next year: N/A

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

> Action from last year: To continue to recruit and train medical appraisers.
>
> Comments: The trust currently has 31 trained medical appraisers and continually recruits appraisers; this provides sufficient capacity for all medical practitioners to have an appraisal with a trained appraiser of their choosing.
>
> Action for next year: Recruit and retain appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

> Action from last year: N/A
>
> Comments: There is a rigorous training process in place for appraisers to ensure a standardised approach, as well as refresher training every 2 years. There is an appraiser forum 3 times a year and appraisers are invited to contribute and provide representation to wider appraisal and revalidation forums.
>
> Action for next year: N/A

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

> Action from last year: N/A
>
> Comments: The appraisal system is quality assured by board, by way of the annual board report.
>
> Action for next year: N/A

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	151
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	107
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	48
Total number of agreed exceptions	48

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

    Action from last year: N/A

    Comments: The GMC were informed of 1 potential fitness to practice issue and advice was sought from the GMC ELA.

    Action for next year: N/A

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

    Action from last year: N/A

    Comments: 1 revalidation recommendation was made to the GMC.

    Action for next year: N/A

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

    Action from last year: N/A

    Comments: The organisation has a clear and robust clinical governance system which enables information to flow from front line to the Board. Systems are in place to share regular reports such as on training, complaints and concerns to the Clinical Governance and Clinical Safety Committee and the Trust Board for oversight. The Trust has a Guardian of Safe Working champion who also presents to the Board annually and via quarterly governance reports. There is a system in place for routine collection and recording of doctors' clinical governance data as part of appraisal minimum dataset (complaints, concerns, compliments, Datix and serious incident reports) for reflection and learning. The Trust supports a values-based and learning approach for all its staff.

    Action for next year: N/A

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> Action from last year: N/A
>
> Comments: All doctors are provided with complaints and incident reports for them to reflect on as part of their appraisal. Appropriate policies are in place to monitor conduct and performance, such as Job Planning Policy and Responding to Concerns Policy.
>
> Action for next year: N/A

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> Action from last year: N/A
>
> Comments: The trust has a Responding to Concerns meeting, which includes the responsible officer/medical director, Director of HR, OD & estates, Director of Nursing and Quality, the AMD for Revalidation, and the Business Manager to the medical directorate. The group meet monthly to review all complaints and concerns that name a medic, whether received formally or informally and to ensure appropriate action is undertake. The trust also has a policy for addressing concerns about medical staff.
>
> Action for next year: N/A

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

> Action from last year: N/A
>
> Comments: Quality assurance is provided in the annual board report. The trust is reviewing the GMC fair to refer document to ensure processes meet the required standards.
>
> Action for next year: Review and implement GMC fair to refer document.

---

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

> Action from last year: N/A
>
> Comments: Information is transferred quickly and appropriately via appropriate channels.
>
> Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

> Action from last year: N/A
>
> Comments:
>
> -Up to date disciplinary policy in place
>
> -All staff in the Trust are required to undertake mandatory equality and diversity training
>
> -Responding to Concerns Advisory Group with Board level director and HR representation
>
> -RO meets with ELA regularly to review cases
>
> -Ensure fairness and no COIs in case management. MHPS cases are only undertaken by a fully trained investigator and someone who is independent of the service in which the doctor works
>
> -Currently reviewing extent to which Trust operates in accordance with GMC Fair to Refer report, with contribution from equality team. Revalidation team took part in regional workshop in 2021 on bias and fairness of referral to GMC.
>
> Action for next year: N/A

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[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

> Action from last year: N/A
>
> Comments: All doctors, whether substantively employed or employed via a locum agency have pre-employment checks that comply with the NHS Employers standards. All doctors, including locums are subject to an interview to ensure they are suitably skilled and knowledgeable to undertake their role.
>
> Action for next year: N/A

Section 6 – Summary of comments, and overall conclusion

> **Please use the Comments Box to detail the following:**
>
> - **General review of actions since last Board report**
>
>   **There were no outstanding actions since the last board report.**
> - **Actions still outstanding**
> - **Current Issues**
>
>   **A key issue is to understand the impact on the pandemic on appraisal and revalidation and ensure that doctors are supported and remain fit to practice.**
> - **New Actions:**
>
> **Overall conclusion:**

Section 7 – Statement of Compliance:

The Board of South West Yorkshire Partnership NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _   Signed: _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Trust Board
28 September 2021
Agenda item 11.3

Title:	SWYPFT Patient Experience – Annual Report 2020/21
Paper prepared by:	Director of Nursing, Quality and Professions
Purpose:	To provide a summary of feedback on experience of using Trust services received via the Customer Services function during 2020/21.
Mission/values:	A positive service user experience underpins the Trust's mission and values. Ensuring people have access and opportunity to feedback their views and experiences of care is essential to delivering the Trust's values and is part of how we ensure people have a say in public services.
Any background papers/ previously considered by:	Previous reports, formerly known as Customer Service reports, have been presented to Quality Board.
Executive summary:	**Complaints process**

Extensive development work on the complaints pathway has been undertaken in 2020/21 to improve both the complaints pathway, process and data quality. We are adopting a continuous quality improvement approach to our complaints process to ensure we have a contemporary service that is fit for purpose and can respond efficiently & effectively to issues people raise.

There were 159 formal complaints in the year, 295 compliments and 426 comments and concerns were raised. Access to treatment and drugs was identified as the most frequently raised negative issue. This was followed by communications, values and behaviours, clinical treatment and appointments. Most complaints contained a number of themes.

Key areas to note:

- For the financial year 2020/21 the customer services team received and dealt with 719 items of feedback in the form of complaints, concerns, comments (excluding compliments). This is a 38% reduction compared to 2019/20 when the Trust received 1165 items of feedback
- Complaints typically contain a number of different themes and issues and anecdotally complaints have become more complex in nature with complainant's expectations about what can be achieved through the complaints process increased.
- Reopened complaints have remained largely stable at 12 in 2019/20 and 13 in 2020/21.
- 426 comments/concerns were received in 2020/21 which is a decrease of 36% from 2019/20 where 667 comments/concerns were received.
- 295 compliments were received in 2020/21 which is a decrease of 11% compared to 332 in 2019/20. The number of compliments does fluctuate and depends on how regularly clinical services send these in for customer services to record. The Trust promotes the importance of submitting compliments so that they can be monitored, used to boost staff morale and to share best practice

With **all of us** in mind.

	• Customer Services monitors the progression of formal complaints against the Trust's internal target of providing a response within **40 working days** from the date that consent has been provided and the scope of the complaint investigation agreed. This is considerably quicker than the guidance set out in the NHS Complaints (England) Regulations 2009 which details that a response should be provided within 6 months from the date that a complaint is received. This information, from the complaints process is shared with BDUs for review. Responding to feedback and ensuring changes in practice is monitored through BDU governance processes. Development work for focus in 2021: • Learning lessons from complaints • Review of complex complaints • Review of process to manage persistent complainants • Review of process for reopened complaints • Continue work on response times • Update of complaint policy • Review of reports to meet commissioner requirements. This report was reviewed in depth at a Clinical Governance & Clinical Safety Committee assurance day on 31 August. Verbal feedback from this was provided when the report was submitted to the Clinical Governance & Clinical Safety Committee on 14th September, as below: • The committee noted that the values and behaviours of staff was the third most common reason for complaints and it was recommended that this is considered by the Workforce and Remuneration Committee • The equality data collected relates to the complainant rather than the service user. Requested that this is considered further to capture the ethnicity data of the person most affected by the complaint. • The equality data requires further analysis around protected characteristics to understand the percentage of complaints in the context of the total service user population. • The Committee asked for benchmarking in future reports such as complaint per service to give more meaningful data • The Committee also acknowledged the aim to resolve complaints early and informally and sought further assurance around training and support for staff to be able to do this.
Recommendation	**Trust Board is asked to NOTE the comments of the Clinical Governance and Clinical Safety Committee and APPROVE the report.**

Patient Experience (including complaints) Annual Report 2020/21

With **all of us** in mind.

Summary

Annual update

- For the financial year 2020/21 the customer services team received and dealt with 719 items of feedback in the form of complaints, concerns, comments (excluding compliments). This is a 38% reduction compared to 2019/20 when the Trust received 1165 items of feedback.
- The customer services team dealt with 159 formal complaints in 2020/21 compared to 166 in 2019/20.
- Complaints typically contain several different trends and issues and anecdotally complaints have become more complex in nature with complainant's expectations about what can be achieved through the complaints process increased.
- Reopened complaints have remained largely stable at 12 in 2019/20 and 13 in 2020/21.
- 426 comments/concerns were received in 2020/21 which is a decrease of 36% from 2019/20 where 667 comments/concerns were received.
- 295 compliments were received in 2020/21 which is a significant decrease of 11% compared to 332 in 2019/20. The number of compliments does fluctuate and depends on how regularly clinical services send these in for customer services to record. The Trust promotes the importance of submitting compliments so that they can be monitored, used to boost staff morale and to share best practice.
- Customer services monitor the progression of formal complaints against the Trust's internal target of providing a response within **40 working days** from the date that consent has been provided and the scope of the complaint investigation agreed. This is considerably quicker than the guidance set out in the NHS Complaints (England) Regulations 2009 which details that a response should be provided within 6 months from the date that a complaint is received.
- We are now trialling a response timeframe based on the increasing nature of complexity of the complaint which would aim to provide a response within **25, 40 or 60 working days** bearing in mind that this is still far quicker than the statutory guidance.
- Proactive partnership working between customer services and clinical services was having a positive impact on achieving the Trust's internal target that 80% of formal complaints should be closed within 40 working days. However, the impact of the Covid-19 pandemic has meant that the gains we had achieved have declined.

Summary
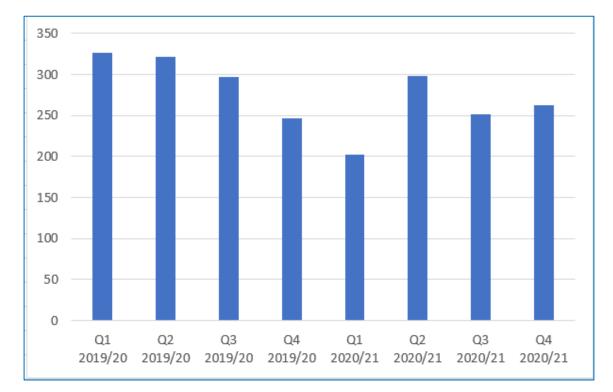
- All complaints are risk assessed on arrival in customer services using the Trust's Risk Matrix. In the first instance, this is undertaken by the customer services manager or their deputy. In addition, complex complaints are discussed with both the associate director of nursing and quality and the assistant director of legal services.

- Work is continuing to improve customer service processes to make sure that the Trust always responds in ways to maximise opportunities for learning and becomes more responsive where service issues arise. This will mean services will see the issues first, with a robust process in place to support them to create actions to resolve.

Risks

- Complaints are often complex and longstanding in nature and require thorough investigation to resolve the issues raised. Complainants' expectations of what can be achieved through the complaints process may be unachievable.

- Resources allocated to habitual or vexatious complainants has increased and requires a consistent and coordinated approach across the Trust. The Trust placed one complainant on restricted access in 2020/21 following a prolonged period of excessive contact.

- The biggest delays in the complaint process are the time for the completed investigation to be returned to customer services. This is being scrutinised further to generate further discussions with clinical services about the specific challenges they face in responding to complaints i.e., resource, and how these can be overcome to improve the Trust's response timeframes. This has become more challenging due to the impact of the pandemic and there have been considerable delays experienced from clinical services during sign off.

Feedback overview

Total number of complaints, concerns, comments & compliments received into the Trust via customer services
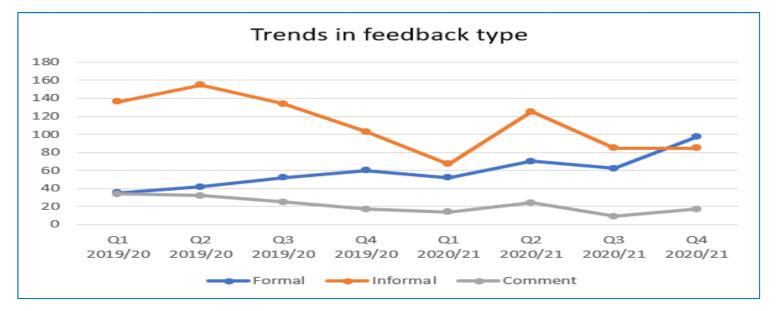
Overall the pattern supports that there has been a decline in the volume of feedback across all categories including compliments since Q1 2019/20. However, the anecdotal trend remains in that the complexity of complaints, concerns and comments are increasing. We have also seen an increase in challenging behaviour from complainants since the pandemic began.

Complaints activity

Number of formal complaints, informal concerns and comments made into customer services per quarter

Trends in feedback type
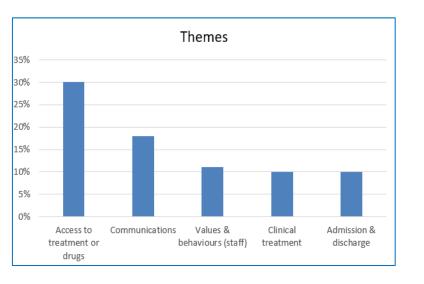
- Overall, the number of formal complaints are increasing from 35 in Q1 2019/20 to 97 in Q4 2020/21 with an average of 59 per quarter. Again, the increased figure for Q4 2020/21 may reflect pent up frustration with mental health services as a result of the pandemic given the changes in service delivery.
- There is a less consistent pattern for informal concerns and this has decreased from a record high of 155 in Q2 2019/20 to 85 in Q4 2020/21 with an average of 111 per quarter.
- There has been a significant reduction in service issues/comments from 34 in Q1 2019/20 to 17 in Q4 2020/21 with an average of 22 per quarter.
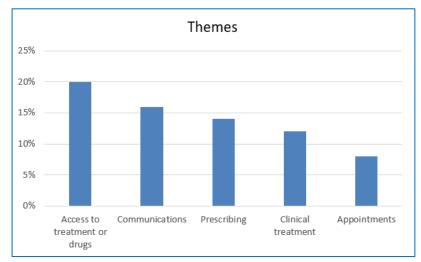
Regulation: Parliamentary and Health Service Ombudsman (PHSO)

- During the previous reporting year, 2019/20 the Trust received 9 requests for information from the PHSO. All requests were responded to, and information shared with the PHSO to enable them to review and decide whether to investigate complaints at the second and final stage of the NHS complaints process.

- The Trust received 5 requests for information from the PHSO in 2020/21
  - The Trust received notification that 3 cases had closed with no further action or recommendations.
  - The Trust is still waiting for the outcome of the PHSO's scrutiny on 2 cases. 1 of these is a very complex and contentious complaint as the complainant's wife died in July 2020 whilst on the Melton Suite in Barnsley. The complainant has recently advised that he no longer wishes to engage with the Trust and is now pursuing legal action.

- As a result of the pandemic the PHSO has advised that it has a backlog of 3,000 cases awaiting review and will only investigate those where there has been the biggest hardship.

Top 5 themes for complaints

2020/21

2019/20
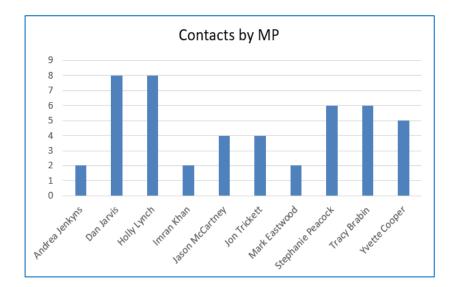
- Complaints typically contain multiple themes/issues
- The top 2 primary subjects for complaints has remained consistent across both years, including by rank order
- Access to treatment is the most common theme for complaints about CAMHS
- It is concerning that Values & behaviours (staff) is the third most common reason for complaints in 2020/21.

MP Contacts
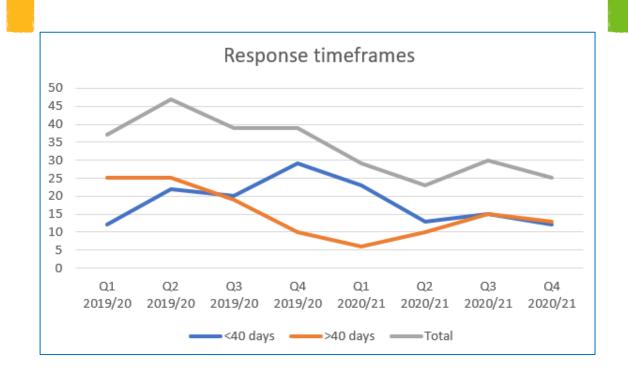
- During 2020/21 the customer services team received 47 MP contacts compared to 55 MP contacts in 2019/20 which is a 15% decrease.

- Dan Jarvis (Barnsley) and Holly Lynch (Calderdale) made the majority of MP contacts in 2020/21.

- Overall the BDU which receives the most MP contacts is CAMHS Specialist Services with 38% and this is primarily about access to treatment.

- CAMHS Kirklees received the highest number of MP contacts at 39% followed by Barnsley at 33%, Wakefield at 17% and Calderdale at 11%.

- Wakefield Community Mental Health Services and Barnsley Community Mental Health Services received the second and third most MP contacts at 19% and 17%.

Contacts by MP

MP contacts by BDU

- ADHD and Autism Service
- Barnsley Community Mental Health Services
- Calderdale Community Mental Health Services
- CAMHS Specialist Services
- Kirklees Community Mental Health Services
- Wakefield Community Mental Health Services

Complaints Key Performance Indicators (KPIs)

The Trust's KPI is to close 80% of formal complaints within 40 working days

Response timeframes

Throughout 2019/20 the Trust was consistently improving on delivering complaint responses within 40 working days from the date that the timescales started (consent received and scope agreed). Unfortunately, many of the gains we made have diminished as a result of the pandemic and we are now trialling a target response timeframe based on the complexity of the concerns. This may help to better manage complainant's expectations as the NHS Complaints Regulations 2009 stipulate that a response should be provided within 6 months from the date it was received and this hasn't been amended as a result of the pandemic. The PHSO is guided by this and simply asks that organisations keep complainants updated about when they expect to respond.

Reopened complaints

During 2020/21 we reopened 13 formal complaints.

Once the individual has received the Trust's response to a complaint any new or outstanding issues this generates should be raised within a reasonable time – a guideline the PHSO use is twelve months from receipt of the response, though it very much depends on individual circumstances. As a Trust we ask complainants to come back to us with any outstanding concerns within one month. In such cases, the complaint file is reopened, and further investigation will take place to ensure that the Trust has addressed all of the issues raised and a further response is sent to the individual with the findings. In some cases, a second opinion or clinical advice will be sought. The Trust will endeavour to resolve reopened complaints through Local Resolution, however, once it is considered by the Trust that this is completed/exhausted the individual is advised of their right to refer their case to the PHSO for independent scrutiny.

Analysis of reopened complaints is complex. The reported figures are those that were reopened within a particular time frame, regardless of when the complaint was initially responded to. Complainants coming back to tell us they are not satisfied with their response is a positive indicator they have not lost faith in our organisation's ability to resolve their concerns as they have actively chosen to come back to us rather than approach the Parliamentary and Health Service Ombudsman (PHSO) directly.

In line with the NHS Complaints (England) Regulations 2009, issues that the Trust has already responded to and is unable to provide any further meaningful comments will not be reopened or re-investigated.

We are currently developing a reporting function on DATIX to better capture the reason why complaints are reopened. This will enable us to monitor any themes and trends and work with services to minimise the need to reopen complaints.

Response times for informal concerns

Informal concerns closed against 2 day target

Resolution of informal concerns against target

■ <2 days   ■ >2 days

The Trust's complaints process supports Local Resolution in the first instance and contact with the service provider to resolve concerns directly at source.

This revised approach means we are dealing with significantly more informal concerns – 363 informal concerns were dealt with in 2020/21. Of these, 42% were closed within 2 working days.

74 informal concerns (20%) exceeded the 2 working days target and had a date where services confirmed it had been resolved; the average number of working days to resolve for these was 13 and the range was between 3 and 64 days.

The figures on the chart are the percentage (%) compliance rates, for responses to informal concerns, within 48 hours (2 working days). However, we didn't receive further information from clinical services for 37% of informal concerns (n=136) to confirm that the feedback had been resolved so the figure of 58% exceeding the target may not be accurate.

The customer services team works closely with clinical services to ensure that informal concerns are responded to by services within 2 working days. However, with agreement from the complainant, this statutory timeframe can be extended.

Improvements in sign off process

- Customer services worked hard in 2019 to clear the backlog of outstanding complaint responses. The service has weekly team meetings hosted by the Customer Services Office Manager (CSOM) where active complaints are tracked and responses that are at 30 and 40 working days are monitored to ensure that these are being managed proactively and flagged as required.
- Sign off process has been streamlined and the internal clock for the 40 working day target now starts when signed consent from the service user has been received **AND** the scope of what will be investigated has been agreed with the complainant. Previously there were issues outside of the Trust's control when consent was received but there were difficulties agreeing the scope with the complainant to allow the investigation to proceed which negatively impacted on response times.
- Since 2018 responses are reviewed by the CSOM for quality at the start of the sign off process and prior to final progression to the Deputy Chief Executive. Quality improvement work on the complaint process has resulted in there being very few amends received in the latter stages of the sign off process which demonstrates that the quality of complaint responses has improved.
- Customer services have completed several reviews working alongside Business Delivery Units. As part of these reviews, it was identified that we needed to understand and identify what challenges the operational teams face when they are asked to respond to a concern or complaint within the established timeframes set out in the complaint regulations i.e. 48 hours for a concern and in the current complaint pathway 15 working days are allocated to operational services to investigate a formal complaint (time from when toolkit is sent to General Manager to the date toolkit is retuned to CS team). Questionnaires were sent out to the services and the information returned was reviewed and recommendations implemented.

Risks
- The current most common delays in responding to complaints are related to the investigation process as customer services are reliant on the findings from clinical services to draft a response. There have been recent issues, particularly from CAMHS, with the quality of toolkits received which has significantly delayed the Trust's ability to respond on target.

Equality Data – April 2020 – March 2021

Equality data is a key indicator of who accesses the formal complaints process. **It is about the person raising the complaint, i.e. the complainant, and they are not necessarily the person receiving the service, i.e. the service user**. Where possible, data is captured at the time a formal complaint is made. However, if this is not captured or available at that time this may be collected at a later date when the equality data form is received. Information is shared with the complainant explaining why collection of this data is important to the Trust to measure equality of access to the complaints process.

