NHS
South West Yorkshire Partnership
NHS Foundation Trust

# Trust Board (business and risk)
# Tuesday 24 April 2018 at 9.30am
# Boardroom, Conference Centre, Kendray Hospital, Doncaster Road, Barnsley S70 3RD

## AGENDA

| Item | Approx. Time | Agenda item | Presented by | | Time allotted (mins) | Action |
|---|---|---|---|---|---|---|
| **1.** | 9.30 | **Welcome, introductions and apologies** | Chair | **Verbal item** | | To receive |
| **2.** | | **Declarations of interest** | Chair | **Verbal item** | | To receive |
| **3.** | | **Minutes and matters arising from previous Trust Board meeting held 27 March 2018** | Chair | **Paper** | 10 | To approve |
| **4.** | 9.40 | **Service User Story** | District Director Barnsley and Wakefield | **Verbal item** | 5 | To receive |
| **5.** | 9.45 | **Chair and Chief Executive's remarks** | Chair<br>Chief Executive | **Verbal item and paper** | 10 | To receive |
| **6.** | 9.55 | **Risk and assurance** | | | | |
| | | 6.1 Strategic overview of business and associated risks | Director of Strategy | **Paper** | 5 | To receive |
| | | 6.2 Assurance framework | Director of Finance & Resource | **Paper** | 10 | To receive |
| | | 6.3 Corporate / organisational risk register | Director of Finance & Resource | **Paper** | 10 | To receive |

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|---|---|---|---|---|---|---|
| | | 6.4 Review of Risk Appetite Statement | Director of Finance & Resource | **Paper** | 5 | To approve |
| **7.** | 10.25 | **Business developments** | | | | |
| | | 7.1 South Yorkshire and Bassetlaw Shadow Integrated Care System update | Director of Strategy | **Paper** | 10 | To receive |
| | | 7.2 West Yorkshire and Harrogate Health and Care Partnership update | Director of Strategy | **Verbal item** | 10 | To receive |
| **8.** | 10.45 | **Performance reports** | | | | |
| | | 8.1 Integrated performance report month 12 2017/18 | Director of Finance & Resource and Director of Nursing & Quality | **Paper** | 20 | To receive |
| | | 8.2 Customer services report Q4 2017/18 | Director of Nursing & Quality | **Paper** | 10 | To receive |
| | | 8.3 Safer staffing report | Director of Nursing & Quality | **Paper** | 10 | To receive |
| | *11.25* | *Break* | | | *10* | |

| Item | Approx. Time | Agenda item | Presented by | | Time allotted (mins) | Action |
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| **9.** | 11.35 | **Strategies** | | | | |
| | | 9.1 Digital Strategy - progress update | Director of Finance & Resource and Director of Marketing, Communication & Engagement | **Paper** | 10 | To receive |
| **10.** | 11.45 | **Governance items** | | | | |
| | | 10.1 Safe Working Hours Doctors in Training annual report | Medical Director | **Paper** | 5 | To receive / approve |
| | | 10.2 Equality and Inclusion Forum annual report | Director of Nursing & Quality | **Paper** | 5 | To receive / approve |
| | | 10.3 Audit Committee annual report including updated Terms of Reference for committees | Director of Finance & Resource | **Paper** | 10 | To receive / approve |
| | | 10.4 Draft Annual Governance Statement | Director of Finance & Resource | **Paper** | 10 | To approve |
| | | 10.5 Trust Board self-certification (G6CoS7) compliance with NHS provider licence | Director of Finance & Resource | **Paper** | 5 | To approve |
| **11.** | 12.20 | **Receipt of public minutes of partnership boards** | Chair | **Paper** | 5 | To receive |

| Item | Approx. Time | Agenda item | Presented by | | Time allotted (mins) | Action |
|---|---|---|---|---|---|---|
| **12.** | 12.25 | **Assurance and receipt of minutes from Trust Board Committees**<br>- Clinical Governance and Clinical Safety Committee 17 April 2018<br>- Audit Committee 10 April 2018<br>- Nominations Committee 10 April 2018 | Chair of committees | **Paper** | 10 | To receive |
| **13.** | 12.35 | **Date of next meeting**<br>The next Trust Board meeting held in public will be held on Tuesday 26 June 2018 in room 49 / 50, Folly Hall, Huddersfield. | | | | |

South West Yorkshire Partnership NHS Foundation Trust

# Minutes of Trust Board meeting held on 27 March 2018
# Rooms 3 and 4, Laura Mitchell, Halifax

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|---|---|---|
| **Present:** | Angela Monaghan | Chair |
| | Charlotte Dyson | Deputy Chair |
| | Laurence Campbell | Non-Executive Director |
| | Rachel Court | Non-Executive Director |
| | Chris Jones | Non-Executive Director |
| | Kate Quail | Non-Executive Director |
| | Rob Webster | Chief Executive |
| | Mark Brooks | Director of Finance and Resources |
| | Tim Breedon | Director of Nursing and Quality |
| | Alan Davis | Director of Human Resources, Organisational Development and Estates |
| **Apologies:** | Members | |
| | Dr Adrian Berry | Medical Director |
| | Other | |
| | Karen Taylor | Director of Delivery |
| **In attendance:** | Carol Harris | District Director - Forensics and Specialist Services, Calderdale and Kirklees |
| | Kate Henry | Director of Marketing, Communications and Engagement |
| | Sean Rayner | District Director - Barnsley and Wakefield |
| | Dr Subha Thiyagesh | Deputy Medical Director |
| | Salma Yasmeen | Director of Strategy |
| | Emma Jones | Company Secretary (author) |

## TB/18/15 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. The apologies above were noted.

## TB/18/16 Declaration of interests – annual declarations (agenda item 2)

Dr Subha Thiyagesh (SThi) declared a conflict of interest in agenda item 9.1 and would leave the room for the item.

The following declarations were considered by Trust Board:

| Name | Declaration |
|---|---|
| **Chair** | |
| MONAGHAN, Angela<br>Chair | Spouse - Strategic Director at Bradford Metropolitan District Council.<br>Spouse - Director of the National Association for Neighbourhood Management. |
| **Non-Executive Directors** | |
| CAMPBELL, Laurence<br>Non-Executive Director | Director, Trustee and Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for |