The questionnaire includes the 9 protected characteristics; age, disability, gender reassignment, ethnicity, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. We also ask whether the complainant is a carer and if they are registered with their GP as one. This is in keeping with the types of services we offer and the Trust includes this additional characteristic which is given the same importance as the other 9 protected characteristics.
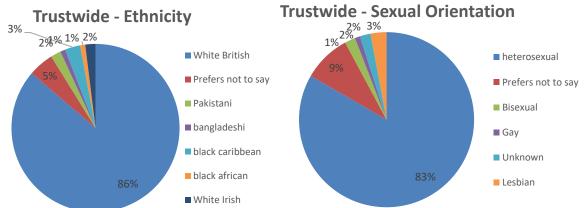
We offer assurance that providing equality data has no impact on care and treatment or on the progression of a complaint.
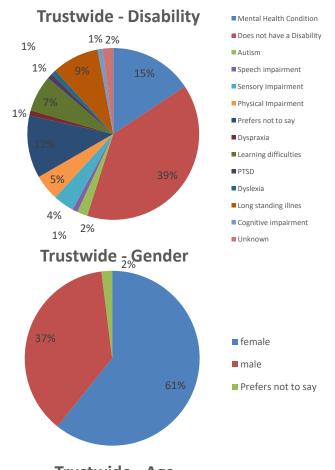
Data is **not** collected for third party agents which includes MPs and advocates.
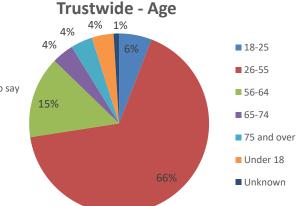
The Team continues to explore best practice for equality data capture, both internally within the team and externally with partner organisations and networks and incorporates any learning into routine processes.

The pie charts shows, where information was provided, the breakdown in respect of ethnicity, gender, disability, age and sexual orientation. Equality data is collated Trust wide.

The Trust's Equality and Diversity Managers are made aware of all complaints/feedback where a concern has been raised that someone considered that they were treated less favorably because they belonged to a group with a protected characteristic. This provides assurance that any trends and patterns of harassment are identified and addressed as appropriate.

Trustwide - Disability

Legend:
- Mental Health Condition
- Does not have a Disability
- Autism
- Speech impairment
- Sensory Impairment
- Physical Impairment
- Prefers not to say
- Dyspraxia
- Learning difficulties
- PTSD
- Dyslexia
- Long standing illnes
- Cognitive impairment
- Unknown

Values: 15%, 39%, 2%, 1%, 4%, 5%, 1%, 1%, 12%, 1%, 7%, 1%, 9%, 1%, 2%

Trustwide - Gender

- female — 61%
- male — 37%
- Prefers not to say — 2%

Trustwide - Ethnicity

- White British — 86%
- Prefers not to say — 5%
- Pakistani — 2%
- bangladeshi — 1%
- black caribbean — 1%
- black african — 2%
- White Irish — 3%

Trustwide - Sexual Orientation

- heterosexual — 83%
- Prefers not to say — 9%
- Bisexual — 2%
- Gay — 1%
- Unknown — 2%
- Lesbian — 3%

Trustwide - Age

- 18-25 — 6%
- 26-55 — 66%
- 56-64 — 15%
- 65-74 — 4%
- 75 and over — 4%
- Under 18 — 4%
- Unknown — 1%

Themes raised through formal complaints

April 2020- March 2021

Trustwide themes and improving from feedback

- **Customer services received 109 new formal complaints (timescales started) during 2020/21. The table below reflects the Primary Subject/Issue/Theme for these complaints. However, complaints typically involve multiple Subjects/Issues/Themes.**
- **The top 3 themes for complaints during this period were: Access to treatment or drugs (36%); Communications (23%) Values and Behaviours (15%)**
- **There are no specific hot spots related to a specific team or service line.**

Trustwide

Theme	Count
Values and Behaviours (staff)	13
Trust Admin/ Policies/ Procedures inc. SU records	5
Restraint	2
Prescribing	4
Patient Care	8
Integrated Care	1
Communications	20
Clinical Treatment	11
Appointments	5
Admission and Discharge	9
Access to treatment or drugs	31

Barnsley General Community Services
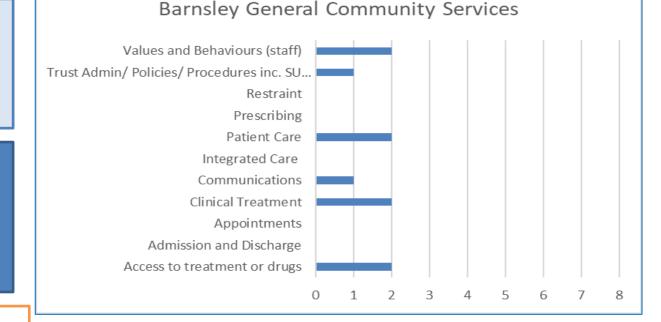
Top three themes:

1. Values and Behaviours

2. Access to treatment or drugs

3. Clinical Treatment

During 2020/21 Barnsley General Community Services received 7 complaints and 60 compliments

- **Compliment examples:**
- District Angels - a small thank you.
- Thank you for the exceptional job you do.
- To the best team of people, you have supported us through some tough and dark times. It has been tough for us all, but you have stood by us and helped us through with magnificent levels of care and support...special place and so are the staff.
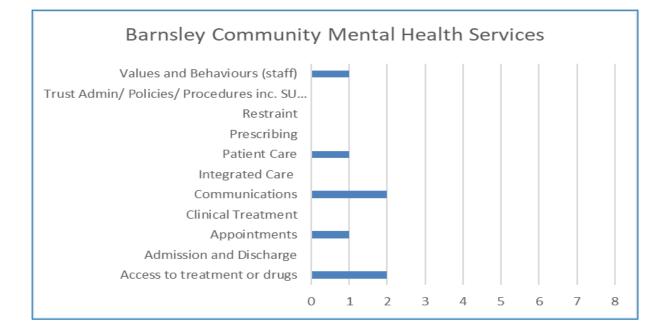
Complaint examples:
SU concerned that practitioner was not motivational or empathetic.

Practitioner concerned with the way in which services are operating and the attitude of staff, for example being disparaging in a racial manner.

Son wishes to make a formal complaint on behalf of his mother. He has received a letter stating that the eye services his mother has are being withdrawn within the next 6 weeks. Carers currently come twice a day to administer eye drops. Patient is unable to do this as she has arthritis in both hands and without the service, she will go blind.

Barnsley Community Mental Health Services

Barnsley Community Mental Health Services

Bar chart categories (top to bottom):
- Values and Behaviours (staff): 1
- Trust Admin/ Policies/ Procedures inc. SU...
- Restraint
- Prescribing
- Patient Care: 1
- Integrated Care
- Communications: 2
- Clinical Treatment
- Appointments: 1
- Admission and Discharge
- Access to treatment or drugs: 2

X-axis: 0 1 2 3 4 5 6 7 8

Top three themes:
1. Access to treatment or drugs
2. Communications
3. Values and Behaviours

During 2020/21 Barnsley Community Mental Health services received 7 formal complaints and 10 compliments

Complaint examples:
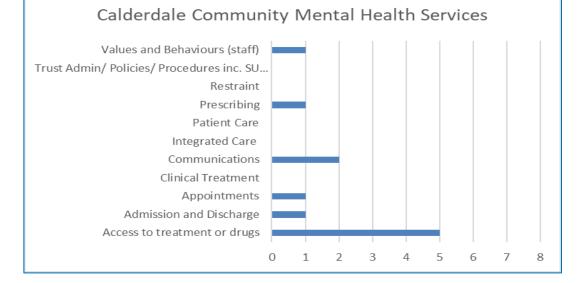
- **SU concerned about the way in which his care has been managed and by a letter he has received regarding his behaviour.**

- **Complaint regarding poor attitude**

- **Unhappy with the lack of contact, communication and care provided**

Compliment example:
I have just had my last CBT session with X and I just wanted to say that she is fantastic. She has made a huge difference to my quality of life. She is a definite asset to SWYPFT and I feel very lucky to have had her assigned to myself and I would just like to formally acknowledge how helpful, understanding and lovely she had been throughout.

Calderdale Community Mental Health Services

During 2020/21 Calderdale Community Mental Health services received 9 complaints and 7 compliments

Top three themes:
1 Access to treatment or drugs
2 Communications
3 Prescribing

Complaint examples:

1. **Unable to access mental health services despite several suicide attempts.**
2. **SU frustrated that he is being denied access to services when he clearly has MH needs.**
3. **Complainant unhappy with her own care and treatment/ follow up plans.**

Calderdale Community Mental Health Services

- Values and Behaviours (staff)
- Trust Admin/ Policies/ Procedures inc. SU...
- Restraint
- Prescribing
- Patient Care
- Integrated Care
- Communications
- Clinical Treatment
- Appointments
- Admission and Discharge
- Access to treatment or drugs

"Thank you so much for all the care and support that you have shown me and my family since you became my CPN. I really appreciate all the extra travelling you had to do whilst I was in Barnsley and all the visits to my home. It has been so reassuring for all of us having you to support us and help when necessary. Thank you for all the referrals! Everyone helped with my recovery. You really are a very caring and special person, and the Trust is very lucky to have you as part of the team. I hope I can keep moving forward and put to good use all your input."

Kirklees Community Mental Health Services
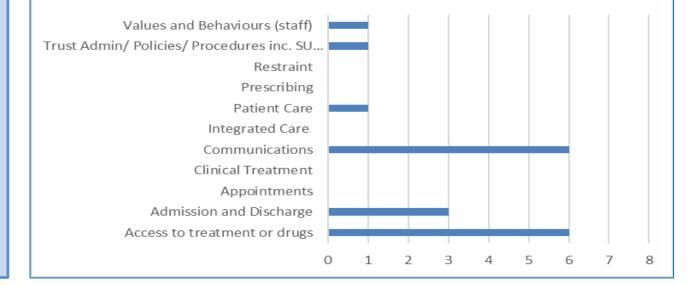
Top three themes:
1. Access to treatment or drugs
2. Communications
3. Admission and Discharge

Complaint examples:
1. Service user feels he is sinking after originally being told he can have counselling sessions, then services not wanting to help.
2. Service user going in circles trying to get psychological assistance with his PTSD and other issues
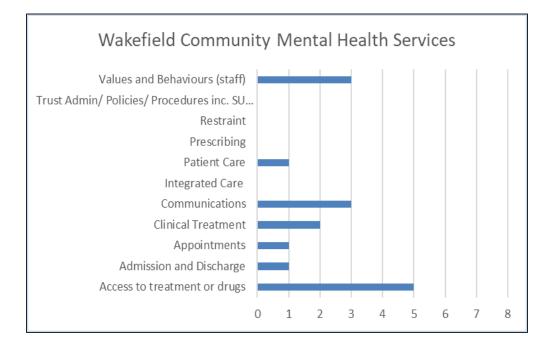
"Thank you so much for everything you have done for me - you are a star."

During 2020/21 Kirklees Community Mental Health Services received 17 complaints and 26 compliments

Kirklees Community Mental Health Services

Wakefield Community Mental Health Services

Wakefield Community Mental Health Services

- Values and Behaviours (staff)
- Trust Admin/ Policies/ Procedures inc. SU...
- Restraint
- Prescribing
- Patient Care
- Integrated Care
- Communications
- Clinical Treatment
- Appointments
- Admission and Discharge
- Access to treatment or drugs

During 2020/21 Wakefield Community Mental Health Services received 9 complaints and 17 compliments

Top three complaint themes:
1. Access to treatment or drugs
2. Communications
3. Values and Behaviours (staff)

"The time and techniques you taught me during our time together has massively improved my quality of life."

Complaint examples:
1. SU concerned about the way in which his care has been managed and by a letter he has received regarding his behaviour.
2. Complaint regarding care and treatment and process for detaining someone under the MHA.
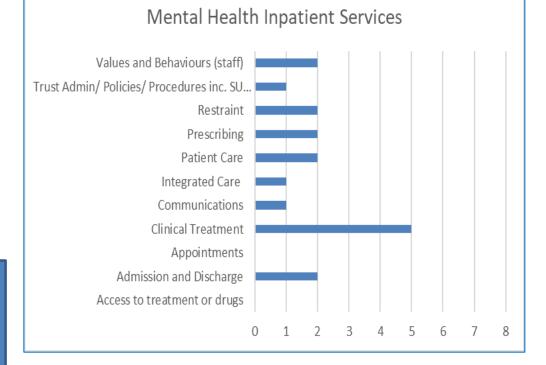
Mental Health Inpatient Services

During 2020/21 Mental Health Inpatient Services received 13 complaints and 47 compliments

Top three complaint themes:
1. Clinical Treatment
2. Values and Behaviours
3. Prescribing

Complaint examples:

- Issue regarding being detained under the Mental Health Act and alleging this is against her human rights.
- Issue regarding non assessment whilst on Section 136 Suite – alleges staff were rude and dismissive.
- Dispute over diagnosis given.
- Staff were rude and aggressive.

Mental Health Inpatient Services

Category	Value
Values and Behaviours (staff)	2
Trust Admin/ Policies/ Procedures inc. SU...	1
Restraint	2
Prescribing	2
Patient Care	2
Integrated Care	1
Communications	1
Clinical Treatment	5
Appointments	0
Admission and Discharge	2
Access to treatment or drugs	0
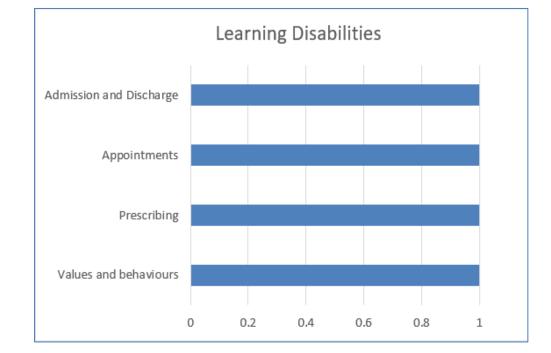
"Thank you to all the staff for doing an amazing job. I cannot praise the staff enough. They have looked after my granddad really well and the staff are really kind."

Learning Disability Services

Complaint example: SU's brother upset by the assessment process that led to his brother being sectioned and feels this could have been avoided.

"I cannot recommend the Horizon Centre more and I send my heartfelt thanks to them all."

During 2020/21 Learning Disability services received 4 complaints and 43 compliments
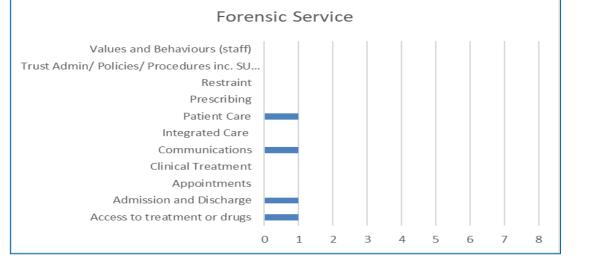
Top three complaint themes:
1. Values and Behaviours
2. Admission and Discharge
3. Prescribing

Learning Disabilities

Category	Value
Admission and Discharge	1
Appointments	1
Prescribing	1
Values and behaviours	1

(x-axis: 0, 0.2, 0.4, 0.6, 0.8, 1)

Forensic Services

During 2020/21 Forensic Services received 4 complaints and 12 compliments

Top three complaint themes:
1. Access to treatment or drugs
2. Communications
3. Patient Care

Forensic Service

	0	1	2	3	4	5	6	7	8
Values and Behaviours (staff)									
Trust Admin/ Policies/ Procedures inc. SU...									
Restraint									
Prescribing									
Patient Care									
Integrated Care									
Communications									
Clinical Treatment									
Appointments									
Admission and Discharge									
Access to treatment or drugs									
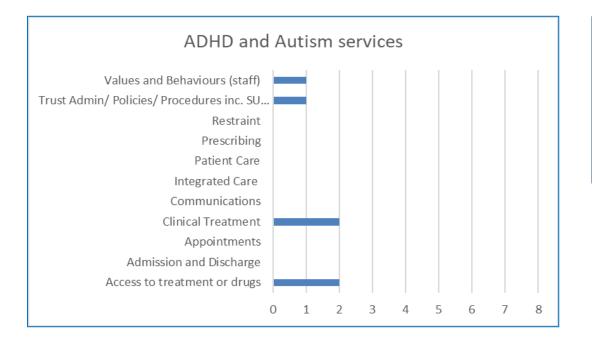
Complaint examples:
Letter from advocate raising concerns on behalf of mum in relation to the suitability of the secure accommodation her son was initially placed in.

Email received from mother refuting decision to discharge son before service have met and worked with him.

Compliment from SU explaining that the staff member had shown a great level of compassion and respect. He felt very comfortable and at ease all evening in their presence and they spent time speaking with them about their concerns. They made him feel relaxed and at ease during this anxious time.

ADHD and Autism Services

ADHD and Autism services

Category	Count
Values and Behaviours (staff)	1
Trust Admin/ Policies/ Procedures inc. SU...	1
Restraint	0
Prescribing	0
Patient Care	0
Integrated Care	0
Communications	0
Clinical Treatment	2
Appointments	0
Admission and Discharge	0
Access to treatment or drugs	2

(Axis: 0 1 2 3 4 5 6 7 8)

During 2020/21 the ADHD and Autism Service received 3 complaints and 3 compliments

"I can't thank you enough for everything you have done and continue to do for me. I would recommend this service to anyone as it's been my lifeline."
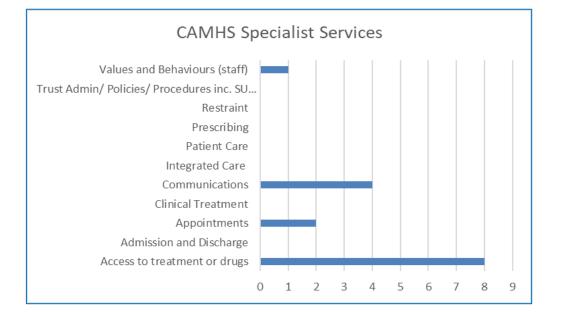
"Very pleased with the care and support given by the member of staff assigned to them. Punctual, professional, and always finds the best solution to any problems."

Top three complaint themes:
1. Access to treatment or drugs
2. Trust Admin/ Policies/ Procedures inc. SU records
3. Clinical Treatment

Complaint examples:
- SU concerned about the assessment process she had. Does not agree with outcome of assessment.
- Believes service has cause an information governance breach.

CAMHS Specialist Services

Top three complaint themes:
1. Access to treatment or drugs
2. Communications
3. Appointments

Complaint examples:

1. Range of issues regarding child's care planning, expertise of team and lack of progress.
2. Concerned that a planned assessment is for the wrong potential diagnosis and the arrangements for the appointment don't make sense.
3. SU's parents upset by the inability to access services.
4. Raising concerns regarding lack of support for daughter when in crisis and concerns raised regarding alleged misconduct of staff.

During 2020/21 CAMHS received 14 complaints and 29 compliments

"Thank you for the time you have put in, I have seen big changes."
"Very grateful for the support."

CAMHS Specialist Services

- Values and Behaviours (staff)
- Trust Admin/ Policies/ Procedures inc. SU...
- Restraint
- Prescribing
- Patient Care
- Integrated Care
- Communications
- Clinical Treatment
- Appointments
- Admission and Discharge
- Access to treatment or drugs

0 1 2 3 4 5 6 7 8 9

Incorporating themes into improvement

Making improvements from feedback:

- Customer services work closely with lead investigators to ensure that any learning from feedback is identified

- Monthly reporting is provided to all Deputy Directors, General Managers and identified key persons from each BDU to assist in monitoring key performance indicators and identifying any themes/trends/hot spots.

- Customer service manager attends clinical governance meetings and clinical risk panel

Next steps:

- Development of a formal system for the triangulation of information with other Trust services such as incidents, QIAT, Freedom to Speak Up, Safeguarding, Legal and Information Governance to identify key themes which will be reported into clinical governance group and used to identify risk and hot spots and to improve policy, practice and service development.

Trust Board 28 September 2021
Agenda item 12 – Assurance from Trust Board Committees

Clinical Governance & Clinical Safety Committee

Date	14 September 2021
Presented by	Nat McMillan Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	**Alert:** • Risk 905 and 1922 were reviewed and committee will continue to monitor. • Ongoing acuity demand across services and pressure on the workforce. • 18 week waiting for CAMHS (Calderdale/Kirklees and Wakefield) • Tier 4 bed base continues to raise concerns around inappropriate stays for children • Risk strategy - a discussion around the ongoing review and acknowledged it will be picked up at board. • Fire training compliance was raised as a significant concern through to EMT. • L & D services have issues with Medical staff cover and high rates of sickness **Advise:** • QM Visits starting - dates to NEDs shortly. • Holding a session outside of formal committee on CQC improvement Plan • SI Q1 report was received. **Assurance:** • Patient Experience Annual report received, and committee comments provided on the cover sheet for board approval. • QMV - increased assurance sought around self-governing approach • Recommend Annex D (NHSE Designated Body Annual Board Report Statement of Compliance - Medical Revalidation) • Business Continuity plan approved • EPRR standards - action plan approved (assurance gained on one partial compliant and one non-compliant and continue to be monitored at committee)
Approved Minutes of previous meeting/s for receiving	Minutes of the meetings on 8 June 2021.

Finance, Investment & Performance Committee

Date	23 August and 22 September 2021
Presented by	Chris Jones, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	A verbal update will be giving at the meeting.

With **all of us** in mind.

Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting on 28 June 2021, 26 July 2021

Mental Health Act Committee

Date	17 August 2021
Presented by	Kate Quail Non-Executive Director (Chair)
Key items to raise at Trust Board	**Advise:** • **Mental Health Act (MHA) reform** - No implementation timescale yet. • **Liberty Protection Safeguards (LPS) -** Still not received the DRAFT Code for the LPS although they are due to be implemented next year. • **Assurance** that whilst MHA reform and LPS are likely to generate a significant amount of work for the Trust and partner organisations, the Trust is well sighted and prepared at this point. • **Independent public inquiry into the government's handling of the coronavirus pandemic** - due to start April 2022 - noted this is likely to put further pressure on the Trust's legal team and others involved in the MHA reforms and LPS implementation. • **Advanced care planning** is now a registered Quality Improvement project. **Assure:** • **Use of the MHA in the Perinatal Mental Health service** - Good practice including strong support for acute/ secondary care. Challenges identified – need for more peer support workers, more trauma informed care and a more diverse staff group reflecting local communities. • **Received compliance reports for** Advocacy and Section 132 (patient rights). Noted further significant improvement - also noted by CQC. • **Assurance from the MHA Code of Practice Group** that we are compliant with MHA Code of Practice. • **MHA CQC actions** - Noted the positive approach of Matrons, Practice Governance Coaches/Quality Governance Coaches who will not sign off as complete/ rate as 'green', until they are satisfied required change is embedded **Risks discussed:** • **MHAC Risk Register** – Agreed to remove risks 1500 & 1501. Follows sustained improvement work and progress. 1646 - Devon Judgement remains. • **Organisational Risk Register** – Noted risks assigned to other committees but which impact on MHAC. Agreed to feed into committees: **Risk 905 (**Clinical Governance & Clinical Safety Committee - CGCSC) **-** *Staffing pressure*: fewer registered nurses, Responsible Clinicians and consultants available for MHA work, attending hearings etc, leading for e.g., to cancellation of MHA Tribunals and pressure on small number of staff. **Risk 1151** (CGCSC) *Unable to recruit qualified staff / nurses*: MHAC implications as for 905 and 1154 **Risk 1154** (Workforce and Remuneration Committee) *Loss of staff due to Covid ill health*: MHAC implications as for 905 and 1151

	Risk 1368 (CGCSC) *Demand and Capacity issues /access to CAMHS beds*: risk that young people remain in our 136 suites for longer periods than is appropriate, and/or that the s136 expires (i.e., after 36 hours). Due consideration is being given to potential new risk identified regarding demand and access to 136 suites, particularly in Barnsley. Focused work is already underway to address this.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting on 11 May 2021.

Workforce and Remuneration Committee

Date	21 September 2021
Presented by	Angela Monaghan (Chair)
Key items to raise at Trust Board	<u>**Alert:**</u> • **Secondment of Chief Executive to WYH ICS:** discussed request from the ICS to extend Rob Webster's secondment to the end of October. Agreed to recommend approval to the Trust Board. • **Revised Terms of Reference:** these were amended to include the FTSUG report on the workplan (moved from CGCSC) and to reflect the change of membership. Recommended for approval. <u>**Advise:**</u> • **Workforce performance report - staff absence**: had a detailed discussion on current staff absence levels and recruitment and retention performance report. Noted increased investment into occupational health has been agreed. • **Directors pay framework and 2021/2022 pay award**: considered the national directive that Directors should not receive an annual pay award for 2021/2022. Committee agreed to follow the national directive but noted that they were disappointed Directors had not been included in the pay uplifts, and recognised the enormous commitment and effort by Directors over the past year. It was noted that a revised pay framework for directors is expected. • **Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES):** considered the 2021 reports prior to discussion by the Board. Noted they will also go to EIIC before consideration by the Board in October. <u>**Assure:**</u> • **Mandatory training**: received assurance that bank and agency staff have completed required mandatory training. Will in future report to WRC instead of CGCSC. • **Compulsory COVID vaccination for staff visiting care homes**: received assurance that there are no immediate concerns and that the small number of staff who are not vaccinated can be managed within the service. <u>**Risks discussed:**</u>

	Risk Register: reviewed risks and support the consolidated risks and levels presented. Will review the consolidated approach in 6 months' time. **New risks identified:** • None
Approved Minutes of previous meeting/s for receiving	Minutes of the meetings on 20 July 2021.

Members' Council meeting

Date	17 August 2021
Presented by	Chair
Key items to raise at Trust Board	**Alert** • An extraordinary Members Council meeting is being held on 19th October to consider the recommendation from the Nominations Committee regarding the appointment of the new Chair. **Assure** • The external audit findings on the Annual report and accounts 2020-21 were received from Deloitte • An update on Quality report was received • The Incident management annual report was received • A focus on item was received on Bullying and Harassment. **Advise** • The motion to amend the Trust Constitution was approved • The new Non-Executive Director appointment was approved
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting on 11 May 2021.

Note: assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

Present: Angela Monaghan (AM) Chair of the Trust
Nat McMillan (NM) 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)
Dr Manoj Mathen (MM) Consultant Psychiatrist (deputising for Dr Subha Thiyagesh)
Dave Ramsay (DR) Deputy Director of Operations
Kate Dewhirst (KD) Chief Pharmacist (for Item 24 and 28)
Kathryn Hemming (KH) Assistant Director of Nursing (shadowing DT)
Gemma Hinchliffe (GH) Quality Manager, North KirkleesCCG

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/21/59 Welcome, introductions and apologies (agenda item 1)

The Chair Nat McMillan (NM) welcomed everyone to her first meeting as chair, invited introductions 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 only and the recording deleted once the notes have been approved. The Committee agreed. The Committee wanted to thank those who had prepared papers given the current pressures.

Gemma Hinchliffe (GH) from North Kirklees Clinical Commissioning Group (CCG) was noted to be observing the meeting in the hope of working together on certain aspects of collaborative work including quality improvement and quality assurance.

Tim Breedon (TB) suggested that as Alan Davis (AGD) and Subha Thiyagesh (SThi) were both absent from the meeting, should any major/significant decisions need to be made, a further discussion could be arranged after the Committee meeting if appropriate.

CG/21/60 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.

With **all of us** in mind.

CG/21/61   Minutes of previous meeting held on 6 April 2021 (agenda item 3)
The notes were approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the meeting held on 6 April 2021.

CG/21/62   Matters Arising (agenda item 4)
The Committee discussed and noted the completed actions and updated the action log accordingly.

CG/21/37 – Transformation & Priority Programmes - A meeting has been organised with Sue Barton and Salma Yasmeen to discuss areas of focus for EQIA and QIA within reports for CGCS.

CG/21/38 - CQC Improvement Plan - Developing care planning, risk assessment and risk management around QI. Escalations from the Clinical Governance group will come into CGCS. TB advised that the whole plan will be coming to Committee with the actions and log against the items of concern. Complete.

CG/21/39 - Mental Health Service User Survey – Carol Harris (CH) has taken back to Operational Management Group (OMG) and Darryl Thompson (DT) had a discussion with Dawn Pearson. The survey will be updated then taken back to the BDU meetings and through the governance routes to OMG. Complete.

CG/21/46 – This action is covered on the agenda at item 16. Complete.

CG/21/47 –CAMHS – Confirmed that future reports will be provided in previous versions. Complete.

CG/21/53 – Sub groups - RRPI team are providing a more detailed report to be submitted to the benchmarking group next week .

CG/21/07 – CQC Improvement Plan -CH informed the Committee that referrals are now going directly to the team and being allocated to the most appropriate treatment pathway. CH informed that an update goes to Committee on waiting lists every 6 months. Complete.

CG/20/140 CAMHS - NM and DT to discuss at the next agenda setting meeting.

CG/20/93 Waiting List Improvement Plans – Waiting lists report will be for the September meeting. Complete.

CG/20/103 - Recovery Planning - TB/DT and Sue Barton will discuss at a meeting later in the month and agree format for future report

CG/20/103   - Quit programme – Manoj Mathen (MM) advised that he was unable to clarify but will ensure update is provided to the September meeting.

CG/20/102 Smoking Policy –This will be included on the agenda today. Complete.

CG/21/63   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. Discussions are ongoing between our CAMHS service, the LCH team and the prison service to ensure that the risks are recorded and mitigated appropriately with a clear understanding of each organisation's accountability. The risks to children requiring alternative accommodation and support remains concerning.
2. Discussion within the Exec Trio around the description of long covid risk continues.. It was noted to be difficult to quantify and is an emerging risk. This will be considered further through EMT.
3. SALT risk – There are differing types of provision across the organisation and the exec Trio will develop a risk description after understanding all the details of the provision.
4. The Trio continue to review all covid-19 risks given the current status of the pandemic however it is not envisaged that anything will change immediately.

NM raised a query in relation to the one 15+ risk which is an increase in demand for services. NM asked whether these can be met and are the Trust still in a position where we are seeing the increase becoming an issue. Angela Monaghan (AM) also had a query on this point and noted that the West Yorkshire & Harrogate Mental Health, Learning Disabilities & Autism Committees in Common had a presentation on surges and demand and this could be made available to Committee members. It shows there is an expected 60% increase in CAMHS, 40% increase in adults and 20% increase in older peoples referrals which is forecasting 30% increase to IAPT by 2023. AM queried what that meant for the risk.

NM queried what should be the next course of action and how the Trust becomes more proactive. CH informed that this remains a risk as services are still trying to understand issues at service level. CH advised of an increase in acuity of patients on the wards and an increase in SPA activity. OMG decided to fill some vacancies with agency staff to try and manage the increase in demand and this is being kept under review. NM noted that this is a risk and not an issue.

Kate Quail (KQ) queried what the Trust is doing to ensure Commissioning take account and noted the national funding issue and was concerned about the demand for services.

CH confirmed that we are working well with all commissioners and noted the need to understand the long term position as we have had recovery funding to manage in the short term which will need to be looked at if this was to be sustained.

CH also informed the Committee that Barnsley Community work closely with acute trusts and one of the south sites is part of an accelerator programme to resolve issues of the number of people waiting for surgery as part of covid. Services are being purchased from the private sector which is enabling people to get seen sooner, however community aspects haven't been considered which is an issue post operatively. Rob Webster has raised this at the ICS leaders' forum.

NM will ask the FIP Committee to consider the above point.

Action: NM

AM to share the presentation mentioned previously with the Committee.

Action: AM

AM noted generally in terms of the executive summary where it shows where the Trust is in terms of risks however there is no commentary or analysis. AM would like this to be added and also to identify more clearly changes to actions within the document. TB advised that this may be due to a change in personnel and will be rectified for future reports.

AM also noted a lot of actions due for review in June and suggested that these needed to be kept in focus. Also, Risk ID 695 – action relating to review and refresh of objectives and priorities in response to Covid-19 phases and recovery and reset plans was green, however needed a completion date adding.

TB informed the Committee that any changes post April Trust Board will be updated for the next submission.

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/21/64 Quality Accounts (agenda item 6)

TB informed that the Board had agreed a revised submission date after some relatively late changes to the timetable for production. The process will be followed appropriately and a discussion around the quality priorities will need to be had at pace given the new time pressures.

DT noted that several priorities within last year's quality accounts are completed, some have been delayed due to Covid and 15 priorities remain in progress. DT suggested rolling those over with the existing priorities for the rest of this year and then taking a more structured approach to 22-23. This approach was supported by the committee.

The Committee discussed and noted that this was a sensible approach however queried if anything had changed in the strategic objectives in relation to focus and priorities. DT advised that some of the priorities were quite broad e.g. staff experience and wellbeing and there will be an opportunity to undertake some adjustments.

DT to share the priorities with NM.

Action: DT

The Committee NOTED the Update of the Quality Account and Plan going forward and support the Quality Priorities approach.

CG/21/65 Clinical Audit and Service Effectiveness (CASE) Annual Plan 2021/2022 (agenda item7)

DT informed the Committee that this was a summary of the work the team had undertaken around audit. It was noted that some are national expectations and others are driven by local quality concerns or areas of focus. DT gave assurance to the Committee on the work undertaken by the team around national requirements and that they are participating where needs be. This is also reported into the quality account.

AM queried the process of the local priorities; how they are derived, what the key themes were, will they be covered by audit and whether there is a process that aligns this.

AM also raised that the governors had discussed at a recent meeting an action which related to how confident the Trust is in the use of "hello my name is". AM queried if this could be included in an audit also and IPC / PPE. Also, how Covid impacts on audit.

DT informed the Committee that there is audit activity within the QIAT team.

TB advised that IPC etc is covered in the annual plan and work plans so consideration would need to be given to how to collate them together. DT noted the need to focus on priority areas.

DT to consider the comments.

Action: DT

CG/21/66   Quality Monitoring Arrangements – Exception Report (agenda item 8)

DT reported that the Trust have conducted 3 visits and are in the process of the report being complied. Conversations have taken place in relation to potential virtual visits. Consideration to be given to different / more active roles on the visits. No visits are planned at the moment but will be arranged at a future time.

DT to discuss with NM outside the meeting in relation to the above.

Action: DT / NM

CG/21/67   Consideration of External Audit Reports and Trust Quality Accounts - (*NOT REQUIRED FOR 20/21*)

CG/21/68   CQC Improvement Plan and MHA Visits (agenda item 10)

DT reported that there was no dramatic shift to the improvement plan and the two remaining aspects are care planning and risk assessment. To give assurance to the Committee there was a new way of approaching the implementation plan for FIRM which has been rolled out and there is now a focus on embedding this in practice. This is now moving towards a roll out where each Business Development Unit (BDU) governance group will take ownership which is overseen by the Clinical Governance Group led by Julie Warren-Sykes. There is now a home within the organisation for clinical risk assessment and clinical risk management and the improvement agenda with FIRM being the current vehicle.

NM would like to sit in a BDU Governance group meeting to observe.

Action: DT and NM to attend together

DT reported that there had been a MHA visit to low secure very recently so there was no feedback as yet, however the Trust would have been informed of any areas of concern that required immediate attention.

The Clinical Governance and Clinical Safety Committee NOTED the CQC Improvement plan reporting.

CG/21/69 Quality Improvement Strategy update of refresh process and Patient Safety Strategy (agenda item 11)

DT gave a brief overview to the Committee and initially talked to the attachment around the patient safety strategy progress. DT noted the use of QI particularly within safety huddles which was helpful in the response to outbreaks and catching immediate learning which captured the interest of the region.

DT then reminded committee that the quality strategy is due for renewal this year. The document has been reviewed and remains relevant in the short term. The ambition is to have a quality strategy with a strong QI focus and ensure it is as a result of clear and extensive engagement across the organisation and our partners. It is recognized that this would be a significant piece of work. DT has had a discussion with Sue Barton and would like this to take place using a QI approach with colleagues, service users and carers.

In view of this approach DT would like the Committee to consider a 12 month action plan to deliver a quality improvement strategy with meaningful engagement.

NM advised that she was happy in principle however what are the risks if the 12 months is not achieved due to unexpected pressures eg covid-19 variants. DT noted that there would be challenges in creating a document that flexes and that there will also be a challenge of drift, although a robust process will be in place to keep it on track.

AM supported this approach and reported that other strategies have worked with this high level of engagement and coproduction. AM asked that whilst in the period of engagement that the Committee keeps close oversight in order to be clear on the risks, priorities and objectives.

TB fully supported this approach also.

DT advised that the first draft will be for review within 12 months and sign off by the Committee in September 2022.

The Committee SUPPORTED the approach and TIMESCALES advised.

CG/21/70 Update on Covid-19 Response (agenda item 12)
National Issues / Phase 3 Letter / NHS Providers Briefing

TB highlighted the key points to note:-
1. Command Structure has been dissolved and the learning has been taken and applied across the organisation and embedded.
2. Awaiting movement around IPC guidance nationally for healthcare organisations. This is not imminent however discussions are taking place.
3. Alert to activity around variants and the IPC team are well networked with strong links. IPC remains a high priority in the workplace.
4. CQC - What has been learnt in terms of management of workplaces throughout the pandemic.

The Committee NOTED the update.

CG/21/71   Workforce Update with response to Covid-19 (agenda item 13)
13.1 Safer Staff
DT gave an overview to the Committee and advised that the paper gives an oversight of how the Trust continues to manage to staff the wards with the challenges of a dilution of skill mix. Discussions have been had at Board in relation to meaningful metrics around safer staffing as the nationally prescribed reporting on fill rates do not give assurance and can risk giving false assurance if the context is not understood.
Given this, the Safer Staffing Group met last week to focus on suggestions for more meaningful metrics (bank, substantive and agency) and the impacts of staffing levels upon the services. Some examples include - cancelled section 17 leave, CHHPD and unfilled shifts and in the future, red flags for Safecare. A proposal is being worked on at the moment with meaningful proxy measures alongside narrative.

NM questioned how the Trust makes sure that they have the right conversations in the right places so not to duplicate in other Committees and Board and there is a clear purpose in trying to seek the metric(s). NM added we need clarity on what we mean by safer staffing. NM and Chris Jones have discussed this around both committees to ensure the right balance. NM welcomed the use of the lived experience of the staff and felt there was more room for development with this.

AM raised a concern in relation to false assurance without seeking to demand further metrics. AM also didn't want to lose sight of (previous discussion at FIP from the matrons) the presence of the numbers of learners on shifts and how this impacts on staff and if staff leave wards for community services. AM stated that there was a basket of measures to triangulate.

DT explained that the trust plans to track movement between community and inpatient services and advised that a document is being developed similar to one from Derbyshire Health Care Trust which can track the number of people leaving departments and which direction they are going.

TB reminded the committee that the issue with reporting against establishment had been identified previously and had led to the work around safe care, unfortunately this has been delayed during the pandemic response. Safe care will provide us with better information in terms of what was predicted to be required and what was actually provided.

KQ agreed that the discussion in FIP was helpful and informed that fill rates are indicative of increased acuity, and it does show where the increase of pressure is in the system. Also, in relation to the learners on the shifts, KQ noted the extra pressures that this would have and had been told that some newly qualified staff have been leaving so it would be helpful to know the timescales and reasons for this.

CH informed that there is a meeting arranged with Margaret Bedford in relation to the learners to deal with these issues. It was acknowledged that there is a challenge however this is being worked through.

The Committee NOTED the UPDATE and ACTIONS taken

13.2 Outbreak and Testing Management
As per IPR. Last outbreak was the 9th March 2021.

13.3 Covid-19 Vaccination Arrangements

As per IPR.

CG/21/72   Delivery of Clinical Services (agenda item 14)
Update on impact on all clinical areas
CH informed that the presentation was self explanatory however noted the key points of the presentation.
- High acuity inpatient services
- High Bed levels
- High levels of service user distress

Bank and agency are being used to help to alleviate some pressure. Recruitment has been challenging.

CH informed the Committee that the complaint from a learner in relation to a group of staff on a ward is being investigated. KQ noted that it is encouraging that the learner felt that they could come forward.

NM highlighted the increase in activity in Barnsley Community Services and suggested that FIP look at the rising activity levels.

Action: NM

NM also noted single point of access and the belief that people are self referring into this service as they are unable to get to see the GP. NM will also ask FIP to consider this.

Action: NM

AM stated that this was a helpful report and had a couple of comments in relation to inpatient Wakefield, Kirklees and Calderdale and trauma informed personality disorder (TIPD), AM noted that a lot of work had been done across the system however it is not clear how the TIPD approach is being implemented and the desired impact. With regards to the last slide regarding adult ASD and ADHD and the surge in referrals, AM felt that more information was needed and for this not to be lost in the breadth of the report. AM also commented on some of the language within the report that needs to be considered.

CH apologised for the language and suggested that this could be down to an editing error CH also advised that an update is received on ASD and ADHD within the waiting list reports and will ensure that the referral position this is highlighted within the next report.

TB noted in relation to TIPD, that the trauma informed approach has been discussed by EMT and will be subject to a paper or a session at Board in the future as it relates to a cultural shift in our approach. AGD has also made the WRC Committee aware of the potential for this approach in the workforce strategy

The Committee RECEIVED and NOTED the update

CG/21/73   Patient Safety (agenda item 15)
15.1 Incident Trends
As per IPR

15.2 PPE Arrangements
As per IPR.

CG/21/74   Issues arising from Integrated Performance Report, not covered on the agenda (agenda item 16)

It was noted that there was nothing new to report or to be escalated for CGCS.

The Committee NOTED the update.

CG/21/75   Child and Adolescent Mental Health Services (CAMHS) including Wetherby and Adel Beck (agenda item 17)

Dave Ramsay briefed the Committee on the CAMHS report.

Covid and service continuity - initially during Covid the service saw a significant decrease in referrals which stayed low however peaks have been noticed since last year and from March this year a large peak which has coincided with children returning to school. There has been an increase in crisis referrals and eating disorders. Associated problems with these areas and referrals is admission to tier 4 specialist beds which has got worse during covid resulting in pressure around access to units. This has led to children in acute hospital wards or SWYPFT adult beds, which has been a feature the last few months.

DR informed the Committee that work is underway locally to look at how the service can be reset.

Barnsley service update
Barnsley has maintained significant progress around waiting list numbers and continues to work with the CCG around moving to a more specified service.

Calderdale & Kirklees
DR noted the similar pressures around crisis referrals and eating disorder referrals and also highlighted the issues with neurodevelopmental pathways and this is a significant risk area for CAMHS and that an increase in capacity is needed. The CCG is aware of the issue and is working with the Trust on this however the resource is unlikely to alleviate the position in the short term.

Wakefield
DR informed the Committee that the progress that has been made around waiting times in had been jeopardised due to increase in referrals and the numbers on the waiting list have now started to increase.

Wetherby Adel Beck
DR advised that the service contract had extended and that also the improvement notice around staffing levels had been lifted however recruitment and retention remains a challenge. Access to specialist beds is particularly a challenge in this area. This has been raised and a letter has been sent to NHS England.

AM noted the good report and raised a query in relation to the new Tier 4 facility in Leeds whether this would be an increase in capacity. AM wanted to know what impact this had on our services and demand. Also, AM asked if the Board / Committee could do anything to assist with the letter to NHS England raising the challenges with access for the young people within Wetherby and Adel Beck.

DR reported that essentiality there is north/south divide and all beds have to be accessed through a national system. The new facility will add additional capacity nationally but this will still be an area of pressure.

CH informed that the NHS England letter had gone to the Chief Nurse and the CQC and will let the Board/Committee know if any support would be needed.

TB informed the Committee that the issue had been escalated and that it had been heard at national and regional levels, with Amanda Pritchard Chief Operating Officer NHSE having discussed it nationally. It is now a case of pushing for the action rather than the awareness. Also, in relation to Wetherby and Adel Beck, TB noted the complicated delivery arrangements and advised that conversations around risks are taking place with LCH for these settings with particular attention including where the risks registers should sit. TB will update at the risk section.

CH also noted the work across the ICS as part of the collaboration and also with acute Trusts to undertake a one night snapshot survey of children and young people who were not in the correct care. SWYPFT will undertake their part and will then join together and discuss at the next collaborative meeting.

AM noted the terrible situation and wanted to ensure that this problem was being dealt with and that actions are taken. The Committee noted that this was an area where SWYPFT had maintained pressure for a solution on this important issue.

DT noted that that the planned of CAMHS in-patient provision for WY&H will not add to the overall national CAMHS Tier 4 bed provision, and demand for CAMHS beds nationally and locally remains very pressured.

DR advised that although the prime issue is a risk to children he highlighted staff also feel the issues and challenges which will always be significant and impact upon their wellbeing.

NM noted that the Board and Committee are fully aware of the situation and offered help and support. CH informed this isn't needed at the moment however it will be kept on a watching brief.

KQ raised a query in relation to the Neurodevelopmental pathway risk and noted the significant risk for CAMHS waiting times and the possibility of 4-5 years without action to address the issues leading to an increase of more challenges. KQ wanted to know what action the Committee needs to take in terms of escalation and that assurance is needed around these waiting times.

DR advised that a business case had been submitted for Calderdale and a response is awaited from the CCG, however the resource would not fill the gaps and there will be a shortfall. In Kirklees there is a financial provision going forward and a business case will hopefully be signed off to be sent to the CCG. DR also informed that the Trust is trying to procure a one off waiting list initiative and consider what capacity it can bring to the system. DR will advise on the position at the next meeting in September.

The Committee noted that they have not received the assurance at this time and this remains a risk.