| Name | Declaration |
|---|---|
| | Kirklees Council. |
| COURT, Rachel<br>Non-Executive Director | Director and Chair, Leek United Building Society.<br>Chair, Invesco Perpetual Life Ltd.<br>Director, Invesco UK Ltd.<br>Director, Leek United Financial Services Ltd<br>Chair, PRISM<br>Governor, Calderdale College Magistrate<br>Chair, NHS Pension Board |
| DYSON, Charlotte<br>Non-Executive Director | Independent Marketing Consultant, Beyondmc.<br>Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional).<br>Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA).<br>Lay member, Bradford Teaching Hospitals NHS Trust Clinical Excellence Awards (CEA)<br>Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee.<br>Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE. |
| JONES, Chris<br>Non-Executive Director | Director and part owner, Chris Jones Consultancy Ltd.<br>Interim Chief Executive Officer at Bradford College. |
| QUAIL, Kate<br>Non-Executive Director | Owner / Director of The Lunniagh Partnership Ltd, Health and Care Consultancy. |
| **Chief Executive** | |
| WEBSTER, Rob<br>Chief Executive | Independent Chair of Panel for assessing clinical commissioning group learning disability commissioning (NHS England).<br>Visiting Professor, Leeds Beckett University.<br>Honorary Fellow, Queen's Nursing Institute.<br>Honorary Fellow, Royal College of General Practitioners..<br>Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership (Sustainability and Transformation Plan).<br>Member of Bercow Review Panel, Royal College of Speech and Language Therapists (RCSLT). |
| **Executive Directors** | |
| BERRY, Dr Adrian<br>Medical Director (to 31 March 2018) | No interests declared. |
| BREEDON, Tim<br>Director of Nursing and Quality | No interests declared. |
| BROOKS, Mark<br>Director of Finance and Resources | No interests declared. |
| DAVIS, Alan<br>Director Human Resources, Organisational Development and Estates | Spouse – Managing Director, NHS North West Leadership Academy |

| Name | Declaration |
|---|---|
| THIYAGESH, Dr Subha<br>Medical Director (from 19 April 2018) | No interests declared. |
| **Other* Directors** (non-voting) | |
| HARRIS, Carol<br>District Director – Forensic, Specialist, Calderdale and Kirklees | Spouse - Engineering Company has contracts with NHS providers including Mid Yorkshire Hospitals NHS Trust. |
| HENRY, Kate<br>Director of Marketing, Communication and Engagement | No interests declared. |
| RAYNER, Sean<br>District Director – Barnsley and Wakefield | No interests declared. |
| TAYLOR, Karen<br>Director of Delivery | No interests declared. |
| YASMEEN, Salma<br>Director of Strategy | Board member, PRISM charity in Bradford. |

There were no comments or remarks made on the Declarations, therefore, **it was RESOLVED to formally NOTE the Declarations of Interest by the Chair and Directors of the Trust.** It was noted that the Chair had reviewed the declarations made and concluded that none present a risk to the Trust in terms of conflict of interests. It was also noted that all Non-Executive Directors had signed the declaration of independence and all Directors had made a declaration that they meet the fit and proper person requirement.

## TB/18/17 Minutes and matters arising from previous Trust Board meeting held 30 January 2018 (agenda item 3)

**It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 30 January 2018 as a true and accurate record.** The following matters arising were discussed:

- TB/18/06a Corporate/organisational risk register - The heat map will be reviewed for the next Business and Risk Trust Board.
- TB/18/07b Customer services report quarter 3 2017/18 - Policy review in May 2018, due to come to Trust Board in June 2018. The second action was included in the annual planning guidance sent into the BDU governance groups.
- TB/18/08a Trust Strategy refresh - Final amendments complete.
- TB/18/08b Digital Strategy - Final amendments complete.
- TB/18/09b Internal meetings' governance framework update - Timings for reporting included in work programme for EMT / Board
- TB/18/09d Board development programme - Board development session now confirmed for the September 2018 strategic session of Board with an external facilitator. Between now and then there will be a development review of leadership and governance using NHS Improvement well led developmental review framework. TB commented that any actions from the Care Quality Commission (CQC) well-led review could also be incorporated.
- TB/18/11 Assurance from Trust Board committees - General Data Protection Regulations (GDPR) presentation circulated to the Trust Board and regular updates provided to the Audit Committee.

## TB/18/18 Service User Story (agenda item 4)

The Trust Board heard a service user story. Carol Harris (CH) advised that at the last public Trust Board meeting the service user story outlined the challenges of an out of area bed placement. From this there was a need to better define the role of the care coordinator, patient flow manager and patient flow clinical lead so that clear roles and responsibilities were understood and the process for communication with the service user and their loved ones was clear. Out of area placements are still challenging for us, as identified in the Integrated Performance Report (IPR), and today's story demonstrates that when we communicate better we can get better outcomes.

"John" is a middle aged man who was under the care of the intensive home based treatment (IHBT) team for depression. He was having relationship difficulties and his marriage was breaking down. This led to him feeling so desperate that he rang the IHBT from Scammonden Bridge. He said he felt suicidal and he wanted to take his own life. The IHBT went to find him and felt he needed an admission to hospital to maintain his safety. There were no beds available in the Trust so he was admitted to Manchester as the closest available bed nationally.

IHBT and bed managers stayed in close contact with each other and with John and his partner. It became clear very quickly that the distance away from home was problematic as his partner could not travel to see him and the distance was not helping them to resolve the relationship difficulties they had. The IHBT and the bed managers immediately recognised this and worked to repatriate John to a local bed to ensure his partner could visit regularly. John was returned into the next available bed on a local ward within 36 hours of his initial admission. John is now discharged from our service. We asked John to tell us about his experience of having to go to an out of area bed. He told us that

- Initially he refused to go out of his local area. He believed that going so far away would increase his levels of anxiety as he felt it would impact on his attempts to reconcile his relationship, so the admission then would make things worse rather than better.
- Support from staff and his family persuaded him to accept the bed in Manchester.
- He felt the communication from out of area placement staff was poor for the day he was with them, however he does accept this may have been because they knew he was due to be transferred back.
- The transfer back to a local ward was welcomed and he appreciated we did everything we could as quickly as possible to move him back and reduce the anxiety of being away from his family.
- Stated he is happy with the care he has received.

Final thoughts on this story are that accessing an out of area bed helped John to manage his own safety in the short term. His worries about this were managed with support from our staff and his family. The IHBT team and the bed managers remained in close communication and the roles between them were clear. The bed managers prioritised a local bed and John's transfer back to the local area was successful and in line with his wishes and needs.

Mike Doyle, Deputy Director Nursing and Quality leads the work across the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) on suicide prevention and the Suicide Prevention Strategy. It is an example of the work we are doing with partners on areas identified as high risk.

Tim Breedon (TB) commented that the story reinforces that we know the importance of keeping people as close as possible to family and friends, what the risks are, and how we try to mitigate them as much as possible. Some of the work we are doing across the system will assist this.

Rob Webster (RW) commented that the Trust talks about safety first always. Under the Single Oversight Framework , out of area placement was now a national indicator that everyone was held to account for. In relation to out of area placements, there was a financial and also human cost. Learning from previous situations helps us make out of area placements work better. The WYHHCP workstreams were about consistency of approach and arrangements, the right communications, and building better and stronger relationships. In relation to Scammonden Bridge, the Trust works with partners including the Police, Local Authority and other NHS organisations to collectively reduce the risk.

The Board asked to pass on their thanks to the couple for sharing their story.

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

## TB/18/19 Chair and Chief Executive's remarks (agenda item 5)

Chair's report

AM advised that voting was underway for the Members' Council election and closes on 20 April 2018. The Trust was appreciative of all of those who have put themselves forward for the available seats on the Members' Council.