The Committee noted
- ➢ Continued need to get updates around Wetherby and Adel Beck for September
- ➢ NHSE response and what will be received back

- ➢ ADHD commissioning needs escalating through to Board
- ➢ NM - general question around this agenda item and whether this is a particularly hot area and whether it comes back as specific actions as mentioned above. AM stated the committee needed to continue to review CAMHS and the risks AM confirmed the committee needed the deep dive into CAMHS.
- ➢ NM and DT will discuss the above at agenda setting and will review

Action: NM/DT

The Committee RECEIVED and NOTED the update.

CG/21/76   Quality Impact Assessment (agenda item 18)

TB stated that this has been a regular item to consider the QIA related to the cost improvement programmes however this has altered during the pandemic due to the interim funding arrangements.

The QIA and EQIA are now being factored into the restoration and recovery work which will come to the next meeting in September as part of the priority programmes update.

The Committee NOTED the update.

CG/21/77   Serious Incident Reports (agenda item 19)

19.1 Serious Incident Quarterly Report Q4 (inc at item 19.2)

Included at 19.2.

19.2 Annual Incident Report inc Leder

DT gave the key headlines as follows;
- ➢ The number of incidents reported across the Trust has decreased by 3.7% on the previous year.
- ➢ 92% of all incidents reported resulted in no harm or low harm.
- ➢ The number of serious incidents reported has reduced compared to last year.
- ➢ Accreditation has been achieved for our Serious Incident Investigation processes from the Royal College of Psychiatrists.
- ➢ During 2020/21 there were no 'never events'.
- ➢ There has been one homicide.
- ➢ Risk assessment and recording keeping were highlighted.
- ➢ No deep dives into all incidents just a small number with identified at patient safety specialists.
- ➢ More in depth conversations around actions to embed assurance
- ➢ The Trust have reviewed 335 deaths that were in our learning from healthcare deaths scope. This compares with 286 in 2019/20.

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.

TB reinforced the plans for next year and the move to the revised system for patient safety incident management which will replace STEIS (Strategic Executive Information System). TB noted the large amount of work required to deliver on this revision and noted that this will be managed by the Patient Safety Manager (Helen Roberts) who will review the resource

required. TB also noted the fact that the report had been produced at pace during a challenging time and thanked the team for their efforts. This report provides important data to support our learning and actions around patient safety.

NM noted the good evidence of healthy culture of reporting incidents.

The Committee SUPPORTED the Report and NOTED the next steps identified.

CG/21/78   Internal Audit Reports (agenda item 20)
Nil

CG/21/79   Health & Safety Annual Report, Objective and Action Plan (agenda item 21)
This was taken to the 6th April 2021 Committee meeting.

CG/21/80   RRPI Annual Report (agenda item 22)
DT advised the Committee that this report can be fully considered at the new assurance days. However, this is already being discussed at the benchmarking meeting next week.

DT reported good feedback from training which was taking place on site and that the conversations are taking place around prone restraints which will be a focus at the benchmarking meeting next week.

The Committee agreed to discuss this report at the assurance sessions.

Action: NM / DT to agree dates of the assurance sessions

CG/21/81   Infection Prevention & Control Annual Report (to be received at assurance session)

CG/21/82   Drug & Therapeutics Annual Report (agenda item 24)
Kate Dewhirst (KD) gave highlights and the key points.

The main focus of the Committee in 2020 was the response to the pandemic and the impact on medicines use and safety and change in service delivery. Usual business was continued were possible as outlined below and particularly, in relation to medication incidents, complex clinical queries and medicines supply issues. In the early months of 2021, the focus was on safe and legal delivery of the covid vaccination programme both for staff and service users and providing guidance.

KD explained how the group were looking at remote prescribing and what this entailed and was fully supported by silver command. There was a focus around high risk medicines which were more likely to have an impact on patients and to ensure they had the Physical health monitoring throughout. Surveillance had been maintained.

There was a continued review of complex queries including end of life care medicines during the pandemic.

KD reported success in electronic prescribing and this is now live on 6 wards, a mix of rehab recovery and older peoples. This will continue to be assessed.

The Committee thanked KD for the report and all the work that had been achieved.

The committee received the report and noted the assurance provided

CG/21/83   BDU Governance Report (deferred until September 2021)

CG/21/84   Smoking Policy update (agenda item 26)

MM gave a brief update on the Smoking Policy to the Committee. In 2020 the Trust took a decision due to the Covid-19 pandemic to relax the Smokefree Policy. It had been agreed to:

➢ Continue promoting smoking cessation services and strengthen the message of the impact on respiratory disease and the fact that it could affect recovery from Covid-19 via smoking cessation groups.
➢ Allow vaping in outdoor areas whilst risk factors of vaping indoors are confirmed.
➢ Designate some outdoor areas for smoking subject to advice from pharmacy and the fire safety team.

SWYPFT was not an outlier in relaxing its Smokefree policy during the pandemic and other organisations had taken similar decisions due to experiencing difficulties when isolating Covid positive patients on ward areas who did not wish to stop smoking.

Next steps
➢ Prepare to relaunch our local Smoke Free policy via a series of workshops from Dr Agrawal Sanjay – Consultant Respiratory Medicine (The national QUIT Clinical Lead).
➢ To re-commence discussions with our Drug and Therapeutic Committee around the use of e-cigarettes.
➢ Await advice from NICE, expected in September 2021, around the use of e-cigarettes.

AM raised a question around the link between violence and aggression and the Smoking policy, what the impact had been and whether there had been any monitoring. MM informed that he had personally seen the correlation when he had been on the wards but had no data at this time. CH reported that a check through Datix for smoking related incidents would assist.

                                                                    Action: SThi to check Datix

AM queried whether this would have an impact on the policy. NM noted that if there was evidence then this should be considered. Committee agreed that this is a challenge.

NP noted there would be an implication to reinstating smoking shelters and also the fire hazard.

The Committee RECEIVED and NOTED the update and action required

CG/21/85   Revised Complaints Approach (agenda item 27)

TB advised the Committee that this is the altered complaints approach in light of covid and the review of appropriate response timescale, reminding the committee that the current 40 day timescales was of our own choice./imposed internally. This has now been tested and the revised arrangements are proposed with a pilot as shown on the paper. The revisions meet national guidance.

The Committee RECEIVED and SUPPORTED the updated approach

CG/21/86   Sub-groups – exception reporting (agenda item 28)
Drug & Therapeutic
As above at item 24.
Safety and Resilience
Safety Services Annual Report
Headline update from NP informed the Committee of the new contract for lone working devices which looks at new ways of deployment and rolls out on the 5th July.
Covid 19 – new risk assessments are taking place however nothing much has changed.
Recent deployment of sniffer dogs following wider drug use in community and Fieldhead had no evidence of drugs on site. Ligature reduction work remains underway.
Report received and noted.

Infection Prevention and Control
At the last Committee AM had asked how we know who has died. DT looked into this and reported back that 2 people who had contracted covid in our care went on to pass away.

As part of assurance this is now going to OMG as part of Clinical risk report.
Report received and noted.

Safeguarding adults and children
Report received and noted.

Reducing Restrictive Physical Interventions Group
Report received and noted.

Improving Clinical Information Governance Group
There has been an ongoing discussion on sharing out of clinical information during the pandemic and a briefing to be brought back to Committee on this.
Report received and noted.

Physical Health
Slight increase in the first jab vaccinations. Some hesitancy of the BAME groups however a lot of work has been done around this.
Report received and noted.

Clinical Ethics Advisory Group
No meeting since the last Committee.

CG/21/87   Serious Incidents Update (agenda item 29)
TB updated the Committee on the 2 incidents which were discussed at Board recently.

TB included a copy of the SANCUS briefing and wanted to ensure everyone was appropriately updated. Key points:

- Meeting held today where evidence was provided against actions of their recommendations and TB will get details of this.
- New timescale - September publication. Comms to be aligned with NHSI/E.
- Provided a summary of risks and key things have been reviewed by CAPSTICKS.
- CQC have been fully briefed throughout and an engagement meeting will take place in a couple of weeks.

Tragic death on Newhaven - toxicology report now received and the cause of death was 'Sudden Unexpected Death In Epilepsy'.

Death on Melton (Barnsley) – Police have been outside of routine processes and made contact with staff directly to interview them further which has clearly caused them concern. The Trust are picking up in terms of process through our legal services team and also supporting staff.

TB advised that given the number of changes in senior personnel and the delays in inquest processes a summary of all key incidents will be provided to the next private board session to ensure all are sighted on the current position.

KQ raised a question re the SANCUS and what assurance do the committee require that the actions are being acted on together with the SI. TB informed that the SI was closed in 2019 and there is a session with NHSE and SANCUS team where they require evidence of the action taken. This will provided in closing report.

CG/21/88 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 30)
Alert
- CAMHS: Youth Offender Institutions (YOI) continue to raise concern around the lack of medium secure care and the use of seclusion.
- 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 waits.

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.

CG/21/89 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance and Clinical Safety Committee (agenda item 31)

- ➢ Tier 4 Beds inc YOI Beds.
- ➢ Rapid increase in CAMHS waiting lists.
- ➢ SANCUS Briefing.

TB suggestion that these 3 things will be included in the Trio review before the next Trust Board.

CG/21/90 Work Programme (agenda item 32)
Work programme received and noted.

CG/21/91 Date of next meeting (agenda item 33)
The next meeting will be held on 14 September 2021 between 2.00-5.00 pm via MS Teams.

Glossary

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

Finance, Investment & Performance Committee (FIP) – Monday 28 June 2021
Virtual meeting, via Microsoft Teams

Members	**Present**	**Apologies**	
Mark Brooks (MB)	Sue Wing (SW)	Rob Webster (RW)	
Chris Jones (CJ) (Chair)		Carol Harris (CH)	
Kate Quail (KQ)			
Sam Young (SY)			
Tim Breedon (TB)			

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Introductions and apologies	Chris Jones (CJ) welcomed everyone to the meeting and noted apologies from CH and RW. Mark Brooks (MB) advised that the meeting was quorate. It was agreed that item 13, Barnsley community services performance report, would be covered first on the agenda to enable SW to present the paper and then leave the meeting.	CJ	
2.	Declarations of interest	There were no declarations of interest	CJ	
3.	Minutes from previous meeting	The minutes from the FIP meeting held on 24 May were approved.	CJ	
4.	Review of progress against agreed actions and matters arising	MB noted the following updates which will be added to the action log Action 058 – this action regarding the circulation of a diagram showing commissioning arrangements has been circulated by RW Action 059 regarding the cash risk is covered in the agenda Actions 060 & 061 regarding learning disability benchmarking information will be provided by CH at the next meeting Actions 052 and 053 covering capital planning and mental health investment standard are both covered in the agenda Action 054 regarding perinatal services – CH has discussed with KQ. KQ noted that any gaps tend to be system gaps and the action can be closed Action 056 and 057 regarding CAMHS. KQ confirmed she has spoken with Izzy Worswick and will also speak with the clinical lead of the provider collaborative	CJ	
5.	Barnsley community	SW introduced this report and noted in recent months there has been a general increase in activity and acuity in patients. This has been particularly notable in MSK and dietetics. An increase in waiting times in some services is also being	CH	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
	services performance report	experienced following the impact of the pandemic. Regarding MSK we are in the midst of recruiting 6 first contact practitioners to work with GPs in MSK services. Face to face was the primary way of having contact with a patient prior to the pandemic and the need for face to face has remained during the pandemic given the nature of many services provided. There has been an increase in use of video consultations during this period where this has been appropriate to use. SW explained we are still learning how to best use digital technology in our patient contacts and more investment in training could prove beneficial. More work has been carried out on waiting times. There has been an impact on ability to use some estates given social distancing and infection prevention requirements, and the time effect of such matters as donning and doffing PPE. Care needs to be taken on understanding some of the waiting time information given what is being agreed and prioritised with patients and staff alike. Caseloads and waiting times are currently being cleansed. Average wait times now and prior to the pandemic are being compared. We do need to ensure SystmOne is being used correctly. Where we were not able to provide a service at any time regular contact was maintained with patients, families, and carers. TB commented that some services are very dynamic in terms of numbers such as asylum seeker service at Urban House. This can notably impact on our referrals and contact numbers. KQ thanked SW and her team for all the work carried out during the pandemic. KQ asked about plans for further digital training. SW explained that staff had to adapt very quickly at the beginning of the pandemic to using digital technology and ways of working. SY asked if there was any issue keeping SW 'awake at night'. SW responded by stating she wanted to ensure the quality of service provided remains high. Given the impact of Covid-19 SW is also aware that there could be pressures on staffing and resources to meet demand and complexity. RA asked if there are sufficient staff in the market to meet our needs. SW explained that there are challenges in some areas and professions such as speech and language therapy. MB asked what the Committee would like to see on this subject matter in the future including tracking performance against outcomes we would expect to see. CJ asked for clarification why anyone would have to wait more than 52 weeks to have access to a service. CJ also asked about SystmOne challenges. SW explained community services in Barnsley are moving to one module in SystmOne. The go-live was during the pandemic and will provide a positive impact. Data is being cleansed to ensure it can be used effectively to report on true waiting numbers and times. CJ reiterated the importance of continued data cleansing to ensure we use data well across the organisation.		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		MB suggested that we need to consider what reporting across all services regrading access and waiting lists. This could form part of regular reporting to the Committee.		
		The Committee resolved to receive the presentation and report and to consider how updates are provided in future		MB
		SW left the meeting at this point		
6	Review of committee related risks	MB introduced this item and provided some headlines the Committee could consider for the risks allocated to it, and what would be covered elsewhere in the agenda. He explained that the regional specialist commissioner does not yet have the details of its final financial allocation and as such a revised financial offer has not been made yet. This has pushed the go-live for the collaborative back until at least August 1st. MB suggested this would also be challenging given the various governing body approvals that are required as well as the risk of going live during the middle of the summer holiday season.	MB	
		MB identified there is no real update yet regarding future funding and that the Committee has already agreed the level of risk to cash resources could be downgraded.		
		MB commented that there is an increasing use of out of area bed placements, which does add to quality and financial risk		
		CJ asked about the risks relating to tendering. MB suggested the nature of this risk will change given the impact of the Health & Care Bill and further development of integrated care systems		
		The Committee agreed to receive the risk report and to recommend to the Trust Board the downgrading of risk 1076 regarding cash resources		MB
7	Month 2 Finance Report	MB explained that month 2 in effect was a continuation of the previous six months with the level of surplus/underspend recorded. This does not necessarily reflect the underlying position and it remains likely that income will reduce from the current level by the second half of the year. He noted there are pay savings compared to plan and that out of area bed costs are increasing. Covid-19 response costs are lower than last year and MB highlighted that further detailed review of BDU and corporate costs is being undertaken to ensure all Covid-19 costs are being captured.	MB	
		SY asked what was included in 'other' vacancies. RA explained this relates to the Trust's budgeted vacancy factor which needs to be allocated in the report to the appropriate BDU / support service.		

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		CJ asked about the reported overspend against non-pay, particularly in estates. RA responded by stating the finance team is reviewing actual rates charges and the amount of budget allocated each month. He will report back on this. **It was resolved to receive the month 2 finance report**		RA
7.	H1 Financial Forecast	MB provided some context on the forecast, recognising the interfaces with the West Yorkshire integrated care system (ICS) and NHS England & Improvement (NHSE&I). The surplus to date and run rate strongly indicates that by the end of H1 there will be a surplus delivered of circa £3m. He added that funding for the second half of the year is not yet known and is likely to be lower than what is being received in the first half. There are uncertainties in the wider system, particularly regarding the level of elective recovery funding, mainly in acute providers. MB sought views of committee members of what the forecast should be. He personally recommended a surplus of £2m - £3m. TB asked about the current financial position in the ICS. MB explained it is currently favourable to plan. CJ summarised by noting that the Trust has followed the principles of doing the right thing for the Trust and system and ensuring professional standards are maintained. CJ questioned whether the surplus could be higher. MB explained that we submit a most likely and best-case forecast. RA noted that monthly reporting to NHSE&I had added some high-level checking in to the process. **It was agreed to support MB's recommendation that the H1 outturn position be improved by £2m-£3m.**	MB	MB
8.	Operating and Financial Plan	MB suggested the paper was taken as read and asked for any questions and comments. CJ asked where the process for driving productivity process is covered. MB responded that this would be included in the updated financial sustainability plan, which is being revisited in line with developing a medium term operating and financial plan. **The committee noted the paper and commented as above.**	MB	
9.	Adult Secure Lead Provider Update	MB reiterated that the go-live date has been delayed given the fact the final funding hasn't yet been agreed. MB suggested that given the indicative timescales regarding H2 funding and the governance required to approve by all members of the collaborative that a more likely go-live date is October 1st.	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		SY asked whether the Trust has any choice over a go-live date. MB replied by stating the Board will need to approve the final business case and be assured it is practically achievable.		
		CJ asked about ownership of clinical risks at committee level. TB explained there has been brief discussion at Clinical Governance & Clinical Safety Committee (CGCS). There is an expectation the detail of clinical governance and quality will be reviewed at CGCS. There needs to be clarity and understanding of what we are responsible for. CJ will discuss separately with Nat MacMillan.		**CJ**
		KQ suggested a similar approach needs to be taken with CAMHS and learning disabilities.		
		CJ will send some separate questions to MB regarding the paper		**CJ**
		The Committee noted the report and commented as above		
10.	Investment Appraisal	MB introduced the paper. He explained it is periodically provided to the Committee and provides details of all business cases and tenders being developed and those that may potentially be required. He noted the Wakefield stop smoking tender has been completed and submitted. He added that much of the work now is bidding for national monies and working with commissioners and the ICSs on developing business cases	CH	
		KQ asked about costs associated with additional clinical space required due to the requirement for social distancing. MB confirmed that currently we could use our allocated Covid-19 monies for these types of costs.		
		SY noted how much work takes place on business cases and tenders. She asked about the nurse prescriber model at Urban House and our ability to recruit into it. MB suggested CH provide a more detailed update, noting it has proven a challenging role to fill. TB commented that this type of issue is picked up in the new roles working group.		
		CJ echoed his thanks for the work the team is doing and asked if any further work is taking place regarding income for locked rehab in Barnsley. MB explained that the current national financial arrangements ensure the costs currently incurred are covered. In terms of the future this income will not necessarily be replicated. There is continuing dialogue with the commissioner and both parties are working to identify solutions. It is clear there is sustained higher demand than historically seen and the issue remains a challenge for the Trust and Barnsley system		
		The Committee noted the report and commented as above		

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
11.	Horizon scanning	MB provided a brief update and suggested the paper was taken as read. Half two financial arrangements are likely to be provided during September. MB noted there are discussions regarding capital expenditure for the year taking place in the West Yorkshire ICS. He added that currently any additional pressures are likely to be covered by slippage. CJ asked about any updates on the White Paper. MB responded that design work is taking place in each ICS and the Committee will be kept updated of any developments **The Committee noted the report.**	MB	
12.	Mental Health Investment Standard	MB explained that spend and headcount against investments is reported against each year. He explained that a further development is understanding of how the investment has supported outcomes. Given the impact of the pandemic this has not been possible for the past year. MB also commented that some of the recruitment into new roles have been from other positions within the Trust, so created a vacancy elsewhere. For 2021/22 there has been confirmed agreement of investments with Barnsley and Wakefield CCGs, with confirmed investment from Kirklees expected within the next week. CJ suggested an update be brough back at a suitable point in time. Identification of any key risks would be a helpful addition to the paper. The Committee noted the report	MB	
13.	Benchmarking Update	MB provided an update of the national Covid-19 benchmarking report for mental health & learning disabilities. Key highlights national include a general increase in referrals. Within the Trust referrals into learning disability services are increasing at a higher rate than what is being seen nationally. IAPT referral acceptance rates have increased, there has been a slight increase in face-to face referrals and our use of digital contacts is below national averages. SY asked if we know why how our use of digital contacts is lower than national averages and if there are any recommendations regarding how we use digital solutions. MB explained this is being covered by the reset and recovery group and suggested an update be asked for. He noted there are differences between services CJ asked for an update of how we are using other benchmarking reports including the model hospital and internal service dashboards. MB responded by noting the P&I team have produced many different reports during the pandemic on such matters as Covid testing, vaccinations and inequalities. As we move back to more traditional planning the use of benchmarking and model hospital can help inform our plans. **The Committee resolved to note the report and request an update on the use of digital technology**	MB	MB

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
14.	Capital	MB explained how the capital prioritisation process works and how the internal in-year capital planning and management process works. MB noted the minor estates works is probably the most complex to manage given the number of sites where access is required and the procurement processes that are undertaken. RA is part of an internal capital group that oversees delivery of the plan. In terms of this year a number of tenders have been completed. There are challenges around cost and availability of supplies and resources. There is a specific issue regarding the costs of the Bretton Centre en-suite and other upgrades, which is looking like it will be significantly more expensive than originally estimated. It is also not yet fully clear how the monies identified for older people's estate will be utilised. These two programmes of work have assumed spend of £2.5m in the year. CJ summarised that given the points raised by MB mean that we cannot yet be assured we will spend our full capital budget this year. MB agreed with this. CJ asked what the consequences of an over or underspend would be. MB responded by stating we do need to work within the West Yorkshire ICS control total for capital expenditure, need to constantly work with colleagues across West Yorkshire ICS to make best use of the year's capital budget. MB suggested one risk could be any new requirements that are identified in the updated estates strategy. TB suggested there could be updated guidance regarding ventilation requirements across the NHS. This may add to capital programmes of all trust. CJ asked how he could take assurance that plans for individual projects are on track. MB suggested one piece of assurance if the monthly Estates TAG (Trust Action Group) that oversees our capital plans. For the next report it will be identified which projects have gone out to tender and which have started work. The nest update will be provided in September The Committee noted the report and noted the challenges surrounding the largest scheme.		MB
15.	Annual work plan	The annual work plan was received. CJ noted that he and MB communicated regularly to discuss and agree agenda items for each meeting and have increased the focus on performance in recent months.		
16.	Items to be brought to the attention of the Trust Board / Committees	• Assurance financial performance is in line with plan for the first six months • Received assurance via the reports on business development opportunities and the mental health investment standard • Less assured about meeting the capital plan given the issues highlighted with the Bretton Centre project • Pressure on inpatient wards and demand for out of area beds was noted		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• The need to ensure there is oversight of clinical and quality risks relating to the forensics lead provider work • Need to gain understanding of plans for use of digital solutions • Recommend the downgrading of the cash risk		
17	The next meeting date of the Committee	The Committee noted the next FIPC meeting will take place via MS Teams on Monday 26 July 2021.	17	

With **all of us** in mind.