Chief Executive's report

RW commented that The Brief communication to staff, that was included in the paper, provided a sense of what was happening across the organisaiton and system. Since publication of the Brief there had been several update and RW highlighted the following:

- Announcement between Staff Side and NHS Employers nationally, recommending a pay deal to members. There had been speculation that staff would lose a day of annual leave which had not been part of any final offer. The proposal was a 6% pay rise over three years for staff on Agenda for Change. The psychological impact of lifting the pay cap was helpful and there has been a commitment of funding to pay for the award. It was important to recognise that staff have yet to accept the change and the Trust may or may not get the total funding required from the centre.
- Significant pressure in the system in mental health and physical care. Staff continue to be supportive across the system. Pressure specifically in relation to out of area beds will be discussed as part of the Integrated Performance Report.
- Nominations for the Trust's NHS70 Superstars has seen over 900 nominations received from staff and service users. RW read two nominations out selected at random.

Chris Jones (CJ) asked if there were examples of how the Trust had supported winter pressures. Sean Rayner (SR) commented that this winter has seen a multitude of pressures both on services and supporting patient flow from hospitals. Staff have been really resilient and our sickness rate, although higher than we want it to be, has been kept at a reasonable level. The NHS organisations over the Trust's geographical area have handled the pressures quite well compared to other areas in the country. CH commented that staff had worked together to maintain resilience and service delivery.

Alan Davis (AGD) commented that part of supporting staff was to ensure they have access to Occupational Health. Support has been provided to managers around individual staff health and wellbeing. AGD spoke to ward managers and staff about how they are supporting each other and, even though the pressure has been, there they have had time to talk about what has been going on in the service. RW commented that hot spots in the services identified in the staff survey point to where we need to do some more work.

Charlotte Dyson (CD) commented that in the media there was a report on where someone's physical health had been prioritised ahead of their mental health in an acute setting, leading to a serious incident, and asked how the Trust works with partners on this. SThi advised this is through the mental health liason team who conduct regular training sessions. Communication and training are two important elements of managing the needs of a service user.

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

## TB/18/20 Performance reports (agenda item 6)

TB/18/20a Integrated performance report month 11 2017/18 (agenda item 6.1)

TB highlighted the following on the summary dashboard:

- Under 18 admissions - remains an issue, there has been one person for 28 days with the proper safeguards in place. Adult beds are only used when it is the "least worst" option for the service user. We need to keep this issue in focus and work with commissioners.
- Out of area beds - remains an issue, some good work being done with partners in the West Yorkshire and Harrogate Health and Care Partnership regarding a shared bed system.
- Safer staffing levels - wards under pressure, however ratios met sometimes with a use of a diluted skill mix.
- Mental Health Act/Mental Capacity Act mandatory training - levels sustained.
- Agency spend - impacted by medical staff vacancies and requirements under waiting lists initiatives.

TB highlighted the following in relation to quality:

- Significant demand and resulting pressure in the system.
- Complaints - process is on an improvement journey, with process mapping producing some benefits, and ownership from deputy district directors and trios.
- Incidents - good reporting culture, particular increase in February in the Serious Incident report.
- Supervision - issue identified in relation to evidencing / recording, a focused piece of work has taken place and have met the target.
- Falls - increased in February, particularly relating to an individual in Forensic services. CH commented that there was a robust action plan in place. TB commented that further work was needed in relation to falls, the Trust has a high level of assessment which needed to be completed in a short period of time and the roll out of safety huddles as standard will support this work.
- Information Governance - whilst RAG rated amber in relation to confidentiality breaches the overall trend compared to last year was much better.
- Friends and Family Test - slight drop in relation to children's vaccination team.

- Prone restraint - internal target, need to continue to monitor closely.
- Mortality - internal audit received significant assurance of the Trust's mortality review process.
- Infection prevention and control - performing in line with the plan and hand hygiene and training levels sustained.
- Managing aggression and violence (MAV) - showing the largest reduction in physical violence to staff due to the Trust's physical intervention programme.

CJ asked in relation to complaints, improvements were not yet shown in the performance reporting and asked when it was expected. TB advised that there is a trajectory for improvement, which would be circulated to the Board.

**Action: Tim Breedon**

CJ asked if delayed transfer of care was showing a trend. TB advised that it was flagged last month as nationally it was not an issue. CH commented that detailed work was taking place with commissioners which may improve our recording. As part of patient flow, teams review anyone that has been admitted for over 40 days.

CH commented in relation to safer staffing numbers that whilst no ward fell below 90% there was an increase in a number of wards not achieving 80% of registered staff. A number of actions took place such as moving staff between units and completing a risk assessment to best manage demand and resources. CH reminded the Board that where the report shows over 100% it relates to acuity and demand where staffing levels have needed to be increased. CD asked what further assurance could be provided in relation to skill mix. CH advised that there was always a registered nurse on each shift and the Trust used registered community staff where needed to enhance numbers. Ward managers work across shifts to provide clinical leadership as well as practice governance coaches. TB added that within the professional guidance tool there was a checklist. RW commented that the Trust was talking to commissioners in relation to the levels of acuity during the contract process.

CD commented that she was surprised at the staff Friends and Family Test results. TB commented that there were a number of factors which link into the staff survey.

MB highlighted that in relation to the National Metrics that the Trust was RAG rated green for almost all indicators.

CD asked in relation to out of area beds if the Trust was an outlier. CH advised that a meeting with Bradford and Leeds identified similar pressures this month. Barnsley had not sent patients out of area for a long time, however they had experienced a higher level of acuity and demand. RW added that Leeds had spent a lot of resources on acute out of area beds and Bradford, Barnsley and Sheffield has not sent anyone out of area in acute. There were differences across the footprint in relation to the availability of Intensive Home Based Treatment and how it was applied as well as differences in commissioning with discussion taking place with commissioners.

CD commented that in relation to Improving Access to Psychological Therapies (IAPT) the Trust had worked hard to meet the target on outcomes. CD asked if information was collected in relation to ethnicity and if there were good outcomes for BAME service users. MB commented that the ethnicity of service users is collected however not specifically correlated to the outcomes. AM suggested that it could be discussed by the Equality and Inclusion Forum when they receive updates on EDS2.

**Action: Angela Monaghan / Tim Breedon**

SR highlighted in relation to Locality - Barnsley that changes to the system were sometimes a balance between operational excellence and change and development and there were a number of workstreams that were under change and development. The Trust strives for operational excellence and improvement in quality and experience for service users, however there may be changes to funding from commissioners.

SR highlighted in relation to Locality - Wakefield that work was taking place to address capacity issues to retain staff.

CH commented that in relation to Localities - Calderdale, Kirklees, Forensic and Specialist services that the areas highlighted in the Integrated Performance Report (IPR) had been discussed under other sections of the IPR.

RW commented that there were different relationships and different commissioners in each of the places within the Trust's footprint. A lot of time and effort was taken by the Trust to ensure the communications, engagement and relationships were right. We make sure discussions always link back to the service, including service excellence and service improvement. Where there are variances in the service we need to work on them and where there are areas where we can learn from them we do. The out of area beds learnings from others has been helpful and IAPT is an example of a service where there is a variance across the BDUs and commissioning.