Finance, Investment & Performance Committee (FIP) – Monday 26 July 2021
Virtual meeting, via Microsoft Teams

Members	**Present**	**Apologies**	
Mark Brooks (MB)	Carol Harris (CH) (item 10)	Rob Webster (RW)	
Chris Jones (CJ) (Chair)	Rob Storr (RS) (360 Assurance	Nat McMillan (NM)	
Sam Young (SY)	– internal auditor)	Kate Quail (KQ)	
Tim Breedon (TB)	David Ramsay		
	Robert Adamson		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Introductions and apologies	Chris Jones (CJ) welcomed everyone to the meeting and noted apologies from RW and NM. MB confirmed the meeting was quorate.	CJ	
2.	Declarations of interest	There were no declarations of interest	CJ	
3.	Minutes from previous meeting	The minutes from the FIP meeting held on 28 June will be completed prior to the next meeting and if possible circulated ahead of the meeting.	CJ	
4.	Review of progress against agreed actions and matters arising	To be reviewed before the next meeting.	CJ	
5.	Review committee related risks and any exception reports as required	MB explained that these risks are reported on every month and as such there is minimal change compared to the previous month. The Forensics Lead Provider programme does have financial risks which the Committee has previously reviewed in detail. MB explained that he has agreed with the specialist commissioner go live will take place on 1 October 2021 rather than 1 August 2021 given the fact a revised financial offer has not been received and the practical difficulties of going live during the summer holiday season. No changes are recommended to other risks allocated to the Committee and MB reminded the Committee the July Board papers include a recommendation to Trust Board that the cash risk is downgraded. MB explained that he expects tendering risks should reduce, albeit the emphasis will shift to ensuring engagement and involvement with each place in both ICSs..	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		SY asked whether for risk 275 (relating to the provision of local authority resource) if anything needs updating referenced on this risk. MB suggested to take away as an action. **Action** CJ wanted to know if the cash risk being downgraded will still be monitored anywhere. MB responded by stating it will remain on the finance risk register. **The committee discussed the report and are assured the risk levels are appropriate.**		**CH**
6	Financial Performance	6.1.2021/2022-month 3 financial performance RA explained that this is the standard finance report that is reviewed monthly and continued to take the Committee through the headlines of the paper. It was flagged that agency costs increased in June and are likely to increase further in July. This is required to cover new roles, staff absence and pressure in services, particularly inpatient wards. RA also noted that the capital costs associated with a major scheme are coming out higher than originally envisaged. This could impact the outturn position for this year and capital budget requirements for next year. CJ asked for clarification about treatment of mental health investment standard income (MHIS). RA stated that agreements are being made with each CCG regarding timing of receipt of the 2021/22 MHIS. CJ asked if the income is likely to appear in the second half of the year rather than the first half. RA confirmed this is the case for much of the MHIS. CJ asked about staffing as vacancy figures were high, particularly in mental health community. MB noted this has been consistently an issue for a period of time with vacancies and staffing managed by each BDU. TB commented that since the pandemic the dynamics of the community roles have changed with face to face visits, PPE requirements, travel and video consultations all having an impact. CJ asked a question relating to one of the transparency disclosures. MB explained it was for Microsoft licences. 6.2 H1 forecast 21/22 RA introduced the paper and commented that the headlines were the same as recent months. He highlighted the month 3 surplus position. Taking into account risk and potential upsides there is a revised forecast of £2.3m surplus for the first half of the year. This could ultimately be higher. CJ asked about timescales for pay awards. MB responded by stating the Trust is awaiting full guidance regarding how this will be funded. **The committee discussed and commented on the report.**	RA	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
7.	Forensics lead provider update	MB informed that a revised go-live date of 1 October 2021 has been agreed with NHS England. He added the Clinical Director Dr Adrian Berry is retiring at the end of September which leaves the adult secure provider collaborative without a clinical director until a replacement is recruited. Sean Rayner is discussing options with partners in the collaborative. Interim resources are being used for commissioning and governance and an updated structure is being agreed with Leeds York Partnership, which is hosting the commissioning function. CJ raised the question of clinical risk and governance. MB to share the proposed governance structure chart with CJ and put on the agenda for the next meeting. **Action**	MB	**MB**
8.	System oversight framework	MB discussed from a performance perspective that we have operated with single oversight site framework for a number of years. The consultation on and updated system oversight framework is now complete and an updated guidance has been provided to the Trust. Some clarification is required as to when all the new metrics need to be reported. He added that there will be further development in the coming weeks, both in the Trust and ICSs. SY asked about the staffing metrics and the number of people who have experienced bullying. MB explained the number of cases reported is actually low and this differs to responses in the annual staff survey. It is understood there could be more frequent surveying of staff to support data gathering on this issue.	MB	
9.	Horizon scanning	MB explained it is likely that half 2 funding and financial guidance will be made available by the middle of September with the planning process taking place from then and through October. It was noted that the threshold has changed from 85% to 95% for the elective recovery fund which will have an impact on acute trusts in particular. Work is taking place within the finance directors' group regarding system design for next year. RA added that half 2 forecasting is still taking place in the Trust.	MB	
10.	CAHMS performance report	CH introduced this item, noting that DR would be giving information on the pressures and waiting list in CAMHS. She added that he also provides a safety report to the clinical governance and clinical safety committee (CGCS) which focuses on the impacts on the waits and the clinical service delivery. For this meeting she has asked DR to focus on the activity and performance and the actions that are being taken by the service to address those. CH thanked DR for attending the meeting. DR explained referrals reduced at the start of the pandemic with an increase experienced since March which coincides with schools returning. The increase has been particularly notable in Kirklees with unprecedented referrals coming into CAMHS. There is a spike in crisis referrals particularly around eating disorders which puts pressure on the service and colleagues. There are national metrics regarding routine clock stops and emergency responses. We have been performing well on these but the increase in referrals and staff capacity issues is adding significant pressure to our ability to continue meeting them. CJ asked if the term "clock stops" could be explained to him. DR explained that a standard case referral should be seen in 24 hours for urgent referrals, for non-urgent referrals it should be within 5 days. It ss from referral to first response, from the first risk assessment.		

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		DR provided an explanation about a more generic indicator regarding the waits from referrals to treatments in CAMHS. The data provided shows a healthy picture of the percentage seen within 18 weeks of referral. Given current demand it is considered likely this position will deteriorate over the coming months.		
		There is still a service continuity plan with a bronze level group that meets every week to make sure things are on track. There is also a CAMHS improvement group looking into performance and initiatives to improve waiting times. There has been new investment into CAMHS and there have been a several business cases developed across all CCGs. Good progress has been made with staff teams with some significant improvement around waiting times.		
		CH added that progress has been made with the staff teams in CAMHS both from a staff survey and waiting list perspective, and DR has done a lot of work with the CAMHs teams. The CAMHS staff survey came out very good but there is a different set of concerns now and a lot of pressure given referral numbers.		
		DR pointed out that there is also work being done at Wetherby and Adel Beck which the paper doesn't reflect.		
		CJ asked if new problems caused by additional demand requires new solutions? There has been great success in reducing waiting time and improving staff morale and he asked what new actions need to be taken.		
		DR commented that the new ways of working paper had quite a lot of support for staff and the serviced to work more flexibly. There are service developments taking place including focus on providing support in schools, we are the lead provider in Kirklees and will be in Wakefield.		
		CJ asked TB for any comments.		
		TB commented that there were issues around eating disorder provision across the system with it coming under significant pressure and this will have an impact on services. He added that Provision of medical staff around the whole CAMHS agenda there have been issues in the past regarding provision of medical staff and whilst there has been good improvement it is an area we need to keep focus on. TB further added that linking in with the third sector is important particularly given the growth that's planned. We need to consider this in terms of support and how we make sure we respond appropriately without disturbing the referrals route. There is potential for further increases in demand from the higher prevalence of domestic violence being reported.		
		SY asked about co-ordinated response and staffing and the continued ability to attract people into CAMHS.		
		DR responded by stating the service models in each area can be quite different. Recruitment can be a challenge for some key positions for example eating disorders. More options are being looked into to make a more attractive package.		

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		CJ asked if in all areas if there any differences in the make-up of referrals and demand thinking about gender, ethnicity and location as Kirklees stands out significantly in terms of the emergency referrals. The growth in Kirklees is much higher than the other three districts, and CJ asked if there is analysis of this demand. DR agreed this would be helpful information. CJ commented that Kirklees referrals were high and asked if any reason for this was known. DR explained he currently does not have any conclusive evidence why this is the case. CJ asked for the 792 people waiting for neuro assessment in Kirklees, when are they going to be seen? DR commented some business cases have been developed with some investment provided which will see capacity to assess double in Kirklees. MB explained that this is not just a Trust issue and that detailed discussions have taken place with commissioners regarding what funding is provided and what service commissioned. He added that other providers as well as the Trust have been engaged to tackle the waiting list in Kirklees. DR noted that the diagnosis process takes up significant resource. CH added the increased investment and waiting list have created another problem especially with Covid and social distancing requirements which is the capacity within existing accommodation. Physical observations need to be carried out to go through the diagnosis. CJ summarised the items discussed and suggested a further update in 3 months to review what actions have been taken. CH wanted to align what is going to committees as she is aware that the data goes to two committees. CJ will pick this up with NM as Chair of CSCG. CH left the meeting.		**DR/CH** **CJ**
11.	Annual work plan	To be covered at a later date.	MB	
12.	Items to be brought to the attention of the Trust Board / Committees	CJ reported that regarding assurance there was no change to any of the risks that this committee monitors and we are on target to hit the half 1 financial plan. CJ wanted to alert the Board to the new system oversight framework and growing vacancy factor that was highlighted in the financial report and the impact this must be having throughout the Trust. Also, the significant pressures being felt in CAMHS and timings of the forensic lead providers. No actions. It was noted this meeting was the final one attended by SY and TB. Both were thanked for their positive contribution to the Committee and wished every success with their future endeavors.		

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
13	The next meeting date of the Committee	The Committee noted the next FIPC meeting will take place via MS Teams on Monday 23 August 2021.		

With **all of us** in mind.

**Minutes of the Mental Health Act Committee Meeting held
Virtually via Microsoft Teams on
11 May 2021**

Present:	Dr Subha Thiyagesh	Medical Director (lead Director)
	Kate Quail	Non-Executive Director (Chair)
	Carol Harris	Director of Operations
	Erfana Mahmood	Non-Executive Director

Apologies:	Members	
	Tim Breedon	Director of Nursing and Quality
	Attendees	
	Terry Hevicon-Nixon	Operations Manager - Working Age Mental Health (Calderdale) – local authority representative
	Gillian Pepper	Head of Safeguarding, Barnsley Hospital NHS FT
	April Ramsden	AMHP Team Leader (Kirklees) – local authority representative

In attendance:	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Julie Carr	Clinical Legislation Manager
	Andrea Dauris	Associate Director of Nursing (Corporate) (Calderdale & Huddersfield NHS FT)
	Alison Edwards	Head of Safeguarding (Calderdale & Huddersfield NHS FT)
	Marie Gibb	Named Nurse Safeguarding Adults (Mid Yorkshire Hospitals NHS Trust)
	Gary Haigh	Independent Associate Hospital Manager, Chair of the Hospital Manager Forum
	Yvonne French	Assistant Director, Legal Services
	Lisa Kelly	Mental Health Liaison Practitioner (item 2)
	Chris Lennox	Deputy Director of Operations
	Olivia Mason	Deputy AMHP Team Manager (Kirklees) – 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/21/16   Welcome, Introductions and Apologies (agenda item 1)
The Chair, Kate Quail (KQ) welcomed everyone to the meeting. The apologies, as above, were noted.

It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

There were no declarations of interest to record.

With **all of us** in mind.

MHAC/21/17 The Act in Practice (agenda item 2)

MHAC/21/17a Eating Disorders within Acute Hospitals (agenda item 2.1)

Presentation from Lisa Kelly (LK) on the treatment and management of people with eating disorders who are admitted to medical wards.

LK talked about the different types of eating disorders most commonly seen in Liaison psychiatry, the MARSIPAN guidelines which were written by a variety of eating disorder specialists after investigations into a number of preventable deaths, parameters which may indicate that a medical admission is needed and the Liaison psychiatry approach. LK also spoke about compulsory admission and treatment which is allowed under the Mental Health Act. LK went on to give a case study example.

LK offered to share the full MARSIPAN report and the local Calderdale and Kirklees pathway document and also advised that there is a 2 hour training package available if any teams would be interested.

Gary Haigh (GH) raised that this is one of the most difficult appeal areas for the Hospital Managers to deal with and sometimes staff on medical wards do not have the experience of dealing with appeals. GH indicated that it is excellent to hear that the Mental Health Liaison Team can provide training and support and LK was happy to be invited to a future Hospital Managers' Forum meeting.

Subha Thiyagesh (ST) thanked LK for her presentation and raised two queries. The first was whether the hub and spoke model was working well and whether there were any gaps, eg with the young people's pathway. LK indicated that there was a separate report for junior MARZIPAN and this would fall within the CAMHS service. LK went on to say that there may be a gap due to the sheer numbers of young people coming through the CAMHS eating disorder service and ST advised that this had been noted.

ST also asked about uptake of the service, particularly from the BAME and LD populations. LK advised that around ten years ago the service dealt predominantly with young white women, however that is no longer a typical presentation. Whilst there are few LD cases, the service is seeing older people, some admissions from the BAME community and two male MARZIPAN admissions this year which was unusual.

Marie Gibb (MG) queried whether there was a similar level of support to acute wards in Wakefield and LK advised that whilst the pathway working group covered Calderdale, Kirklees, Wakefield and Leeds, she was unsure of the specific arrangements for Wakefield.

MG gave some examples of the difficulties experienced on the Gastroenterology wards at Mid Yorks and indicated that expert input from people trained in eating disorders and support to the acute wards would be really beneficial.

Chris Lennox (CL) advised that there is no locally commissioned pathway in Wakefield and suggested that this could be further discussed with the Mental Health Alliance which includes a broad range of colleagues including commissioners. CL agreed to raise it there and update Committee.

Action: Chris Lennox

LK will share the documents as mentioned above.

Action: Lisa Kelly

KQ thanked LK for an excellent presentation and for the fantastic work of the team.

MHAC/21/18   Legal updates (agenda item 3)
MHAC/21/18a Reforming the MHA; the White Paper (agenda item 3.1)
Julie Carr (JC) advised that, as discussed at the last Committee meeting, the consultation had taken place and involved a wide range of Trust staff, partners and service users. We were able to submit a detailed response, taking a balanced view of opinions expressed during the consultation process, to 35 of the 36 questions, along with a high level report to the NHS Confederation. The government will now consider the responses and we await an update on what the bill will contain. Committee noted that there is no timeframe for this as yet.

KQ thanked JC for all the hard work that had gone into the consultation process and the submissions. It was noted that Committee had previously agreed that, given the deadline for submission, the executive trio could sign this off and that had happened.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/21/18b Briefing – Mental Capacity (Amendment) Act Liberty Protection Safeguards Implementation (agenda item 3.2)
JC reported some resurgence of the plans to implement Liberty Protection Safeguards (LPS).

JC advised that the Trust is working closely with Local Authority, CCG and Acute Trust colleagues via the Local Implementation Networks in preparation.

It was noted that the Trust will prepare and submit a response to the Code of Practice and Regulations and a consultation process, similar to that done for the White Paper, will be undertaken shortly. The Clinical Design Group are also aware of the requirement for a LPS module in SystmOne.

Yvonne French (YF) advised that we continue to work to the implementation date of April 2022 although it is not yet clear whether that will be feasible given the timescales the government are working to.

KQ acknowledged the short lead in time for implementation and the amount of work still do to, including training. Committee felt assured that the Trust is well placed to deliver this and YF will keep Carol Harris (CH) and the deputy directors updated.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/21/19   Updates from partners (agenda item 4)
MHAC/21/19a Local Authority and Acute Trusts (agenda item 4.1)
The following updates were noted:

Shirley Atkinson (SA) – Barnsley Council
➢ Still seeing a big increase in Mental Health Act assessments with a knock on increase in Tribunals. A lot of work for people involved in the processes.
➢ Struggling with bed availability which is causing some delays.
➢ Would help for AMHPs in Barnsley to have access to SystmOne. This is proving difficult to arrange although it would save time all round. KQ queried whether this is being resolved and SA advised that their head of service is liaising with Dave Ramsay. Stephen Thomas (STh) added that Wakefield have also been asking for access for a number of years and it would help a lot. SA gave an example of a

coroner's inquest where they had been asked if they had access to mental health systems which would have helped in that situation. CL advised that the issue was more to do with technical challenges rather than information governance and it should be possible to work towards a solution now. CL will check on progress and update.

Action: Chris Lennox

Stephen Thomas (STh) – Wakefield Council

➢ Out of hours AMHP team asked STh to raise that the Barnsley 136 suite is being closed more frequently now which puts a lot of pressure on the AMHPs and they are not clear what is available as an alternative. Between the start of December and the start of April, it has been unavailable out of hours on 14 occasions.

CL indicated that there had been particular problems with availability in Barnsley and the 136 suite was not always closed but sometimes we were not in a position to take admissions due to staffing levels which left us with no alternative but to divert them.

CL advised that James Waplington, General Manager was working to improve access to all three of our 136 suites and SWYPFT did appreciate the impact on the wider system. CL added that we are doing everything we can to mitigate the situation and have contingencies in place such as extra bank staff so that we can always facilitate admission. CL will ask James to give an update to the Wakefield and Barnsley systems and feed back to Committee.

Action: Chris Lennox

KQ thanked CL for the assurance to Committee.

Erfana Mahmood (EM) indicated that this illustrates the importance of having local authority colleagues at the table for Mental Health Act Committee (MHAC) although it was concerning to hear about this situation.

CL advised that the issue was on the local Risk Register. CH asked CL to also consider the organisational risk if we cannot provide access to 136 admissions and whether this should also be added to the organisational Risk Register.

Action: Chris Lennox

EM queried where people would be redirected to if they could not access the 136 suite in Barnsley. CL advised that we are part of the South Yorkshire system which includes Rotherham and Doncaster so we would not always default to using another SWYPFT suite. CH added that if there was no capacity in the rest of the system, we would look at doing something else/stop doing something in order to open the Barnsley suite so if the patient needed to go somewhere, they would go somewhere.

SA indicated that there had been discussion in a meeting this morning about the frequency of people being redirected to Rotherham and Doncaster and this was likely to be raised as an issue.

Marie Gibb (MG) – Mid Yorkshire Hospitals NHS Trust (MYHT)

KQ gave a summary of the feedback MG had sent through in advance of the meeting.
➢ Strong partnership working with SWYPFT.
➢ Interesting and innovative working with the Mental Health Champion and Mental Health Navigation work.
➢ No issues to raise.

MG added that Mid Yorks are currently looking at where the mental health agenda sits within the safeguarding portfolio and the operational divisional leads are on board.

Calderdale & Huddersfield NHS FT (CHFT)
KQ asked if there were any points to raise for CHFT.
> - CL advised that a lot of work had been in done in the last quarter around availability of mental health beds and there was nothing to flag from either CHFT or Mid Yorks.
> - KQ queried the position in relation to delays for eating disorder care and CL advised that this had not been a feature in the last quarter.
> - Alison Edwards (AE) advised that feedback at the safeguarding committee was that all eating disorder patients had been reviewed in terms of their mental health needs and the waiting times had reduced significantly.
> - AE also referred to good partnership working in SWYPFT and support with explanation of the Mental Health Act. KQ suggested liaising directly with YF to arrange learning sessions.

MHAC/21/19b Independent Hospital Managers Forum notes 13 April 2021 (agenda item 4.2)
The Committee received the notes of the Mental Health Act Managers' Forum meeting from 13 April 2021.

GH highlighted the following points:
> - Despite the pressures and problems caused by Covid, the relationships between the Mental Health Act officers and Hospital Managers were excellent.
> - Recently moved from using Skype to MS Teams. GH gave an example whereby an administrator had made multiple efforts to connect the Hospital Managers approximately an hour prior to a scheduled meeting and had eventually gone home to log in and facilitate a successful meeting. GH indicated that this showed great initiative and outstanding commitment.
> - There had been issues with the paper reviews with some poor reports and evidence of cutting and pasting, incorrect dates, etc which made it difficult for the managers to review. This had been flagged and was being addressed.
> - Planning for hearings to resume as face to face when restrictions allow.

MHAC/21/20 Minutes/Actions (agenda item 5)
MHAC/21/20a Minutes of previous meeting held on the 9 March 2021 (agenda item 5.1)

It was RESOLVED to APPROVE the notes of the meeting held on 9 March 2021 as a true and accurate record of the meeting.

Post meeting note: Andrea Dauris (AD) had subsequently asked for her title to be updated to correctly read Associate Director of Nursing (Corporate) for Calderdale & Huddersfield NHS FT.

MHAC/21/20b Action points (agenda item 5.2)
The action points were noted and the following items raised:

> - MHAC/21/05b – Action points – to convene a meeting to discuss reducing inequalities across the board. ST reported having an interesting and informative discussion on this including anything we can do quickly to understand the disparities or discrepancies. Dawn Pearson is to lead on work with service users to understand the different experiences of white and BAME patients.

In relation to service users' experiences of Tribunals, JC updated that following a meeting with governance leads, it had been agreed to join ward community meetings in June with three structured questions to facilitate discussion with the service user group as a collective and wards were supportive of this approach.

KQ highlighted the really good quality improvement (QI) approach being taken.

➢ MHAC/21/07a – Performance report – to work with Mike Garnham on coding of ethnicity on SystmOne and specifically the three actions as set out in the performance report. CL reported that there had been a meeting since the last MHAC with Mike and Roland Miller. The ethnicity codes have been reviewed and Mike has supplied teams with the list of service users whose records will need to be updated. Committee noted the positive work since the last meeting to improve ethnicity data.

➢ MHAC/21/10b – CQC MHA action plans – to pick up care planning on SystmOne with Karen Batty and consider a QI approach to improving care planning. YF advised that the quality improvement group have already developed a new care plan template and this has been implemented in services. An audit tool is being developed as part of the clinical record keeping work.

MHAC/21/21   Risk Registers (agenda item 6)
MHAC/21/21a Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.1)
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/21/21b Mental Health Act Committee risk register (agenda item 6.2)
YF gave an update:
➢ A risk had been added in relation to the Devon Judgement and potential litigation.
➢ The assessment of capacity risk overseen by the Trust NICE organisational steering group was almost reaching a conclusion. JC is working to get information from SystmOne and then the risk can be closed.
➢ In relation to the risk of inconsistent recording or practice relating to patients' rights and Section 17 leave, this will be picked up later in the agenda and it may be possible to close the risk.

MHAC/21/22   Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)
MHAC/21/22a Performance report – Monitoring information Trust wide January-March 2021 (agenda item 7.1)
The report was considered and CL noted the following:

➢ The latest NHS Benchmarking Report shows where we are in relation to admissions. There was an increase to 40.2% in 2018/19 from 37.9% the year before.
➢ 42% of all new admissions in Quarter 4 were under the Mental Health Act and this is an increase of 4% on Quarter 4 activity in 2019/20.
➢ There were 4 admissions to the Trust under the Mental Health Act of individuals aged under 18 in Quarter 4. This represents an increase.
➢ Wakefield had the highest number of internal transfers with 52 in total. The majority were returned to their home area.