Salma Yasmeen (SY) highlighted the following in relation to Priority Programmes:

- Significant amount of work taking place, despite pressure across the system.
- Perinatal - fully operational and handing over to business as usual with a Quality Impact Assessment (QIA) completed. There will be a post-implementation review conducted in the future.
- Child and Adolescence Mental Health Services (CAMHs) - launch of referrals through single point of access.
- Clinical Records System - now in the co-design phase of the project and is on track with key milestones.
- Older People's Service Transformation - Business case is progressing and work continues with the community workforce model to ensure new roles are an integral part of the model design.
- Patient flow and out of area beds - action plans are in place to reduce immediate out of area expenditure and sustainability plans are being developed to reduce people being placed out of area.

RC commented in relation to the clinical records system, a risk in relation to data migration was the time period given by the suppliers of a 10 day window which will need to be negotiated down. SY commented that there was a comprehensive risk register maintained and updates provided to the Audit Committee. There will be a robust process in place for the cut over period and conversations have started at an early stage to ensure best and safest transition. Other risks identified with mitigating actions in place are in relation to training and loss of data. LC commented that the Audit Committee would be focusing on critical milestones and evidence to ensure safety was not compromised.

RW asked if the RAG rating for the patient flow was because the programme had not delivered as planned. SY commented that ultimately the aim of the programme is to reduce out of area bed placements and redesign patient flow and to date the work has not made the impact originally expected.

MB highlighted the following in relation to Finance:

- Encouraging pre-STF surplus - £0.6m generated in February, driven by an unplanned gain on disposal of £350k, pay savings and an agreement to refund some bespoke care costs
- In-month out of area bed costs - increased to £373k meaning the year-to-date overspend is now in excess of £1.9m. Part of this was the cost of a particular service user, with agreement by the commissioner to refund.
- Agency costs - increased to £563k in the month which is the highest of the year with increasing acuity on inpatient wards a key factor. Projected to be above the cap at year end.
- Cash is ahead of plan at £25.5m due to the timing of capital expenditure and asset disposal receipts.
- Capital - lower than plan, expected to catch up some of that in the last month through the expenditure for the Fieldhead redevelopment
- Contracting - commercial in confidence at this time and will be discussed in the private session of Trust Board.
- CIP delivery of £6.8m is £0.7m lower than plan

CD asked for assurance that the right controls were still in place around agency spend. MB advised that a recent internal audit provided limited assurance in relation to controls around agency spend and this report will be taken in full to the Audit Committee One action was in relation to community staff, which has been resolved since moving to a new supplier, and some were in relation to medics. SR commented that in relation to medics there was a clear trail of approval of use of medical locums. CH commented in relation to nursing staff it wouldn't be appropriate for a Director to need to approve all use, however ward managers had oversight and this is reported to the Operational Management Group.

CJ asked about performance against the drug cost target. MB commented that in the past the target may have been set on insufficient evidence. A tool has been purchased to identify high drug costs and ownership is needed to achieve better efficiencies. SThi commented that based on what she has seen so far there was scope for further work to reduce the spend.

AGD highlighted the following in relation to Workforce:

- Sickness absence - whilst the Trust compares well to peers, a stretch target was set and performance was not where planned. A number of actions have been put in place including KT leading a task group to look at sickness absence and a staff wellbeing and attendance programme for managers. Health trainers have been appointed to work with Occupational Health in relation to rapid referral for stress and musculoskeletal issues. A hot spot was identified in Forensics who have set up their own wellbeing group for focused work. 70% was long term and a lot of the preventative work was to mitigate staff getting to that level of absence.
- Appraisals - new appraisal system from 1 April 2018 which was a streamlined value based appraisal.
- Turnover - the Executive Management Team and Remuneration and Terms of Service Committee supported a Trust retention plan as part of NHS Improvement programme. NHS Improvement have received the plan and confirmed they are happy with the actions in place. The plan will focuses on hot spot areas, developing better career pathways, streaming the recruitment system, and marketing and branding ourselves.

RC asked in relation to trainee doctors and recruitment challenges what further actions could be put in place. SThi advised that there were national issues as well as local issues in comparison with other trusts with a number of gaps to try to address. Previously 69% went on to do medical training, now the number is between 30-40%. Through the guardian of staff working process and regular meetings working is taking place to try to understand the issues and how to support trainees with more robust systems to be put in place. The Trust was taking place in a medical training initiative which is a national initiative and another aspect is widening access to specialist training. AM commented that it was an area that the Remuneration and Terms of Service Committee could focus on through workforce reports.

TB/18/20b Serious incident report quarter 3 2017/18 (agenda item 6.2)
TB highlighted the following:

- Includes learning from deaths Quarter 2 information as part of new reporting system.
- Already highlighted the number of incidents and 'low harm' incidents are at a good level.
- Report has been considered by the Clinical Governance and Clinical Safety Committee in detail including a suicides report. A number of actions were agreed including deep dives on CAMHs and themes from Kirklees.
- Whilst the number of incidents has increased, the same level has been experienced in previous years. It was important to consider them over a longer period of time to provide real intelligence around themes.

CJ asked what a themed review would include. TB advised that it would look at recommendations from each individual report, scan across all the individual interviews including staff and about comments of issues they have seen themselves or any shortfalls identified. It would also review against national framework or any local or regional incidents. For CAMHs, an independent person would conduct the review to give an independent view.

KQ asked if there was a role for a Non-Executive Director as part of the Serious Incident process. TB would look into this and advise.

**Action: Tim Breedon**

KQ commented that she had attended an event on learning from deaths where a psychiatrist said trusts were implementing the requirements but "there was a long way to go in terms of implementing the spirit", and what does it mean for our Trust? TB advised that when the requirements were reported to Trust Board it was clear that there was a concern that they could become process driven. From our perspective we have been clear to maintain focus around outcomes not just reporting. Further work around embedding this will take place after Quarter 4. CD commented that she had spoken to Mike Doyle, Deputy Director Nursing and Quality, regarding the learnings that had come out of the initial review around better communication.

LC asked how the Trust knows that it was collecting the data of all the people within the required scope. TB advised that the reporting was reliant on everyone entering the required information. We trust our staff know the requirement and data is also collected from the broader NHS system. To really make an impact we need to know everything. Conversation was ongoing on with coroners to assist with gaining better information.

**It was RESOLVED to:**

- **NOTE the quarterly report on incident management, including learning from healthcare deaths Quarter 2 data;**
- **NOTE the ASSURANCE and FURTHER ACTION REQUIRED by the Clinical Governance and Clinical Safety Committee; and**

- **REQUEST reports from the Clinical Governance and Clinical Safety Committee on any areas where they are not assured.**

TB/18/20c NHS staff survey (agenda item 6.3)
AGD reported that the NHS staff survey reflects the importance of ensuring we have regular feedback to staff, noting that surveys were more about engagement, action, and feedback and highlighted the following:

- BDU forums were already using the survey information to understand what action we need to take.
- Results showed a mixed picture, with some good elements and areas we need to respond to.
- Previous years' surveys were only sent to a sample of staff and this year it was opened to everyone, which gives us a better picture across the different parts across the organisation.
- Sickness and appraisal rates in relation to CAMHs is provided to the Clinical Governance and Clinical Safety Committee
- Actions would also be linked to work in place as part of the Workforce Strategy.