- Of the 136 assessments carried out, 51% resulted in an admission to hospital which is an increase from Quarter 3.
- Addressing recording of protected characteristics is currently a Trust priority and the re-mapping of ethnic categories will help with this.
- Barnsley has a lower use of CTO
- Decrease in Hospital Manager appeals from Quarter 3 to Quarter 4.
- One concern was raised by the Hospital Managers in relation to quality of the information provided about the patient not being person centred.
- There are 4 exception reports to be noted from Quarter 4. Two related to SOAD requests and two to the use of old forms, which is being worked through.
- Covid has had an impact on the usual time scales for s.49 activity, as clinicians are limited by local restrictions. Court of Protection activity is now beginning to build.
- The Mental Health Act office are monitoring outstanding DoLS applications, relating to wards in Barnsley.
- There was one CQC notifiable death of a detained patient in Quarter 4 which is being investigated.
- The Trust remains compliant with MHA/MCA training although 'hot spot' areas have action plans in place.

JC advised that the performance report now includes information on conditional discharges. At the close of Quarter 4, a total of 62 patients under the care of the Trust were subject to a conditional discharge. There was one new conditional discharge and two recalls across the Trust in Quarter 4.

EM queried whether, given there was a relatively small number of Black & Black British people accessing services compared to Asian & Asian British but a much higher proportion of new admission and new section rates attributed to All Black Groups, were they coming to us when they were more unwell and therefore not being seen as early as other groups.

EM also wanted to understand more about the average length of stay on Section 3. CL indicated that there were no issues in relation to length of stay and the figures reflected the levels of need for services as well as community issues and challenges of pathways. CL added that there was a lot of good work in complex care and crisis management so if someone comes onto a ward then they really need to be there. There can also be complications around specialist placements.

GH raised that the number of appeals to Hospital Managers had reduced by 50% in 6 months and queried whether there was any correlation between this and a lack of clarity in relation to rights of appeal. JC indicated that there was no clear reason for the reduction in appeals and that whilst the CQC had raised an issue in relation to one or two individual patients, there was no suggestion that reiteration of rights was a concern. JC added that the piece of work to gather feedback from service users will ask them how easy it is to make an appeal and whether there is anything else we can do to support them to make an appeal.

Carly Thimm (CT) agreed with JC and indicated that Tribunal figures have also dropped slightly although not to the same extent as Hospital Managers' appeals. CT suggested that the work JC is doing could also explore why people may be choosing a Tribunal rather than Hospital Managers. YF went on to say that the next 132 audit may also give some feedback on why there has been a reduction.

KQ noted the improvement in ethnicity recording and thanked CL for the work and update on progress.

KQ referred to a drop in MHA/MCA training figures in some services and noted the additional training to be provided to address that. YF advised that a paper had been taken to OMG last week to update on all mandatory training, including MHA/MCA. The deputy directors and service managers are keen to support a return to full compliance.

KQ suggested that a focus for MHAC, CGCSC and Trust Board should be that a 14 year old was detained in a 136 suite due to the lack of a Tier 4 bed and whilst it was noted that this was not the ideal situation, it was the least worst option at the time. CH advised that the risk level on the Risk Register had increased as there were two cases involving 14 year olds and three young people detained at Wetherby and Adel Beck when a Tier 4 bed would have been more appropriate.

ST indicated that there was a huge level of focus and scrutiny both regionally and nationally on access to Tier 4 beds and the Royal College president was liaising with his counterparts in paediatrics and emergency medicine to try to address this.

AE agreed that there was a notable increase in young people on acute wards who require specialist placements and there is a lot of work going on in SWYPFT and paediatrics to support this.

KQ thanked colleagues for their assurances that this is being addressed at a local, regional and national level.

It was RESOLVED to RECEIVE and NOTE the contents of the monitoring report.

MHAC/21/23   CQC compliance actions (agenda item 8)
MHAC/21/23a MHA/MCA Code of Practice oversight group feedback (agenda item 8.1)
YF gave an update on the following workstreams:

➢ Section 17 leave will be picked up later in the agenda.

➢ Liberty Protection Safeguards had already been covered.

➢ Blanket restrictions – meeting next week to review the Blanket Restrictions policy. It was noted that this is in date although it has been agreed to review it at this point. No service users affected by blanket restrictions because of care but there are some blanket restrictions in place such as access to kettles, etc. The safeguarding team are liaising with services on a monthly basis to get an update on any restrictions and this is working well.

➢ CAMHS pathway and 136 place of safety – developing a Standard Operating Procedure for the use of 136 suites, specifically for under 18s. Committee noted that there is no age limit for use of the suites. Lengthy discussions around the referral process for Tier 4 beds.

➢ CQC feedback discussed and will feed back to clinical staff.

➢ Advocacy – met with Dawn Pearson and the patient experience team. Want to advertise the use of remote access and tablets. Plans to put together an information leaflet by the beginning of June advising what service users can do by virtual means if they cannot go out. The virtual visitor tablets are funded for the next 2 years.

- ➤ Section 135 – required when someone is detained and access to their property is needed. This has been done by the Local Authority for a number of years and we are now tasked with completing the paperwork and applying to the Court, however the Local Authority are still providing support. A draft process has been added to the intranet and will be signed off by next week.

EM queried the position with the 22 Tier 4 beds in Leeds. CH advised that work is progressing to open the new beds in December. CH added that some beds are currently closed across the system due to Covid although the system works well in relation to beds as well as preventing admissions and getting young people into placements. CH indicated feeling more optimistic although it is still very challenging.

It was RESOLVED to RECEIVE and NOTE the activity.

MHAC/21/24   Audit and Compliance Reports (agenda item 9)
MHAC/21/24a Section 17 leave - cancellation (agenda item 9.1)
JC reported that, following concerns being raised by patients during the CQC Mental Health Act visits that they have at times been unable to access their authorised Section 17 leave, a review was carried out for any patients whose leave is escorted. This was incorporated as routine in the matrons' sit rep and managed by services rather than the Mental Health Act office. A robust escalation process has been developed and issues can be dealt with close to source. It was identified that the highest levels of cancelled leave are in the Forensic service and there is a project underway to address staffing issues.

The recommendations are:

- ➤ Clinical services to continue their robust escalation process to give assurance that cancellation of leave is managed on a local level in a timely manner.
- ➤ Given the improvement and clear escalation routes, it is proposed that the current cancellation of Section 17 leave report be incorporated into the MHAC Performance report with any exceptions being noted and associated assurances provided.

KQ asked for an update to come back to Committee on the specific piece of work to appoint staff to the Forensic service and added that, apart from Forensics, there were a very small number of leaves cancelled and praise should be given to the staff facilitating this, particularly given the restrictions and pressures of the Covid 19 pandemic.

It was RESOLVED to RECEIVE the briefing, to AGREE the recommendations and to NOTE the next steps identified.

MHAC/21/24b Consent to Treatment (agenda item 9.2)
JC reported that an audit of completed T2 and T3 forms was carried out over a weekend in April of this year with a focus on the certificate of authorisation and prescribing within the scope of the medication authorised on the statutory T form.

The findings were that 91% of all certificates of authorisation were consistent with the copy held by the Mental Health Act office. Of the 9% where there was a discrepancy, these were dealt with and are all now compliant. 95% of all certificates of authorisation were consistent with the prescribed medication and all discrepancies have been rectified.

Committee noted the improvement against previous audits and the positive impact of a move to electronic prescribing. JC added that there has also been positive input from Pharmacy and nursing staff who have helped to improve compliance.

YF assured Committee that this was in response to the CQC wanting a more detailed process rather than any large scale issues being identified.

Next steps/recommendations:
> For the report to be accepted by MHA Committee as assurance of compliance with consistency of correct statutory T form in use and Prescribing being consistent with the authorised treatment.
> Given the improvement shown in the appropriate certificate of authorisation in use and the evidence of maintained high compliance rate for prescribing within the scope of the certificate of authorisation it is proposed that the current consent to treatment report be incorporated into the MHAC Performance Report with any exceptions being noted and associated assurances provided.
> In preparation for the resumption of CQC scrutiny of consent to treatment records and the identified themes raised by CQC it is proposed that a QI style approach be made to the following points;
  - Recorded evidence of contemporary assessment of capacity to support consent to treatment
  - Record of the RC providing feedback to the patient following SOAD review.

It was RESOLVED to RECEIVE the briefing and to APPROVE the recommendations identified under Next Steps.

MHAC/21/24c Section 17 Leave – Key Performance Indicator (agenda item 9.3)
JC referred to the QI approach taken in relation to completion of Section 17 leave forms which had proven to be very beneficial. Each ward has implemented a system whereby either the ward clerks or ward managers are monitoring completion of the Section 17 leave forms and this is overseen by the Matrons and Practice Governance Coaches. At a recent review of the Key Performance Indicators in the Trust-wide IPR, it was suggested that monitoring of this piece of work should move solely to the Mental Health Act Committee, with exceptions reported to Board as necessary.

Recommendations:
> The monitoring of the KPI is reflected in the quarterly compliance report.
> A threshold of 80% before scrutiny is set to allow for human error.
> The monitoring and compliance of the form is moved from Mental Health Act administration to the clinical services.

JC added that the 80% threshold would be at the point of scrutiny and it would be 100% at the point of sign off.

YF acknowledged the huge amount of extra work the Mental Health Act office had undertaken to improve compliance. YF added that if Committee agreed to the recommendations, this would make way for more QI work.

KQ asked Committee to note that this had been an issue for a number of years and the huge efforts of the Mental Health Act office, who had, in addition to their usual workload, reviewed 4,532 S17 forms this year, had significantly improved the situation.

KQ noted and praised the fantastic achievement in Forensics where their hard work has resulted in non-compliance reducing from 44% to 7% in a year.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/21/25   Care Quality Commission visits (agenda item 10)
MHAC/21/25a Visits and summary reports Quarter 4 including BDU actions from previous visits (agenda item 10.1)
JC advised that, as agreed at the last MHAC meeting, the BDU actions had been included in the summary report.

JC reported that there were 3 CQC Mental Health Act visits in Quarter 4 to Beamshaw, Beechdale and Ward 18.

The 3 action statements received in Quarter 4 gave rise to 22 actions, raised 10 concerns from service users and 5 from carers.

There was one outstanding issue from previous visits, being advance care planning. JC advised that there was a QI project underway to address this and all workshops for the project should be completed by the end of the month.

Committee considered the summary of actions across the Trust and it was noted that the total number of actions open at the end of March in Wakefield and Barnsley was 1 and not 12, which was an error. Of the three actions that were overdue, two would be addressed as part of the Trust wide project on care planning and one related to a Covid 19 cohort ward which was out of our control.

JC confirmed that all issues raised by service users and carers had been addressed.

It was RESOLVED to RECEIVE the update and NOTE the progress of the actions following CQC visits.

MHAC/21/26   Key Messages to Trust Board and other Committees (agenda item 11)
The key issues to report to Trust Board were agreed as:

  ➢ Act in Practice - Eating Disorders within Acute Hospitals
  ➢ Audit and compliance reports and progress on those
  ➢ CQC visits
  ➢ Improvement in ethnicity recording as shown in performance report

It was suggested that LK could be asked to join Trust Board to present on eating disorders.

No issues for other Committees were identified.

MHAC/21/27   Work programme (agenda item 12)
The Committee reviewed the work plan which will be updated prior to the next meeting.

MHAC/21/28   Date and time of next meeting
The next Committee meeting will be held on 17 August 2021 2.00pm to 4.30 pm via Microsoft Teams.

**Minutes of the Workforce and Remuneration Committee
held on 20 July 2021**

Present:	Sam Young	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Natalie McMillan	Non-Executive Director

In attendance:	Alan Davis	Director of HR, OD and Estates
	Mark Brooks	Interim Chief Executive
	Chiara DeBiase	Insight Programme Attendee at Trust Board Committee meetings
	Lindsay Jensen	Deputy Director of HR and OD
	Estelle Myers	Ambassador for Cultural Change Freedom to Speak up Guardian (in attendance for agenda item 9)
	Janice White	PA to Director of HR, OD and Estates (author)

WRC/21/52 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Sam Young (SY) welcomed everyone to the meeting.

It was noted that the meeting was quorate and could proceed.

WRC/21/53 Declaration of Interests (verbal item) (agenda item 2)
There were no declarations over and above those made in the annual return to the Trust Board in March 2021 or subsequently.

WRC/21/54 Minutes of the meetings held on:

- 16 March 2021 (attached)
- 18 May 2021 (attached)
- 29 June 2021 (attached)

The Committee confirmed that the above minutes were an accurate reflection.

The Committee RESOLVED to APPROVE the minutes of the meetings held on 16 March 2021, 18 May 2021 and 29 June 2021.

WRC/21/55 Matters arising (agenda item 4)

(a) *WRC/21/22 Review of workforce performance indicators during the pandemic– RIDDOR reporting in relation to Covid Infections*

AGD confirmed that the Executive Management Team (EMT) had discussed the RIDDOR reporting as agreed.

In terms of the vaccinations it was agreed to pick this issue up under the Workforce Performance Report item.

AGD said in relation to PPE guidance it was noted that following Silver Command being stood down now the Organisational Management Group (OMG) are keeping this under review reporting into EMT. It was also noted that there are arrangements for Silver to be stood back up at short notice if required. In terms of notification of any PPE breaches, NM agreed to check that it is noted and acknowledged that any breaches are notified through the Clinical Governance and Clinical Safety Committee.

The Committee agreed to close this action as it is picked up through OMG, EMT and CGCSC.

(b) **WRC/21/40 Off Payroll Staff Annual Report (agenda item 10)**

AGD said a report had been brought into a previous WRC meeting. MB confirmed that further information is in the Annual Report and Accounts and once this has been audited, he would bring a more detailed report back to this Committee on the individual Consultants who are off payroll later in the year. AM said she would like this to be an annual standing item to ensure it is kept under regular review.

The Committee agreed to close this on the action tracker and to keep as a standing annual agenda item on the Work Programme. AGD mentioned that this is on the Work Programme but the timing may need looking at following these comments and this can be discussed when discussing the Work Programme later on the agenda.
Action: AGD

(c) **WRC/21/42 Annual Work Programme 2021/2022 (agenda item 12)**

(i)   AM said that recruitment and retention is not explicit in the programme and this is normally discussed at the Committee. AGD said this would usually be part of the Integrated Workforce Performance Report. The Committee prior to the Covid-19 had agreed to re-look at the way the Integrated Performance Report was produced for the Committee and that this would resume hopefully for the meeting in July.

(ii)   AGD suggested that we use the July meeting to bring a prototype report so we could ensure it is developed to cover the key responsibilities of the Committee including recruitment and retention, bullying and harassment, middle management training and the Workforce Strategy.

In terms of actions (i) and (ii) above, AGD said due to the current Covid situation, normal reporting has not been able to be resumed for this meeting and it was agreed to keep these actions open.
Action: AGD

The Committee NOTED the actions from the previous meetings and COMMENTED as above.

WRC/21/56 Covid Workforce Performance Report (agenda item 5)

LJ introduced the Covid Workforce Performance Report to the Committee and highlighted the following:

- There is currently a daily increase in the number of Covid related staff absence which is consistent with the picture across other Acute and Mental Health Trusts. The biggest impact is in in-patient services, particularly Forensics, Wakefield and Learning Disabilities, however, non-Covid absences remain lower than those prior to Covid.

- Staff vaccine uptake figures shows the Trust has done really well on the first dose but lower on the second dose although it is believed that some of this is due to under reporting. Work is on-going to ensure that staff are reporting their second dose.

- The staff vaccination programme in the organisation has been stood down but there is still encouragement and support for staff who have not been vaccinated to have the vaccine and where they can obtain it.

AM asked about the changes around staffing having to isolate when they have been pinged and whether this would impact on staff absence. MB said that the new rules are not fully clear yet and we are doing work to understand what the exceptional circumstances are. MB said the detailed guidance is being reviewed as it comes out today but broadly a third of staff that are off with Covid related absence are self-isolating due to symptoms and they would not be covered by the change. LJ said on the face of it, it looks straight forward but there are exceptions and the general view is it will have a low impact.

AM asked about the classification change of BAME colleagues and the position on recording the second dose. LJ said in terms of the changes around the classification definitions, this was purely a technical issue due to national changes in the categorisation of different BAME groups, which meant we had to move people around, but the overall numbers stayed the same. LJ said she could get a further technical answer if required and share it around the Committee. LJ clarified that if a member of staff has their second vaccine in another healthcare setting then this is classed as external and they need to notify the Trust.

The Committee said it would be helpful to have further information on the changes around definitions.

Action: LJ

The Committee discussed the vaccination position in detail and noted that the Trust continues to communicate the benefits of the vaccine for Staff, their families and service users and is ensuring access to vaccination is still available. NM asked if we have any further information about the next steps. LJ said that we are now getting information about the booster vaccination as a phase 3 and the Trust has been asked to make preparation for these to possibly start from 6th September 2021 but we are still awaiting more detail. Alongside starting planning for a possible booster, the Trust is preparing for the Flu vaccination programme and this will mean added pressure.
The Committee noted the importance of the Flu Vaccination programme given the potential for flu to have a much greater impact this year compared to last.

SY asked in terms of the 632 people who haven't been vaccinated is there any pattern and have we continued to engage with them? LJ said there was no particular pattern and confirmed these members of staff have been written to and been offered further support.

AM asked if these members of staff have had one to ones with their manager. LJ said that the OMG had confirmed this had been done early on in the process.

The Committee NOTED and COMMENTED on the Staff Covid Vaccination Report.

WRC/21/57: Workforce Strategy 2021-2024 (agenda item 6)

AGD said that the Workforce Strategy is being developed into a digital document on the Trust' s intranet and presented what was currently on the intranet through MS Teams. The ambition is to continue to develop the intranet pages into a live and working document for all staff to use. The Committee felt that it was a good start and recognised that it is work in progress.

AM said the Workforce Strategy had been well received at Board.

(a) **Workforce Strategy Implementation Plan**

AGD said this item had been deferred from the previous meeting and is here to update the Committee on progress on implementing the agreed Workforce Strategy.

AM asked given the huge amount of change in terms of leadership of the organisation is there more we need to do on staff engagement and My Voice Counts at the present time. AGD said that the Great Place to Work Programme has a very strong focus on both wellbeing and staff engagement, and this is being piloted in quarter one with roll out starting in quarter 2. In addition, it was noted there has been increased engagement with Staff Side through weekly meetings, Staff Equality networks have continued to be engaged with, Chief Executive Huddles are carrying on, Mark and the Trio are continuing with safe service visiting. The HR directorate is continuing to use regular team meetings with services and working in in-patients to gain insight. AGD said one theme that has continued to come out is the importance of maintaining the commitment to the Trust's Values and Staff and Staff Side have felt reassured by the strong commitment on this.

AM also mentioned that it appears with the update of WorkPal that you can't report any problems direct to Thirsty Horses and asked how you report issues around the appraisal system. AGD said he would clarify this with Andrew Broadhead and report back

Action: AGD

AM asked given there was a lot of reference to trauma informed organisations was there any information on what a trauma informed organisation is. AGD said that a paper went to EMT on a Trauma informed organisation, and he would try and circulate that before the next meeting.

The Committee discussed the Performance Indicators for the Workforce Strategy and felt that some of the milestones could be clearer and have more detail. AGD recognised that there was further work to do on the key performance indicators but said they are designed to reflect progress on a range of key areas but has a strong focus on the 4 factors in the NHS Staff Survey which are common in Outstanding MH/LD/Community Trusts and these are:

- Staff Engagement
- Staff Wellbeing
- Immediate Managers
- Team Working

AGD said that achieving upper quartile performance across these 4 areas at the end of the Strategy is the key performance indicators in line with CQC outstanding Trusts. Other NHS Staff Survey areas the Trust is committed to achieving above average scores. It was agreed to bring back more detail of KPIs for the Workforce Strategy in November with milestones.

NM mentioned the KPIs, she said she couldn't get a sense of whether we were being bold or cautious. AGD said we want to be ambitious, we also want to focus on areas where we know we make a difference and this can be discussed further when the KPIs come back to the Committee for agreement in November.

SY mentioned that we have only had Covid reporting for quite some time now and need to have a good discussion around the whole Workforce agenda including the workforce strategy KPI's. SY also mentioned the importance of internal Comms for the Workforce and OD Strategies and FTSU. It was agreed as part of the review of the terms of reference to look to see whether we need to have a stronger internal comms remit coming into this Committee.

(b)   **Equality Impact Assessment (EIA): Workforce Strategy**

The Committee considered the Equality Impact Assessment (EIA) and noted that it used the Annual Workforce Equality Report as the basis of the assessment and actions.

AM said she supports this EIA. She mentioned that on number 9, "what monitoring arrangements are you implementing or already have in place etc". "A set of metrics and measures will be developed to support the delivery of the workforce strategy and making SWYPFT a great place to work", she wants to make sure that these reflect all the protected characteristics. It was agreed this could be picked up as part of the future workforce KPIs agenda items.

The Committee agreed the Workforce Strategy EIA.

(c)   **Annual Plan: Summary Workforce Plan**

The Committee discussed the workforce plan summary and recognised that a number of issues had been covered in earlier discussions. It was agreed that for the next meeting this report should focus on Recruitment and Retention.

Action AGD

The Committee NOTED and COMMENTED on the Workforce Strategy 2021-2024.

WRC/21/58: Organisational Development (OD) Strategy (agenda item 7)

LJ informed the Committee this an outline of our direction of travel for the new OD Strategy. The proposal is that the revised OD Strategy continues to use the 7S model as this is quite well embedded in the organisation. LJ said that there has been an initial piece of work that maps some of that work against the Great Place to Work themes in the Workforce Strategy and it also picks up some of the work that is coming out of the NHS People Plan. LJ said she would like to ask the Committee if they support the direction of travel and is it on the right lines.

The Committee supported the continued use of the 7S model as this was already embedded across the Trust and felt overall it was going in the right direction. There were some areas the Committee felt needed to be developed/considered further:

•   Communications will be key and needs to be more explicit.
•   Need to recognise the leadership challenges in the OD Strategy.
•   OD priorities felt like aims not actions.
•   Need to emphasise that the OD Strategy is not stand alone and links to the delivery of other organisational strategies.

LJ said in response she agrees with the comments and recognised the importance of the link to other strategies. The feedback from the Committee has been very helpful and LJ stated that these will help develop the strategy and the proposal is that a more detailed paper will come back to the September or November meeting.

Action: LJ

The Committee NOTED and COMMENTED on the Organisational Development Strategy.

WRC/21/59: Board succession Planning (agenda item 8)

AGD updated the Committee on the Chair's appointment and said the Job Description and Person Specification are being finalised by Gatenby Sanderson and will then go to the Lead Governor, the Deputy Lead Governor and one of the public Governors for them to sign off and then will be advertised either the end of this week or beginning of next week. Also Gatenby Sanderson have been engaged to support the possible Chief Executive recruitment process given the likelihood Rob Webster will to go to the ICS. AGD said the Interim Director of Finance, James Sabin commences on 11th August and Mandy Griffin's, appointment as a NED replacing Sam Young will go the Members Council on the 17th August for approval and she will commence on the 1st October 2021 if agreed.

The Committee NOTED the update.

WRC/21/60 Freedom to Speak up Guardian (FTSUG) Report and Action Plan (agenda item 9)

AGD said that it had been agreed that the FTSUG report would sit more appropriately with this Committee rather than the Clinical Governance, and an alteration to the Terms of Reference will need to be agreed at the next meeting. It was noted that the draft workplan does include the FTSU reporting arrangements.

Estelle Myers the lead FTSUG has been invited to this meeting to give an update on the report circulated with the agenda. SY said that Estelle could assume the Committee had read the report. EM asked the Committee if they had got any questions on the report.

The Committee felt that the report was very helpful, and it was useful to see the data.

AM asked as this has just moved over to this Committee if there is a strategic document around FTSU that gives the background. EM said that the Trust had approved a Freedom to Speak Up Strategy some time ago which she is now updating which will come back to this Committee later in the year before going to the Trust Board.

EM was asked how we benchmarked against other Trusts on the Freedom to Speak Up Index and also on numbers reporting issues to the FTSUG. EM said that we are slightly below average on the Freedom to Speak Up Index compared to other Trusts and said that in terms of numbers reporting this has gone up but remains low. It was agreed for the annual report it would be helpful to have further benchmarking information.

EM said that October was Freedom to Speak Up month and she has been planning with Communications a number of promotional activities and events to raise the FTSUG profile.

It was noted that Chris Jones in his role as Deputy Chair and Senior Independent Director has a link to EM and the other Guardians. It was agreed that in a future report it may be helpful to hear from Chris and the other Guardians on their experience.

AM also mentioned Equity Guardians and asked how they are going to relate to FTSU. AGD said that whilst there is some overlap the Equity Guardians have a distinct role of being a support and advocate to staff in a clinical settings suffering from bullying, harassment and abuse from Service Users and Carers. However, they are well connected with the lead FTSUG.

The Committee recognised that the Trust Board has an important role in demonstrating their commitment to a culture where staff feel, able, safe and free to speak up about concerns at work. EM felt it was important that all Board members complete the FTSU training, and this was supported by the Committee.

The updated FTSU Strategy being signed off and support by Board was seen as key to demonstrating the organisations is fully committed.

EM said that Internal Audit has been commissioned to review the Trust's approach to FTSU in order to support the development of the Strategy and an 18 months action plan. It was noted that the Internal Audit report will come to the WRC when it has been finalised.

The Committee thanked EM for her report and recognised that whilst there has been a lot of development there is still further work to do and it was looking forward to receiving the FTSU Strategy and action at a future meeting.

The Committee NOTED the report from the Freedom To Speak Up Guardians and SUPPORT the ongoing actions.

WRC/21/61 Clinical Excellence Awards (agenda item 10)

AGD updated the Committee on the national agreement between NHS Employers and the British Medical Association (BMA). NHS Employers and the BMA have reached an agreement on the Clinical Excellence Award process for 2021 in light of the current pandemic which is not to run the process but to give an equal share of the total awards to each eligible consultant. It was designed to enable clinicians and managers to focus on immediate priorities of responding to the pandemic. The existing funding (including any money rolled over from the last two years or from award rounds that may not yet have been run or completed) will be distributed equally among eligible consultants as a one-off, non-consolidated payment in place of normal Local Clinical Excellence Award rounds.

The Committee AGREED to RATIFY the payments of the clinical excellence awards in line with the agreement between NHS Employers and the BMA but would have preferred it to be a more equal distribution of resources.

The Committee NOTED the report.

WRC/21/63 Horizon Scanning (agenda item 12)

LJ updated the Committee that there has been some changes that have come from the Treasury around Settlement Agreements in the NHS and tightening up of the process.

LJ also wanted to update on the Flowers case that has been reported previously. This came out of the Employment Tribunal around looking at overtime in terms of ensuring that when overtime is paid it had an element of annual leave built in. All NHS Trusts were asked to pay this by September and we paid this last month.

The Committee NOTED the update.

WRC/21/64 Workforce Risk Register (agenda item 13)

AGD mentioned that we have had a few discussions on how we consolidate any risks and the best way to do this and asked the Committee for any comments.

SY said it would have been helpful if the ones that were closed referenced the ones that was going to be replacing them. AGD said he will make sure all the connections are referenced before the Board.

<div align="right">**Action: AGD**</div>

AM said we need to highlight to the Board that there have been some significant changes made at this meeting.

<div align="right">**Action: AGD**</div>

The Committee DISCUSSED and COMMENTED on the Workforce Risk Register

WRC/21/65 Draft Revised Annual Work Programme 2021/2022 (agenda item 14)

AGD said he had moved some dates around following discussions at the last meeting and also added the Freedom To Speak Up Guardian (FTSUG). Following discussion at today's meeting the review of the off-payroll may need changing to a different month.

SY asked if we could have a key to the colour codes.

AM asked if the meetings could go back to two hours but agreed to keep the frequency.

SY mentioned internal Comms potentially being something to bring to the Work Programme and this can be discussed further at the next meeting.

<div align="right">**Action: AGD**</div>

The Committee DISCUSSED and COMMENTED on the Annual Work Programme

WRC/21/65 Review of Terms of Reference (agenda item 15)

The Committee need to review FTSU coming into this Committee. Reflect change of membership from Rob to Mark. Look at internal communications piece and whether this Committee wants to take any role in that.

AM said to note that we are going to be one Non-Executive Director (NED) down and make sure the meeting is quorate. As long as AM and NM are present the meeting will be quorate. AGD said yes the Committee will be quorate with AM and NM but having a third NED would be helpful even if not a member of the Committee. He suggested asking Mike Ford as Chair of the Audit Committee as he is required to attend one meeting per year. Also the Committee will require a temporary Chair.

<div align="right">**Action: AM**</div>

WRC/21/66 Matters to report to the Trust Board and other Committees (agenda item 16)

The key points to report to Trust Board and other Committees are as follows:

- ➢ Freedom to Speak Up Guardians update:
  - Receive a report from the lead Freedom to Speak Up Guardian.
  - Recognised the importance of the Board in supporting a culture of feeling safe to speak up and all Directors were ask to undertake the FTSU training.
  - Discussed the low numbers in terms of reporting and the FTSU Index and agreed to undertake further work to understand the reasons staff reporting maybe low when compared to other organisations.
- ➢ Vaccinations – discussed vaccination levels and work to continue to increase uptake particularly in BAME colleagues, discussed potential COVID Booster and position on self-isolation for NHS Staff.
- ➢ Workforce Strategy – WRC discussed importance of staff engagement, internal communication and asked for strengthening around My Voice Counts area in terms of actions and in terms of the metrics.
- ➢ Horizon Scanning – New Treasury guidance for Trusts on settlement agreements relating to termination of employment and Flowers case.
- ➢ Risk Register – highlight significant proposed changes through WRC and Board to note the changes.

WRC/21/67 Any other Business (agenda item 17)
There was no any other business.

WRC/21/18 Date and Time of next meeting
The next meeting will be held on 21 September 2021 at 9.00am, Microsoft Teams Meeting.

Minutes of the Members' Council meeting held at 10.00am on 11 May 2021
Meeting Held Virtually by Microsoft Teams

Present:	Angela Monaghan (AM)	Chair
	Bill Barkworth (BB)	Public – Barnsley (Deputy Lead Governor)
	Bob Clayden (BC)	Public – Wakefield
	Jackie Craven (JC)	Public – Wakefield
	Claire Den Burger-Green	Public - Kirklees
	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
	John Laville (JL)	Public – Kirklees (Lead Governor)
	Cllr Steven Leigh (SL)	Appointed – Calderdale Council
	Cllr Ros Lund (RL)	Appointed – Wakefield Council
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Cllr Pauline McCarthy (PMc)	Appointed – Barnsley Council
	Helen Morgan	Staff – Allied Health Professionals
	Imran Mushtaq	Public - Kirklees
	Debbie Newton (DN)	Appointed – Mid Yorkshire Hospitals NHS Trust
	Cllr Mussarat Pervaiz (MP)	Appointed – Kirklees Council
	Beverley Powell	Public – Wakefield
	Tom Sheard (TS)	Public – Barnsley
	Phil Shire (PS)	Public – Calderdale
	Jeremy Smith (JS)	Public – Kirklees
	Keith Stuart-Clarke (KSC) (left at 11am)	Public – Barnsley
	Debs Teale (DT)	Staff – Nursing support
	Dr Abdul Nusair	Staff – Medicine and Pharmacy
	Nik Vlissides	Staff – Psychological Therapies
	Lisa Ward	Public - Kirklees
	Tony Wilkinson (TW)	Public – Calderdale
	Tony Wright (TWr)	Appointed – Staff Side organisations
In attendance:	Prof Marios Adamou (MA)	Consultant Psychiatrist (former staff governor)
	Adrian Deakin (AD)	General Manager, Forensic services (former staff governor)
	Rob Webster (RW)	Chief Executive
	Tim Breedon (TB)	Director of Nursing & Quality
	Mark Brooks (MB)	Director of Finance & Resources
	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates
	Carol Harris (CH)	Director of Operations
	Chris Jones (CJ)	Deputy Chair / Senior Independent Director
	Mike Ford (MF)	Non-Executive Director
	Natalie McMillan	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Sean Rayner	Director of Provider Development
	Salma Yasmeen	Director of Strategy
	Sam Young (SYo)	Non-Executive Director
	Csilla Fabian	Corporate Governance Manager
	Elaine Lovell	Corporate Governance Administrator
	Andy Lister (AL)	Head of Corporate Governance (Company Secretary) (author)
Apologies:	Members' Council	
	Dylan Degman (DDe)	Public – Wakefield
	Trevor Lake	Appointed – Barnsley Hospital NHS Foundation Trust
	Barry Tolchard (BT)	Appointed – University of Huddersfield

Attendees
Erfana Mahmood   Non- Executive Director
Dr Subha Thiyagesh   Medical Director

MC/21/10   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.

AM welcomed new governors Helen Morgan, Dr Abdul Nusair, Nik Vlissides, Claire Den Burger Green, Imran Mushtaq, Lisa Ward and Beverley Powell. AM also welcomed new Non-Executive Director Nat McMillan who had started with the Trust on 1 May 2021.

AM gave thanks to all those governors who had recently finished terms of office:
- Paul Batty – Staff – Social Care on Integrated Teams
- Lisa Hogarth – Staff – Allied Health Professionals
- Kate Amaral – Public - Wakefield
- Adrian Deakin – Staff – Nursing
- Prof Marios Adamou – Staff – Medicine and Pharmacy

Adrian Deakin and Marios Adamou had both served three full terms of office and were both present at the meeting. AM thanked them for their exceptional contributions over nine years and presented them with certificates of appreciation. She stated all governors will receive a certificate thanking them for all their work.

Action: Andy Lister

MC/21/11   Declarations of Interests (agenda item 2)

BARKWORTH, Bill Publicly elected - Barnsley	Director, Barkworth Associates Limited. Member – HealthWatch Barnsley
CLAYDEN, Bob Publicly elected - Wakefield	Chair, Portobello Community Craft and Camera Group. Occasionally contracted for sessions as freelance artist, this may be employed by groups funded or partially funded by SWYT Member of West Yorkshire & Harrogate Cancer Alliance Community Panel.
CRAVEN, Jackie *Publicly elected - Wakefield*	*Board member, Young Lives Consortium, Wakefield.* *Member, Alzheimer's' Society.* *Member, Versus Arthritis.* *Member, Dementia UK.* *Volunteer, HealthWatch, Wakefield.* *Volunteer Ambassador, Dementia UK.* *Parish Councillor, Crigglestone Parish Council.* *Trustee, Crigglestone Village Institute.* *Trustee, Hall Green Community Centre.* *Trustee, 45 Durkar Scouts.* *Trustee, Worrills Almshouses.*

DEGMAN, Dylan *Publicly elected - Wakefield*	*No interests declared.*
DEN BURGER-GREEN, Claire Publicly elected - Kirklees	Expert by Experience and part of the Inspectorate team employed by Choice Support which are contracted to the Care Quality Commission (CQC) to carry out inspections. This is carried out in a variety of settings including NHS services. Awareness Trainer (Volunteer), National Autistic Society Mystery shopper/ accessible venue consultant (volunteer), Attitude is Everything Active member of the support group, Ehlers Danlos UK Active member of the group, Kirklees Mental Health Carers Forum (KMHCF) –
DOOLER, Daz Publicly elected - Wakefield	Chair, S.M.a.S.H Society Community Group in Wakefield and the 5 Towns. Volunteer with SWYT Live Well Wakefield Advisor, employed by Nova Wakefield Seconded position through Nova, Live Well Wakefield and Barnsley Team, South West Yorkshire Partnership NHS Foundation Trust.
IRVING, Carol Publicly elected – Kirklees	Volunteer Ambassador, Dementia UK.
JACKSON, Tony Staff elected – Non-clinical support (services)	No interests declared.
JHUGROO, Adam Publicly elected - Calderdale	Bank registered at Calderdale and Huddersfield NHS Foundation Trust Medical care representative for Diabetes in the Specialist Driven Primary Care business unit for Napp Pharmaceuticals (full time basis) and cover South Yorkshire, which includes Barnsley. Daughter – works on the staff bank at SWYT
LAKE, Trevor *Appointed - Barnsley Hospital NHS Foundation Trust*	*Chair, Barnsley Hospital NHS Foundation Trust.* *Chair, Joint Independent Audit and Ethic Committee, West Yorkshire Police and Crime Commissioners and West Yorkshire Police Force.* *Director, Six Degrees Consultancy (non NHS work).* *Chair, Trustees of Barnsley Hospital Charity.*
LAVILLE, John *Publicly elected - Kirklees*	*Director and Shareholder, EMS (Hartshead) Ltd (dormant company).* *Member/Carer Representative, Kirklees Mental Health Partnership Board.* *Trustee and Chair, Popplewell Charity.* *Patient Representative North Kirklees Primary Care Commissioning Committee*
LEIGH, Steven *Appointed – Calderdale MBC*	*No interests declared.*

LUND, Ros *Appointed - Wakefield MDC*	*Wakefield MDC: Deputy Cabinet Member, Adults and Health* *Member of The Labour Party*
McCARTHY, Pauline *Appointed – Barnsley MBC*	*Director of Credit Union – Acres Food and Allied Workers Union*
McCOURT, Andrea Appointed – Calderdale and Huddersfield NHS Foundation Trust	Company Secretary, Calderdale and Huddersfield NHS Foundation Trust
MORGAN, Helen Staff elected – Allied Health Professionals	No interests declared.
MUSHTAQ, Imran *Publicly elected - Kirkles*	
NEWTON, Debbie *Appointed Governor for Mid Yorkshire Hospitals NHS Trust*	*Director of Community Services, Mid Yorkshire Hospitals NHS Trust.*
NUSAIR, Abdul *Staff elected – Medicine and Pharmacy*	
PERVAIZ, Mussarat Appointed – Kirklees MC	No interests declared.
POWELL, Beverley Publicly elected – Wakefield	Senior Advisor to National Direct Jacqueline Davies (full time), NHSE/I Provide informal Coaching/Mentoring to some SWYPT staff members (non-board or SLT level)
SHEARD, Tom *Publicly elected – Barnsley*	*Director and Company Secretary of Barnsley TUC Training Ltd.* *Member of 'Monk Bretton Cares' a voluntary group who organise and provide a Dementia Café in Monk Bretton once per week. This is in conjunction with BIADS Barnsley Dementia Support.* *Member and Chair of Patient Group at White Rose Medical Practice.*
SHIRE, Phil *Publicly elected - Calderdale*	*Director, Greenroyd Bowling Club Limited.* *Trustee and Director on the board of Impact Education Multi-Academy Trust.*
SMITH, Jeremy *Publicly elected - Kirklees*	*Director, Predictlaw Ltd.*
STUART-CLARKE, Keith *Publicly elected - Barnsley*	*Volunteer with West Yorkshire and Harrogate NHS trust CCG, in the post with their reduction of suicide project which is based at White rose house Wakefield*
TEALE, Debs Staff elected - Nursing support	Trustee in National Centre for Creative Health
TOLCHARD, Professor Barry Appointed - University of Huddersfield	No interests declared.
VLISSIDES, Nik Staff elected – Psychological therapies	No interests declared.
WARD, Lisa Publicly elected - Kirklees	Volunteer Facilitator, Richmond Fellowship Volunteer, Recovery College

WILKINSON, Tony Publicly elected - Calderdale	Trustee Board member Healthwatch Kirklees, covering Kirklees and Calderdale.
WRIGHT, Tony *Staff elected – staff side organisations*	*Non-executive director (Trustee) with Barnsley Civic Enterprises.*

Where no return has been received by the Trust, the current entry on the Register has been included in italics.

Past governors (who left in 2020/21)

Name	*Declaration*
ADAMOU, Marios *Staff elected - Medicine and Pharmacy*	*Director, Marios Adamou Ltd.* *Board member, UKAAN.* *Secondary Care Doctor member, NHS Northumberland Clinical Commissioning Group (CCG).*
AMARAL, Kate Publicly elected - Wakefield	No interests declared.
ARMER, Bill *Appointed - Kirklees Council*	*No interests declared.*
BATTY, Paul *Staff elected - Social care staff working in integrated teams*	*No interests declared.*
BECKLEY, Evelyn *Appointed - Staff side organisations*	*No interests declared.*
DEAKIN, Adrian *Staff elected - Nursing*	*No interests declared.*
HARRISON, Lin *Staff elected - Psychological therapies*	*Fulltime secondment as Suicide Prevention Project Manager for West Yorkshire and Harrogate Health and Care Partnership (WYHHCP).* *Member of the Labour party.* *Volunteer Co-ordinator for sub area of Crookes Mutual Aid Group (COVID-19 Community Support)* *I commission services for the ICS as Suicide Prevention Project Manager, for example the West Yorkshire and Harrogate Suicide Bereavement Service fulfilled by Leeds Mind.* *My wife is a Commissioning Manager for Sheffield CCG.*
HOGARTH, Lisa *Staff elected - Allied Healthcare Professionals*	*Member governor, Salendine Nook High School Huddersfield.* *Member of the Labour Party.*
MASON, Ruth *Appointed - Calderdale and Huddersfield NHS Foundation Trust*	*Member, Board of Directors, 'Mind the Gap' theatre company, Bradford, which employs actors with a learning disability.*
PILLAI, Chris *Appointed - Calderdale MBC*	*Independent Hospital Manager.*
SUMNER, Nicola *Appointed - Barnsley MBC*	*No interests declared.*

It was RESOLVED to NOTE the individual declarations from governors and to CONFIRM the changes to the Register of Interests.

MC/21/12   Minutes of the previous meeting and the joint Trust Board and Members' Council meetings held on 29 January 2021 (agenda item 3)

It was RESOLVED to APPROVE the Minutes of the Members' Council meeting held on 29 January 2021 as a true and accurate record.

MC/21/13   Matters arising from the previous meeting held on 29 January 2021 and action log (agenda item 4)

MC/21/04 – Discharge letter action to be closed for MC and become an item for Members' Council Quality Group for monitoring.

Action: Members' Council Quality Group

MC/21/04 – AM has had a follow up conversation with Sean Rayner (SR). Bob Clayden (BC) reported the position has moved on and the action can now be closed.

MC/21/07d – TB reported CAMHS data would be included in the performance presentation later today. Action closed.

MC/21/10 – Discussed the principle of having a Governors-only WhatsApp Group in the meeting prior to this one. The outcome is that the majority think it is a good idea to try with no obligation to join. JL to progress outside of the meeting. Action closed.

MC/20/25 – AL updated on current position regarding the recording of meetings and will update later in the year.

MC/20/26 – The setting up of the Intranet for Governors has not been able to progress due to pressure of the Covid pandemic, therefore it remains on the action log.

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

MC/21/14   Chair's report – to include feedback from the Trust board meeting held on 27 April 2021 (agenda item 5)

AM's report outlined activity of Chair and NEDs since last meeting and AM noted the following key items:
- The Trust Board Business and Risk meeting took place on 27 April 2021.
- Changes in the Corporate Governance team: Aimee Willett has left on a secondment to Wakefield CCG. Csilla Fabian has joined and introduced herself. Laura Arnold currently away from work – any governor queries to go to Andy Lister.

Tony Wright (TWr) queried if there was any Green Plan update?

AM reported in the March meeting the Board approved the Green Plan. Sustainability work continues and more engagement will take place on the development of a wider sustainability strategy, which incorporates the full engagement of our staff and service users.

We are also doing work with the West Yorkshire and Harrogate Integrated Care System on climate change, which includes more than carbon reduction.

Tony Wilkinson (TW) asked for an update on Rob's dual role.

AM gave background on Rob Webster's (RW) dual role and reported that Integrated Care Systems are going through significant change. Chief Executive (CEO) appointments to integrated care systems are subject to legislation and the appointment process is expected to start around July.

In the meantime, RW continues in the dual role of Lead executive for the ICS and Chief Executive of SWYPFT. The CEO appointment process will take place in all 42 ICSs across the country simultaneously, with the new statutory roles starting from April 2022.

In the meantime, the Board discusses and reviews Rob's dual role every meeting to ensure it continues to work in the way it should. The Board is satisfied that it is working well.

It was RESOLVED to NOTE the Chair's report.