RC asked if the actions in place regarding CAMHs did not have the desired effect what would be the next steps. CH advised that initially the challenge was around first assessments with improved access to first appointments, however there was a lot of work to do on the pathways. One of the challenges in recruiting is around on-call, which has been reported to Clinical Governance and Clinical Safety Committee and ranges from distress to impact on morale and job satisfaction. Human Resources and wellbeing staff are engaged in relation to managing stress and demand. AGD commented that previously, Learning Disability staff was an area that had a concern with some additional work and support put in place and it now shows improvement in this survey. Sometimes results can show areas where the system isn't working which puts pressure on our services. CH added that this was the reason why updates are a standing item on the Clinical Governance and Clinical Safety Committee agenda.

AM noted that there were already a lot of actions taking place as part of the Workforce Strategy and we now needed to determine what additional actions were required in response to these results.. The Remuneration and Terms of Service Committee would review the results in detail.

SR commented that it was important that Staff Side were engaged in the process, particularly in areas were staff are transferred, as they are a supportive group to work with. AGD commented that there was regular dialogue with Staff Side through the wellbeing group and local partnerships groups. Working is taking place to further break down the data in order to understand the results more. This will also identify areas of good practice as it is important to learn from those areas too.

**It was RESOLVED to NOTE the report, the high level actions and next steps.**

## TB/18/21 Operational plan 2018/19 (agenda item 7)

MB highlighted the following:

- The draft operating plan was submitted to NHS Improvement (NHSI) on 8 March 2018 in line with what was agreed at the previous Trust Board.
- Contract variation negotiations are progressing with each commissioner.

- The Trust has requested a reduction in control total. This is challenging but achievable based on the work carried out to date and would mean a cost improvement programme of 4.6%.
- The Trust did not accept its control total of £374k surplus in the draft plan submission.
- The West Yorkshire and Harrogate Health and Care Partnership has submitted an expression of interest to become an Integrated Care System (ICS). This will potentially mean working to a single control total across West Yorkshire.
- The full plan needs to be submitted to NHSI by 30 April 2018. It will therefore be presented in full at the Trust Board meeting in April 2018.
- Work is continuing on the financial plan which will be discussed further in private session of Trust Board.

## TB/18/22 Business developments (agenda item 8)

TB/18/22a South Yorkshire and Bassetlaw Integrated Care System update (formally STP) (agenda item 8.1)

AGD advised that the collaborative board had discussed consultation and were keen to ensure there was a strong engagement process. There was good debate around the complex agenda and the process that they have gone through was robust. They would be moving into shadow Integrated Care System (ICS) arrangements from 1 April 2018. They discussed what they need to do to put the ICS in place including governance arrangements and that the list of priorities would need to be streamlined. SY added that the review of stroke services would have an impact on the Trust's services in Barnsley and the Trust was working with partners and other providers to consider the impact. The Trust continues to be a proactive partner contributing to ICS discussions.

RW commented that Staff Side had asked what the Trust's status was in the ICS and we reminded them at we are a "partner in". The Trust expressed an interest in being a "party to", which would give us a greater say in decisions, and that this would be reviewed during the ICS process.

**It was RESOLVED to NOTE the update and that the Trust continues to be an active and supportive partner in South Yorkshire.**

TB/18/22b West Yorkshire and Harrogate Health and Care Partnership (formally STP) and local integrated care partnerships update (agenda item 8.2)

SY reported that the 'Our Next Steps to Better Health and Care for Everyone' document outlined the significant amount of work that was taking place and progress made since 2016 and sets out ambitions and delivery plans to address the challenges. A lot of work is taking place on the delivery of the key priorities and detailed updates on each of the programmes was provided in the report.

**It was RESOLVED to:**

- **NOTE the contents of the 'Our Next Steps to Better Health and Care for Everyone' document and progress made by the WYHHCP; and**
- **NOTE that the Board would be engaged in any further developments in shared arrangements.**

## TB/18/23 Strategies and policies (agenda item 9)

TB/18/23a Quality Strategy (agenda item 9.1)

TB reported that the Quality Strategy sets out our commitment to providing high quality care for all while achieving our organisational mission, to help people to reach their potential and live well in their communities. It sets out the framework of how we assure and improve from a quality perspective. A lot of consultation has taken place and the draft was discussed at Clinical Governance and Clinical Safety Committee. One of the challenges of updating the strategy was to include immediate goals, ambition, and links into other supporting strategies. The detail will form part be shown in each of the implementation plans over the three years of the strategy, with 2021 aims reflecting our aspiration. The Strategy aligns with the Care Quality Commission (CQC) domains, and existing narrative around where are we now, where do we want to be, what do we need to get there. The work described in the Strategy is already part of the Integrated Performance Report and discussions. It is also linked strongly to the #allofusimprove campaign.

KH commented that there had been a soft launch of the #allofusimprove campaign, focusing on key three themes - experience, safety and effectiveness. Feedback on the campaign will be built in as part of the implementation.

CJ commented that it was a good document and it was important to continue to revisit what success looks like in order to track achievement.

CD asked who would oversee the implementation. TB advised that the Quality Improvement Group would oversee it, although it may become part of a priority programme in order to coordinate the implementation. RW commented that, as the action plan is developed, it needs to emphasise the role of partnership with service users and carers.

AM asked how the Trust ensures that it is open and learning from others and taking on best practice. TB advised that there were mechanisms in place and it was important to ensure the Trust continued to have the right links with other key trusts.

CD commented that the Clinical Governance and Clinical Safety Committee discussed the draft in detail and was clear that everyone was accountable for delivering this Strategy. It was important to have strong messages in the campaign.

RW commented that this Strategy has a clear thread for delivery, through Quality Account and the links with the Integrated Performance Report and scrutiny at committees and Trust Board.

**It was RESOLVED to APPROVE the Quality Strategy.**

TB/18/23b Update to the Trust Board declaration and register of fit and proper persons, interests and independence policy (agenda item 9.2)

AM reported that the policy had been updated to align it further with the wording in the Standards of Conduct in Public Service Policy for staff, which had been updated in accordance with newly-issued NHS England guidance for NHS organisations on managing staff conflicts of interests.

**It was RESOLVED to APPROVE the updated policy which is aligned with the guidance issued by NHS England on managing conflicts of interest.**

*Dr Subha Thiyagesh declared a conflict of interest and left the meeting for item 9.1.*

## TB/18/24 Governance matters (agenda item 10)

TB/18/24a Appointment of Responsible Officer for Medical Revalidation (agenda item 10.1)

AGD reported that the decision of Dr Adrian Berry (ABe) to retire from the post of Medical Director on the 11 April 2018 gave the opportunity to re-look at the role. The Remuneration and Terms of Service Committee considered the key priorities of the Medical Director role for the next two years and the importance of attracting high calibre candidates. It was agreed to redesign the role to allow the new Medical Director to maintain a clinical case load in the first instance. In order to do this it was also agreed to separate the Medical Director role and the Responsible Officer for Medical Revalidation. In order to facilitate this redesign, the Committee agreed to the retire and return of ABe to continue with his current role as Responsible Officer for medical staff revalidation. Dr Berry is required to have a break in service and will leave on 11 April 2018 and be re-employed on the 1 May 2018. This would mean a potential gap in the Trust having a Responsible Officer for Medical Revalidation. SThi has been appointed as Medical Director and will take up the role on the 12 April 2018 following ABe's retirement. SThi has attended the training for a Responsible Officer and the proposal is that she acts as Responsible Officer from the 12 April 2018 to 30 April 2018.

**It was RESOLVED to:**

- **CONFIRM the appointment of Dr Subha Thiyagesh as Responsible Officer for Medical Revalidation from the 12 April 2018 to 30 April 2018; and**
- **CONFIRM Dr Adrian Berry as Responsible Officer for medical staff revalidation with effect from 1 May 2018.**

*Dr Subha Thiyagesh returned to the meeting.*

TB/18/24b Eliminating mixed sex accommodation (EMSA) declaration (agenda item 10.2)

TB reported that the paper was to provide assurance to the Trust Board of the organisation's level of compliance with the national standard in respect of EMSA. The Trust is expected to make a declaration to commissioners by 31 March 2018 to confirm the Trust's position regarding compliance with the EMSA standard and the statement of compliance would then be published on the Trust's website. While the Trust was compliant with the regulations, there are still further improvements that we can make.

**It was RESOLVED to APPROVE the compliance declaration.**

TB/18/24c Information Governance toolkit (agenda item 10.3)

MB reported that the Information Governance (IG) Toolkit is an annual requirement with compliance at level 2 across the 45 requirements needed to remain IG Statement of Compliance (IGSoC) compliant. An internal audit has been conducted which has provided significant assurance on the process. The Trust has surpassed the 95% target on IG mandatory training, which is a good achievement as a new training programme was implemented, which takes longer to complete and was not in place at the start of the financial year. In relation to IG incidents there is one outstanding incident remaining with the Information Commissioner's Office (ICO). A voluntary audit was conducted by the ICO at end of 2016 and a General Data Protection Regulation (GDPR) internal audit was completed in September 2017.

The Board noted the significant work that had taken place despite capacity issues in the team.

**It was RESOLVED to NOTE the current position regarding the points noted and APPROVE the submission of the IGTK for 2017/18.**

TB/18/24d Review of Risk Appetite Statement (agenda item 10.4)
MB reported that at the strategic session of Trust Board in February 2018 the Board discussed the current risk appetite to ensure that what we present in our risks is reflected accurately. The current Risk Appetite Statement would be reviewed by the Executive Management Team and Audit Committee with a proposal for any changes to come back to Trust Board for approval.

**It was RESOLVED to SUPPORT the approach to review the Risk Appetite Statement.**

## TB/18/25 Receipt of public minutes of partnership boards (agenda item 11)

A list of agenda items discussed and minutes where available were provided for the following meetings:

- Kirklees Health and Wellbeing Board 22 March 2018 - arrangements for an integrated commissioning board were discussed.
- Calderdale Health and Wellbeing Board 16 March 2018
- Barnsley Health and Wellbeing Board 30 January 2018 - Falls Prevention, Early Help and Frailty is one of the health and care working together arrangements.

AM commented that the Trust continues to be actively involved and engaged with all Health and Wellbeing Boards.

## TB/18/26 Assurance from Trust Board Committees (agenda item 12)

AM highlighted that the latest approved Minutes for each committee were included in the papers for receiving by the Board.

Clinical Governance and Clinical Safety Committee 6 February 2018
CD highlighted the following:

- Minutes from 14 November 2018 approved and attached.
- Review of Draft Quality Strategy prior to approval by Trust Board.
- Report on apparent suicides for 2016/17, looking at key themes with 48% males under 35 and a high proportion unemployed. There are key areas of review including what we can do recognise external work taking place.
- Waiting lists are included on the organisational risk register and are part of the Care Quality Commission (CQC) inspection 'must do's'. The Committee has a good understanding of areas where we have made improvement with work still to do including commissioning and pathways.
- There is a proportion of Quality Impact Assessment (QIA) for our CIPs which are still RAG rated as red. MB commented that these were not included in the plans for 2018/19.
- Audit Committee review of cross committee synergies, on occasions where we might want to ask other committees to review items.

Nominations Committee 22 February 2018
AM highlighted the following:

- Minutes from 24 October 2017 approved and attached.
- Future Non-Executive Director recruitment - CJ has advised that he will not seek renewal at the end of his three year term and RC will not seek full renewal at the end of her three year term. A recruitment process was agreed to be conducted internally

as more cost efficient. Recruitment/information events will be held in each of the four localities. The Committee will continue to meet throughout the process.

- Non-Executive Director re-appointment recommendation to Members' Council - recommendation that CD be re-appointed for a further three year term and RC for a furtherr flexible term up to one year would go to the next Members' Council meeting.

Mental Health Act Committee 6 March 2018
CJ highlighted the following:

- Minutes from 21 November and 19 December 2018 approved and attached.
- It was Dr Adrian Berry's last meeting as Medical Director and lead director for the Committee. The Committee thanked him for his service.
- Increase in young people in 136 suites in the last quarter.
- Changes to places of safety requirement showed good partnership working in districts and across West Yorkshire.
- Recording of ethnicity.
- Review of internal audits – what audits come to Committee and ensure correct coverage.
- Operational Management Group (OMG) – strengthening work of the Committee in the Trust.
- CH was able to attend which assisted in providing assurance from BDUs.

Equality and Inclusion Forum 6 March 2018
AM highlighted the following:

- Minutes from 2 October 2017 approved and attached.
- Agreed annual report 2017/18, revised Terms of Reference, and work programme for 2018/19. The Forum will recommend to Trust Board that it becomes a standing Forum rather than time limited and that a Governor who has been in attendance becomes a full member.

Remuneration and Terms of Service Committee 26 March 2018
RC highlighted the following:

- Workforce Strategy and action plan with the vast majority of actions complete.
- Freedom to Speak Up Guardians role including the lack of protected time for staff governors. A review of process will go through the Clinical Governance and Clinical Safety Committee.
- Turnover and retention and agency expenditure as included in the Integrated Performance Report.
- Gender pay gap will be required to be published by the Trust. The gap is just under 20% which means the Trust is not an outlier in relation to other NHS trusts, however is driven by proportion of females in lower-paid roles versus males in higher-paid roles. Males are also more likely to go on-call and receive Clinical Excellence Awards. RW commented that 80% of Band 1 and 2 staff are women and 50% of male consultants get a Clinical Excellence Award compared with 40% of female consultants.
- Clinical Excellence Awards will be reinstated, subject to clarification on backdating.
- Reviewed workforce risks and impact of pay gap on morale.
- Annual report 2017/18, work programme for 2018/19, and Terms of Reference reviewed to give an increased focus on broader workforce matters. The Committee will recommend to the Trust Board that it be renamed the Workforce and Remuneration Committee.
- Confidential items will be updated to Trust Board members outside of this meeting.

LC asked what communications would be put in place in relation to the gender pay gap. AGD commented that the required report was lengthy and an infographic would be produced.

**It was RESOLVED to receive the approved Minutes of the above committees.**

## TB/18/27 Use of Trust seal (agenda item 13)

**It was RESOLVED to NOTE use of the Trust's seal since the last report in December 2017.**

## TB/18/28 Trust Board Work Programme 2018/19 (agenda item 14)

TB commented that it was important to ensure that, once the work programmes for the committees of the Board were approved, that the sequencing of reports from committees into Board is aligned.