MC/21/15   Chief Executive's comments on the operating context (agenda item 6)
RW reported:
- **Covid-19:**
  - Four tests at each stage of easing of lockdown dependant on success of vaccine, including breaking the link between infection, hospitalisation and death.
  - The Prime Minister is lifting restrictions as of next Monday.
  - Main concern in Europe is the "Kent" variant.
  - Variants of concern in the UK – Brazil, South Africa and India. India now a variant of concern.
  - Considering if variants can negotiate the vaccine/immune system, which may cause problems with the Government's strategy.
  - The current situation in India is difficult for our communities and our staff. Support is in place for staff who may be affected and RW's personal thoughts are with those affected.
  - West Yorkshire and South Yorkshire currently have infection rates around 50/100,000 on average. The national average is 0.1% but in West Yorkshire and South Yorkshire. It is 0.2%
  - Over 60's prevalence of Covid is lower due to double vaccination effect.
  - Lower prevalence is reflected in lower staff sickness. RW showed a slide demonstrating staff sickness over the last 12 months.
  - Normal staff sickness is lower than average and Covid-19 sickness is about 0.5% therefore there are more staff, though there is more demand. With many restrictions in place, delivery of care continues to be impacted.
  - Lateral flow testing continues to take place with front line staff, and effective use of PPE and vaccinations campaign.
  - RW showed slide of staff vaccinations: 87.4% vaccinated once, 76.2% vaccinated twice and 12.6% no vaccination. First and second doses continue.
  - Ethnicity of staff vaccinations: white nearly 90%, Indian 86%, Black Caribbean 58% and Black African 71%.
  - The vaccination campaign will be a true success when everyone who wants a vaccination has had one.
- Performance over 20/21 is good. We are in a reasonable place with a lot to do going into 21/22.
- Strategic priorities going forward led by Carol Harris (CH) and Salma Yasmeen (SY) and linked to the digital agenda. Covid-19 has exacerbated inequalities.
- Income impact of Covid: By age and by ethnicity (MORI polling): People over 65 are more financially stable. 23% state they are better off and 19% say they are worse off. 45% of working age (ages 35-44) say they are worse off because of the pandemic. Ethnic minorities: 46% say they are worse off and only 33% of white people say they are worse off.
- We will continue to look at these factors (ethnicity, depravation and age) and not just by looking at averages.

AM noted comments in the chat on MS Teams.

TB reported he believed the India variant included Pakistan.

RW reported some staff are not having the vaccine due to personal fears and concerns. The Trust approach is to raise confidence in the vaccine. The age and gender profile shows fewer young women having the vaccine, which may be due to fears about fertility. Some Black and Asian staff have different views dependant on their different heritage.

We have been working with BAME network through the West Yorkshire and Harrogate Health Care Partnership, (renamed the Race and Equality Network) and staff are talking about issues and concerns. Some staff have subsequently changed their mind and had the vaccine.

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

MC/21/16   Members' Council Business Items (agenda item 7)
MC/21/16a   Re-appointment of Non-Executive Director (agenda item 7.1)
All directors left the meeting with the exception of AGD. John Laville (JL) introduced the item and asked for the paper to be taken as read:
- JL reported there is a tried and tested re-appointment process. Nominations' Committee have recommended to the Members' Council to approve Erfana Mahmood (EM) as a Non-Executive Director for a second three-year term from 03/08/21 – 02/08/24.
- JL explained the Members' Council can reappoint a NED as long as the chair guarantees that the NED has performed effectively and remains committed to the role. AM has assured the Members' Council that EM is doing a great job.
- AM confirmed EM remains committed and effective.

It was RESOLVED to SUPPORT the recommendation from the Nominations' Committee to reappoint Erfana Mahmood as Non-Executive Director for a second three-year term from 3 August 2021 to 2 August 2024.

All directors returned to the meeting.

MC/21/16b   Governor Engagement Feedback (agenda item 7.2)
JL gave a slide presentation.
- Feedback process we have been developing over the past few months
- Developing governor feedback is part of the Equality, Involvement, Communication and Membership strategy action plan.
- Governors are here to support members and signpost to where they can get a good answer.
- To reassure any group or individual that their input will be fed back to the Trust and capture that information clearly.
- If people need independent support, we can refer them to Healthwatch.
- It is planned to have a 'You Said, We Did' section on the Trust website.
- The process for feeding in an individual concern is via Customer Services, which can then be added to Datix to capture the type of information from different areas across the Trust. This gives the opportunity to review the process and change or modify the process if required.
- If an individual has concerns and is not comfortable with the Trust's response, they can be directed to Healthwatch for advocacy.
- Data is captured: new group, captured as per the data form. If information is limited, this can be emailed in. All emails/information/forms need to be sent to InvolvingPeople@swyt.nhs.uk.
- Reporting: The Communications Team are to produce a quarterly Insight report, into which all feedback will go. Quarterly: 1 June, Sept. etc. Reports will be shared with Governors. The report will go to the Equality, Involvement and Inclusion Sub-Committee, onto the

executive management team and the Equality, Inclusion and Involvement Committee will receive a report on the final recommendations, ending in the 'You Said, We Did'.

- A new leaflet for Improving Access to Psychological Therapies (IAPT) has been designed.
- Platform 1 – a men's mental health support group in Huddersfield have had a great increase in referrals and report that other organisations are contacting them, though not giving support.
- A Halifax group, Calderdale Carers' Project, have increased their use of digital platforms to keep their group going.
-

11.00 Keith Stuart-Clarke left the meeting

RW noted "The Choose Well guide", produced by the Trust, could be used well for this engagement. AM suggested to include this in the induction pack.

Action: Andy Lister

TWr introduced the Staff side:

Staff side acts as a critical friend in the Trust, being a friend to our staff and the Trust. Staff side also serve the needs of service users, families and carers. Members take part in strategic high-level meetings. There are also leads for key areas such as equality, health and safety and sustainability.

SWYPFT is well known for partnership working with Staff side. The fact Staff side are present at induction meetings is a very positive thing.

The meetings and processes Staff side are involved in on behalf of our members and wider staff groups include extended EMT, Employment Policy Group, Organisational Change and more.

Regionally Staff side attend partnership meetings for South Yorkshire and West Yorkshire ICS organisations.

The Staff side role has been developed further in the response to Covid-19 – working with Alan Davis (AGD) in weekly meetings, giving a chance to keep up with things as policy changes within hours. We are engaged in silver command. Staff side play their part in Recovery and Restoration, including in risk assessments.

With regard to the resolution process, previously disciplinary processes, Staff side are looking at a different way of doing things, as a learning process.

Bullying and harassment processes are under review in order to support members, not just reviewing bullying and harassment, but preventing it.

The partnership agreement process is being refreshed.

Staff side are passionate about being involved with the work around sustainability and feel this is changing culture.

There are 8 recognised unions in the Trust. Consideration has been given to ensure there is at least one union for every staff group.

AM explained Staff side is an appointed governor role.

It was RESOLVED to RECEIVE the governor engagement feedback.

MC/21/16c   Governor Training and Development (agenda item 7.3)

Bill Barkworth (BB) introduced the item:

BB reported recently reviewed objectives are supporting governors to be more effective in their roles. More structure and clarity are needed around a training and development plan.

Suggested program of development is a tiered approach:

Level 1 - first year of a governor's term of office – areas governors would benefit from by way of training. E.g. provide specific information regarding SWYPFT. Engagement with the public. Effective questioning and challenging. Quality Monitoring visits around the Trust.
Level 2 - second year – More specific/specialist e.g. Finance, Performance and Accountability.
Level 3 - third year – Training good to have though not as essential as during first year.

Sessions are complementary to the Chair's induction and not mandatory. There is a need for a mix of training both from Governwell (governor training run by NHS Providers), and/or other external trainers and internal trainers.

BC queried the cost implications of training and whether the finances would restrict attendance.

RW reported cost is not a barrier this year. It is hoped to prioritise this work in the next six months.

RW thanked BB for his comprehensive work and encourages everyone to take up training opportunities if they can.

It was RESOLVED to RECEIVE the update on the training and ENDORSE the development plan.

MC/21/16d   Assurance from Members' Council Groups and Nominations' Committee (agenda item 7.4):

AM explained the breakdown of the different groups that sit underneath the Members' Council.

BC asked about the Members' Council Quality Group. Phil Shire (PS) is worried about the amount of time to look at IPR report and asked if this has been resolved?

PS reported people are reading it well and there is a good level of engagement. The work programme of MCQG has been reviewed so that we can focus on items of concern. Governors are urged to attend meetings if they wish as they will find it useful.

Action to notify new governors about sub meetings of the Members' Council.
Action: Laura Arnold

The Members Council is asked to RECEIVE the assurance and minutes from the Members' Council Co-ordination Group, Members' Council Quality Group and Nominations' Committee.

MC/21/16di   Members' Council Coordination Group annual report 2020/21 including update to the Terms of Reference (agenda item 7.4.1):

It was RESOLVED to RECEIVE the annual report for 2020/21 and APPROVE the updated Terms of Reference for the Members' Council Co-ordination Group

MC/21/16dii   Members' Council Quality Group annual report 2020/21 including update to the Terms of Reference (agenda item 7.4.2):

It was RESOLVED to RECEIVE the annual report for 2020/21 and APPROVE the updated Terms of Reference for the Members' Council Quality Group

MC/21/16diii   Nominations' Committee annual report 2020/21 including update to the Terms of Reference (agenda item 7.4.3):

It was RESOLVED to RECEIVE the annual report for 2020/21 and APPROVE the updated Terms of Reference for the Nominations' Committee.

MC/21/16e   Members Council Elections Outcome (agenda item 7.5)

AL introduced the item and updated governors on the outcome of the elections earlier this year:

Vacancies before the election and numbers of nominations for each constituency:
- Public Kirklees: 3 seats, 4 nominations
- Public Wakefield: 2 seats, 3 nominations
- Public Rest of Yorkshire and the Humber: 1 seat, 0 nominations
- Staff Allied Health Professionals: 1 seat, 1 nomination
- Staff Medicine and Pharmacy: 1 seat, 1 nomination
- Staff Nursing: 1 seat, 0 nominations
- Staff Psychological Therapies: 1 seat, 1 nomination
- Staff Social Care and Integrated Teams: 1 seat, 0 nomination

Following the elections, there are still three vacancies: 1 – Rest of Yorkshire and the Humber, 1 – Staff Nursing and 1 – Staff Social Care and Integrated Teams.

BC noted there had been more postal votes than digital and should we involve our members more by post. AL agreed to review this proposition during the next round of elections. RW pointed out the work taking place around digital inclusion that Dawn Pearson (DP) was involved in and AL should link with DP around this.

Action: Andy Lister

It was RESOLVED to RECEIVE the update.

MC/21/16f   Review of Audit Committee terms of reference (agenda item 7.6)

MF, chair of the audit committee, introduced the brief changes and noted that Deloitte, our external auditors, have approved the terms of reference.

It was RESOLVED to NOTE the updates to the Terms of Reference for the Audit Committee.

MC/21/16g   Updated Scheme of Delegation (agenda item 7.7)

AM noted BC's comments in relation to the Scheme of Delegation and asked MB to introduce the item.

MB explained the purpose of the scheme of delegation and where changes were in relation to partnership working and provider collaboratives.

BC queried whether the aspects of standing orders were things that had to be undertaken.

MB reported the committees are expected to carry out delegated tasks each year. MB described the committee effectiveness process.

BC agreed to contact AM, AL and MB in relation to a potential issue around standing orders.

ACTION: Bob Clayden

It was RESOLVED to APPROVE the updates to the Scheme of Delegation as set out in the paper.

<u>MC/21/16h   Update Members' Council Declaration of Interests Policy (agenda item 7.8)</u>

MB reported the policy is based on an existing policy used in previous years, and there were minor changes only e.g. job titles and cosmetic changes.

It was RESOLVED to APPROVE the revised Members' Council Declaration of Interests Policy.

MC/21/17   Trust Performance (agenda item 8)
<u>MC/21/17a   Trust Performance Update Q4 (agenda item 8.1)</u>

Mike Ford introduced the item:

<u>Summary of performance metrics for Quarter 4</u>
- Impressive set of metrics given the context of the year the Trust has been through. The Trust continues to meet the majority of its performance metrics and makes improvements in certain areas.
- Single Oversight Framework is Care Quality Commission (CQC) linked. The rating of 2 means the Trust only needs targeted support to help it meet the CQC's ratings, which is positive.
- Children and Young People in adult patient wards has a low threshold (zero) to try to avoid the situation. There were three young people who had spent a total of 6 days in an adult ward during Q4.
- Use of out of area beds has declined and is at its lowest in Quarter 4.
- Good to see we still receive compliments.
- Confidentiality breaches - no cases resulted in ICO referral, which is positive.
- MB confirmed who sets the threshold figures. Some are regional, some national and some internal. Targets could be identified by colour coding.

Action: Mark Brooks

- IAPT at 50% is an agreed national target.
- Good performance by Trust in finance.
- Non Covid-19 sickness is at a historical low and staff turnover at an acceptable level.

<u>Covid-19 Response Metrics</u>
- Staff sickness decreasing.
- Increase in staff testing.
- Use of MS Teams for video consultations.
- Positive outcome on staff vaccinations, while monitoring discrepancies around ethnicity to ensure no one left out.
- In control of PPE demand and supply.
- Command structure continues to operate.

<u>Patient experience</u>
- Positive responses and good levels of response being maintained.

<u>Safer staffing</u>
- TB explained the context of the Safecare pilot. This is a review of planned staffing establishment figures, reporting and recording staff needs for each day. It is a new way of reporting and recording our staffing against actual need. The results will give a better understanding of what we think we need and how well we are doing in filling those requests.
- Tony Jackson (TJ) asked for a breakdown of registered staff - what percentage is agency? TB will provide to TJ outside of the meeting direct.

Action: Tim Breedon

<u>Incident reporting</u>
- TB updated governors on how incidents are recorded on the Datix system. Large incidents are investigated through Root Cause Analysis to gain any learning if appropriate.
- Trends are reviewed over the year and we are within acceptable parameters, but we have increased self-harm levels and we are monitoring these, as we are also doing with our apparent suicides.
- Although a quarterly report, we also produce an annual report that looks at trends over the past two or three years. An annual report is going to board in the next few months.
- TB confirmed all protected characteristics are looked at in the incident review.

<u>NHS Improvement</u>
- Targets are set by NHS Improvement.
- The six-week wait target for diagnostic procedures has not been met, having been affected by Covid-19. Significant progress has been made to get this back on target.
- MB added this relates to one service only. The requirement to achieve that threshold has been paused during the pandemic. It is still measured as an important metric.

<u>Workforce</u>
- Non-Covid sickness is at an historically low level.
- Stress and anxiety is the largest single reason for non-Covid-19 absence.
- Strong performance on the vaccine.
- Compliance with mandatory training has been good given the year.
- Staff turnover rates are 10% lower than last year with a lot of support being put in place.

AGD reported that peer support workers will be in the detail of the workforce plan included in the workforce strategy.

<u>Making SWYPFT a great place to work</u>
AGD highlighted key points from the slides and gave context to the following areas of which staff have identified as being the essentials for making SWYPFT a great place to work:
- Feeling Safe
- Supportive Teams
- Keeping Fit and Well
- Developing Potential
- My Voice Counts

These have all been developed into pledges and are being implemented.

The strategy is being developed digitally so that staff can see the live document, which will be continually updated.

JL reported the workforce strategy is first rate but noted bullying and harassment figures from the Integrated Performance Report are 1 in January, 1 in February and 0 in March. However, the BAME network report 40% of staff being bullied and harassed.

AGD reported the figures may need splitting for accuracy due to some of the figures relating to bullying and harassment by service users. There is a commitment and lots of work to do over the next three years to improve and learn what needs doing to support staff and prevent bullying and harassment.

AGD reported Freedom to Speak Up Guardians have a network with an appointed lead. There are representatives from the all the staff equality networks. Civility and respect guardians are currently being appointed and the equality networks are involved in these appointments to ensure diversity. Staff side are also involved. We are looking to create a network with many channels where people are comfortable to report issues.

AM asked if governors can be informed as to who the Freedom to Speak Up Guardians are. The lead guardian is Estelle Myers and there are a number of others.

Action: Csilla Fabian

Financial Performance
- Last year was an unusual year for NHS finance as it did not have the normal contracts in place.
- The Government reacted to Covid-19 and in the first six months of the year we were enabled to break even by being given block income.
- In the second half of the year we were given fixed income and targets to meet.
- We were given the targets late August early September, when Covid-19 was at a low level.
- Since then, Covid-19 has been more prevalent, and we could not spend as much money as we thought we could.
- We were given more national support towards the end of year, with funding attached.
- Ultimately, we received more money than we spent, which is not typical of normal years.
- Lockdown had a significant impact on capital spend due to the restrictions of companies attending site.
- We now have a similar financial arrangement for the first six months of 21/22 and expect to return to normality in terms of individual contracts with commissioners and different targets to meet within the second part of this year.

MB reported the Trust did not have to give any surplus back. This will be used for capital expenditure.

It was RESOLVED to RECEIVE the update on Trust Performance.

MC/21/17b   Care Quality Commission (CQC) action plan update and update on our inspection annual report unannounced/planned visits (agenda item 8.2)
TB reported:
- TB gave context the CQC and what their role is.
- TB reported the table displayed shows the summary findings.
- There was an overall rating of GOOD.
- The action plan is created to respond to areas for improvement.
- 12 "must dos" and 37 "should dos" were put into an action plan.
- TB summarised the key themes from the feedback.
- TB reported against the improvement plan.
- TB then presented the governance framework and summarised progress against the plan and position at April 2021.
- Actions on risk assessment planning and psychology provision on older people's wards are ongoing.
- Reports are still going into Clinical Governance and Clinical Safety committee so that progress is not lost.
- The CQC are fully appraised of our progress against the plan.
- The Quality Monitoring Visits programme is being developed for 21/22 following the pandemic.
- Virtual visits pilots have taken place in March and April and now looking at how safety can be reported.
- The Members' Council Quality Group take a regular report against the Quality Monitoring Visits.
- The next scheduled visits are September 21 – March 22.

TB confirmed the overall rating for Trust is Requires Improvement for Safety, and Good for the Effective, Caring, Responsive, and Well Led domains. There are various different scores against different services.

It was RESOLVED to RECEIVE the update on the Care Quality Commission action plan.

MC/21/18   Closing remarks, work programme, and future meeting dates (agenda item 9)

AM explained the context of the workplan and its purpose. Every quarter we write to governors asking what they want on the agenda. The Members' Council Coordination Group will then determine what agenda will be.

BC asked if there had been any progress on making some items biennial rather than annual?

Bill Barkworth confirmed going to the next MCCG on 21 June 21.

AM reported the next meeting of the Members' Council is the 17 August 2021.

The next item is the Chair's Appraisal, which takes place in private session. All directors except AGD and CJ will leave the meeting and JL will take the chair. The item will be led by Chris Jones, deputy chair and senior independent director.

It was RESOLVED to NOTE the work programme for 2021/22.

Signed: **Date:17.08.21**

![NHS South West Yorkshire Partnership NHS Foundation Trust]

Trust Board 28 September 2021
Agenda item 13

Title:	**Use of Trust Seal**
Paper prepared by:	Company Secretary on behalf of the Interim 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 and Resources 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 been used three times since the report to Trust Board in June 2021.
	• Deed of surrender for the Keresforth Centre, Barnsley. The Keresforth Centre was deemed surplus to requirements for the Trust in January 2015 and contacts are exchanged for the sale of the site for a new academy school set to open in September 2023.
	• Deed of variation and early works licence for the Keresforth Centre, Barnsley. The purchaser wishes to demolish buildings on site in advance of completion of the sale. - In order to allow this work to go ahead a licence is required in advance of the sale and the sale contract requires variation. The cost of the demolition will be funded by the purchaser and subtracted for the gross sale price in line with normal practice
	• The lease of Unit 9, Agbrigg and Belle Vue Community Centre, Montague Street, Wakefield. - This is to renew the lease for

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	occupation at the above community centre by the Health Integration team providing TB services to Wakefield.
Recommendation:	**Trust Board is asked to NOTE use of the Trust Seal since the last report in June 2021.**
Private session:	Not applicable.

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	✖		✖	✖		✖	✖	✖		✖		✖

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	Item												
■■	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			✖									

Trust Board work programme 2021/22

Patient Experience annual report			✖			✖									
Serious incidents annual report			✖												
Equality and diversity annual report							✖								
Medical appraisal / revalidation annual report						✖									
Sustainability annual report						✖	✖								
Workforce Equality Standards						✖	<mark>✖</mark>								
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)											✖				

Trust Board work programme 2021/22

		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))*

(Draft) 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

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												
Welcome, Introduction and Apologies	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Declarations of Interest	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Minutes from the previous meeting	✖		✖	✖		✖	✖	✖		✖		✖
Action log and matters arising from previous meeting	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Service User/Staff Member/Carer Story	✖		✖	✖		✖	✖	✖		✖		✖
Chair's remarks	✖		✖	✖		✖	✖	✖		✖		✖

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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
Chief Executive's Report	✖		✖	✖		✖	✖	✖		✖		✖
Questions from the public	✖		✖	✖		✖	✖	✖		✖		✖
Risk and Assurance												
Board Assurance Framework	✖			✖			✖			✖		
Corporate / organisational risk register	✖			✖			✖			✖		
Strategic overview of business and associated risk									✖			
Review of Risk Appetite statement							✖					
Serious Incident investigations update (private session)	✖		✖	✖		✖	✖	✖		✖		✖
Serious Incidents quarterly report (public)			✖			✖		✖				✖
Safer Staffing report	✖						✖					
Risk assessment of performance targets, CQUINS and System Oversight Framework and agreement of KPIs	✖						?					
Business Developments and Collaborative Working												
Integrated Care System developments	✖		✖	✖		✖	✖	✖		✖		✖
South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	✖		✖	✖		✖	✖	✖		✖		✖
West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	✖		✖	✖		✖	✖	✖		✖		✖
Receipt of Partnership Board minutes	✖		✖	✖		✖	✖	✖		✖		✖

Trust Board work programme 2021/22

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
Performance reports												
Integrated Performance Report (IPR)	✖		✖	✖		✖	✖	✖		✖		✖
Strategic Direction												
Board Development		✖			✖				✖		✖	
Covid-19 Reflections NEW		✖			✖				✖		✖	
Horizon Scanning – Focus On NEW		✖			✖				✖		✖	
Investment Appraisal Framework (private)							✖					
Strategic Objectives												✖
Trust Board Annual Work Programme											✖ (draft)	✖
Operational Plan (private)										✖ (draft / private)	✖ (draft / private)	✖ (draft / private)
Five-year plan (for review November 2023)												
Governance (further work required on this section)												
Constitution (including Standing Orders) and Scheme of Delegation *(January 2020) (deferred to June 2021)*						✖						
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✖		✖									
Assessment against NHS Constitution				✖				✖				
Audit Committee annual report including committee annual reports and terms of reference	✖											
Assurance from Trust Board committees and Members' Council	✖		✖	✖		✖	✖	✖		✖		✖
Guardian of safe working hours annual report	✖											
Workforce Equality Standards						✖						

Trust Board work programme 2021/22

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Medical appraisal / revalidation annual report						✘						
Data Security and Protection toolkit	✘											
Use of Trust Seal			✘			✘		✘				✘
Annual report and accounts		✘										
Annual Governance Statement	✘											
Equality and diversity annual report							✘					
Serious incidents annual report			✘									
Health and safety annual report			✘									
Patient Experience annual report			✘			✘						
Sustainability annual report						✘						
Premises Assurance Model			✘									
Strategies and Policies												
Digital strategy (including IMT) **update**							✘					
Estates strategy **update**				✘						✘		
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)*				✘								
Workforce strategy *(March 2020)*	✘											

Trust Board work programme 2021/22

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
Quality strategy *(September 2021)*						✗						

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