**Action: Angela Monaghan**

**It was RESOLVED to NOTE the Work Programme for 2018/19.**

## TB/18/29 Date of next meeting (agenda item 15)

The next public meeting of Trust Board will be held on Tuesday 24 April 2018 in the Conference Centre Boardroom at Kendray in Barnsley.



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

South West Yorkshire Partnership NHS Foundation Trust

# TRUST BOARD 27 MARCH 2018 – ACTION POINTS ARISING FROM THE MEETING

**Actions from 27 March 2018**

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| TB/18/20a Integrated performance report month 11 2017/18 | CJ asked in relation to complaints, improvements were not yet shown in the performance reporting and asked when it was expected. TB advised that there is a trajectory for improvement, which would be circulated to the Board. | TB | | |
| TB/18/20a Integrated performance report month 11 2017/18 | CD commented that in relation to Improving Access to Psychological Therapies (IAPT) the Trust had worked hard to meet the target on outcomes. CD asked if information was collected in relation to ethnicity and if there were good outcomes for BAME service users. MB commented that the ethnicity of service users is collected however not specifically correlated to the outcomes. AM suggested that it could be discussed by the Equality and Inclusion Forum when they receive updates on EDS2. | AM / TB | | |
| TB/18/20b Serious incident report quarter 3 2017/18 | KQ asked if there was a role for a Non-Executive Director as part of the Serious Incident process. TB would look into this and advise. | TB | | |
| TB/18/28Trust Board Work Programme 2018/19 | TB commented that it was important to ensure that, once the work programmes for the committees of the Board were approved, that the sequencing of reports from committees into Board is aligned. | AM | May 2018 | |

**Outstanding actions from 31 October 2017**

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| TB/17/86c Strategic overview of business and associated risks | AM asked while the weaknesses and threats of the priority programmes were matched against risks, could the risks be matched against the opportunities to ensure we are capitalising on them and have enough resources in place? SY advised that whether there was a relationship between existing risks and opportunities would be included in the next report to Trust Board. RW commented that it was important to identify commissioning and other opportunities and whether we have the right capacity to realise them. | SY | April 2018 | Report included on agenda for April 2018. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 5

| | |
|---|---|
| **Title:** | Chief Executive's Report |
| **Paper prepared by:** | Chief Executive |
| **Purpose:** | To provide the strategic context for the 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 references several of the papers in the public and private parts of the meeting and also external papers and links. It will be supplemented by a verbal update. |
| **Executive summary:** | The latest edition of *The Brief* is attached and provides details of the national and local strategic context, performance, staffing and other issues. The narrative for the brief includes a number of links to detailed documents which may be of interest to Board members.<br><br>Since publication of the Brief, there are areas to update and of emphasis to draw to the attention of the Board:<br><br>• We are in the **pre-election period for local government elections** which restricts government and some public sector activities to a "business as usual" basis. This has reduced the volume and scope of announcements and policy developments from national bodies.<br><br>• We are subject to **restrictions** in the pre-election period and guidance on this is attached for Board members: https://nhsproviders.org/media/4469/nhs-providers-purdah-briefing-march-2018.pdf<br><br>• Prevention and public health measures were in the spotlight this month, with the planned introduction of the **"sugar tax"** on fizzy drinks. This forms part of a strategy from Government on tackling obesity, which also includes changes to food and beverages in NHS Trust sites (which we are compliant).<br><br>• I attended the national **Equality and Diversity Council** and **Workforce Race Equality Standard Strategy Group** this month. These groups continue to monitor progress against equality duties and consider how we are developing mechanisms to embed improvements. This includes training for Care Quality Commission (CQC) inspectors and it was pleasing to note that there was |

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| | significant coverage of these issues in our CQC well led review.<br>• National bodies continue to engage with local health and care systems on ensuring appropriate **planning assumptions are in place for 2017/18.** This is focused on physical health, trajectories for out of area placements and also the mental health investment standard. We are working closely with our commissioners and the wider partnerships to ensure we have a reasonable set of plans.<br>• Nationally, the NHS has seen **performance affected by the weather** with widely reported pressures<br>• We continue to operate in a very fluid environment and the **substantial report on business tenders, opportunities and risks** belies the rhetoric that collaboration has now replace competition as the default approach of the system.<br>• The Board should reflect on the **progress made in 2017/18,** which is reflected in our quality, performance, workforce and finance metrics. **Quality has been assured whilst finance targets have been delivered.**<br>• Initial **feedback from the CQC** has been shared with Board members and staff. This has a number of areas that we will continue to work on as well as some very strong attributes of our leadership and culture identified. A draft report will be available towards the end of May.<br>• The culture of the trust is being reinforced through the right infrastructure, and Board members will note that there is a revised **appraisal process, based on our values and behaviours.** This has been coproduced with staff and training of appraisers is being delivered across the organisation.<br>• We continue to innovate and improve and congratulations to the **finance department** for being **accredited by the Heath Finance Managers' Association for meeting Future Focused Finance standards**, and to the **scanning bureau on their International Standards Office Accreditation** which means we can now dispose of paper records, reducing costs and increasing efficiency. These corporate functions are essential to the health of the Trust.<br>• **Celebrations for the 70th birthday of the NHS continue.** We have been running our **#NHS70Superstar** campaign recently and have now had over 1,000 nominations from staff, service users, carers and partners.<br>• We will be supporting the **Windrush70** celebrations on 12th June for the **contribution of diverse communities to the NHS.** We know that the NHS is made of people and was created with the support and labour from people of all nations. As well as nominating staff for awards to recognise their contribution, we will |

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| | be attending the celebration event. I have personally always felt it was essential to highlight the enduring legacy of the people who created the NHS - whether from Wakefield or the West Indies. We are forever in their debt and their legacy is felt in our culture today and the nominations we see in our #NHS70Superstars.<br><br>This Board meeting straddles the end of 2017/18 and the beginning of 2018/19. We should spend some time thanking staff and partners for their role in delivering another successful year in the toughest times for a generation. We must then ensure we have the clarity of strategy and planning to see us through the year ahead. |
| **Recommendation:** | **The Trust Board is asked to NOTE the Chief Executive's report.** |
| **Private session:** | Not Applicable. |

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# The Brief

## 29 March 2018

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

With **all of us** in mind.

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# Our mission and 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

Creative Minds won 'Organisation of the Year' in Disability Sport Yorkshire's annual awards

With **all of us** in mind.

# What's happening externally

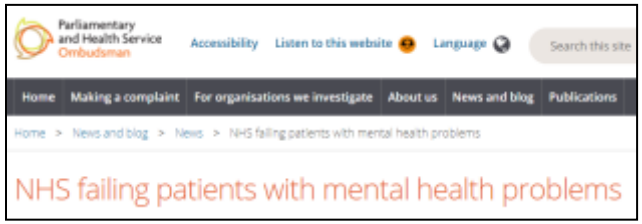
## National and local news


Plans for 3yr pay deal and 10yr NHS budget


Jeremy Hunt speech on social care proposals ahead of Green Paper

NHS Improvement consultation on serious incident reporting and investigations


Bercow report on support for children with speech, language and communication needs


Ombudsman mental health care findings

**£25m**

capital funding awarded to West Yorkshire and Harrogate Health and Care Partnership

With **all of us** in mind.

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# What's happening internally

## Safety and quality

- 1,113 incidents reported in Feb:
  - 977 were rated green (no/low harm)
  - 130 were rated yellow or amber
  - 6 were rated as red
- 4 Serious Incidents reported in Feb – 3 apparent suicides and 1 self harm with suicidal intent
- We're reviewing themes in Kirklees from recent apparent suicides of young people
- Our quarter 3 serious incident report went to Trust Board on 27 March:
  - Oct-Dec 2017 saw 2,948 incidents, similar to the previous two quarters
  - 87% were no or low harm, showing a positive risk management culture
  - 'Physical aggression' was the highest reported incident type

CareQuality Commission

- Unannounced visits to services took place in February and March
- 200+ information requests received
- Well-led review 9-11 April
- Reports due back by July – we'll keep you updated

With **all of us** in mind.

# What's happening internally

## Quality improvement and innovation


- Our new 3-year Quality Strategy was approved at Trust Board on 27 March. It sets out our aims to improve and be outstanding.
- To help achieve our aims, our new improvement campaign, #allofusimprove, focuses on three areas of quality - patient safety, operational excellence and experience of care
- **Together, all of us can improve. We must get from where we are to where we want to be. You can do something to make a difference.**
- Read more on the intranet

#allofusimprove
and be outstanding

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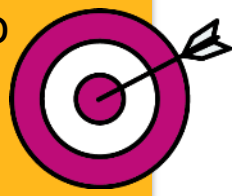
# What's happening internally

## Performance (Feb)

- **118%** overall safer staffing fill rate, which helped us to manage increased acuity
- **98%** average registered nurse fill rate, with **4** wards not reaching 80% on days
- **97%** of people recommend our community services, **85%** our mental health services
- **81%** of prone restraint lasted ≤3mins
- **10** confidentiality breaches
- **613** out of area bed days, the highest it's been all year and up from 268 in Jan
- **1** young person admitted to an adult ward

**National metrics**

- Overall, we're performing well against measures set by NHS Improvement
- We narrowly hit our target for people moving to recovery in IAPT
- Out of area beds is now reported nationally and remains a challenge



With **all of us** in mind.

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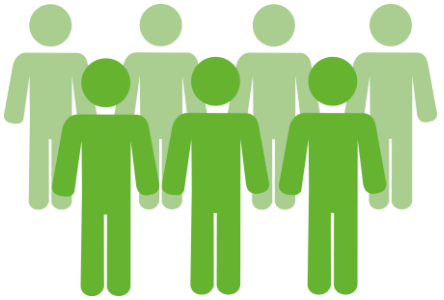
# What's happening internally

## Staffing

- All NHS organisations now publish details on their gender pay gap – ours will be shared in the Headlines and on our website
- We've hit our 80% target for staff receiving and recording supervision – thank you
- 1000 staff have now been nominated as an NHS70 superstar - more info on our website
- Voting for staff governor elections is now open – cast yours before 20 April
- Don't forget you can buy additional 2018/19 annual leave - details are on the intranet



Attend a staff listening event in May or June – they'll cover our 2018/19 plans as well as developments in each of our localities. Read more on the intranet and register.

With **all of us** in mind.

# What's happening internally

## Staffing

Our NHS Staff Survey results are now out. Thank you to the 1,900 staff who took part. The results will be addressed in our Workforce Strategy action plan.

| Better than average results | Worse than average results |
|---|---|
| • Quality of non-mandatory training, learning and development<br>• Trust taking positive action on health and wellbeing<br>• Satisfaction with flexible working opportunities<br>• Numbers of staff working extra hours<br>• Reporting physical violence at work<br>• Reporting harassment and bullying at work | • Witnessing errors, near misses or incident that could hurt staff<br>• Bullying and harassment from service users/carers<br>• Staff motivation at work<br>• Effective team working<br>• Effective use of patient/service user experience feedback<br>• Staff feeling unwell due to work related stress |
| **Positive changes since 2016** | **Negative changes since 2016** |
| • Satisfaction with opportunities for flexible working<br>• Feeling safe in raising concerns about unsafe clinical practice | • Satisfaction with the quality of work and care delivered<br>• Satisfaction with the amount of responsibility<br>• Trust acts fairly with regard to career progression/promotion |

# What's happening internally

## Month 11 finances (Feb)

- We had a £0.6m surplus in Feb mainly due to the sale of properties – our underlying position was worse than this
- We spent £563k on agency, the most we've spent this year – we're now likely to breach our cap for the year of £5.6m set by NHS Improvement
- We've saved £6.8m so far this year in cost improvement initiatives, £0.7m less than planned
- We have an NHS Improvement financial risk rating of 1 – the highest possible out of 4

Hard work and one-offs this year means we could deliver financial targets. A deficit position next year is likely. We're discussing this with NHS Improvement.

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With **all of us** in mind.

# What's happening internally

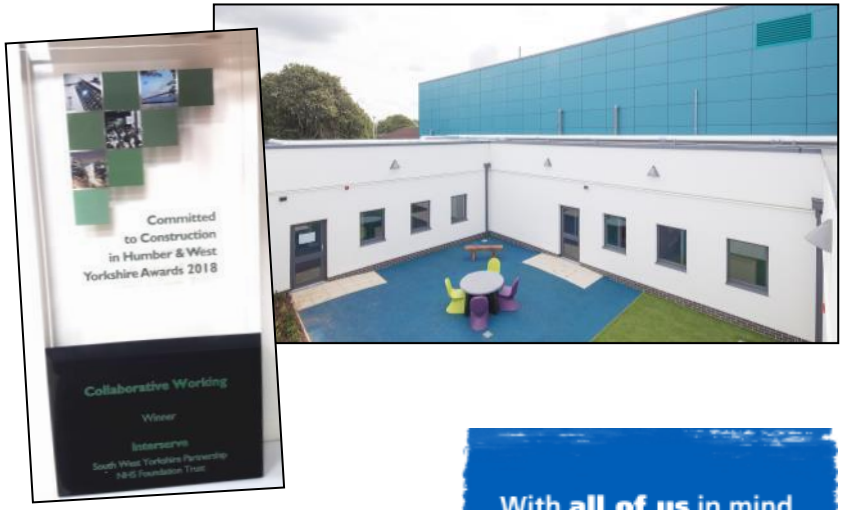
## Infrastructure

**SystmOne – our new mental health clinical record system**

- Co-design workshops have taken place in forensic and specialist services – more are happening across other services
- If you want to champion this change, email to get involved in data testing, co-create the new system, or become a super-user: crsprogramme@swyt.nhs.uk
- Read more on the intranet

**Award win for Unity Centre**

The Unity Centre at Fieldhead has won a Chartered Institute of Builders regional award for collaborative working




With **all of us** in mind.

# What's happening internally

## Service change

- Our diabetes staff in Barnsley transfer to Barnsley Hospital on 1 April. On the same day our smokefree staff in Rotherham transfer to Parkwood Healthcare. Thanks to both groups of staff for your commitment.
- Our Barnsley musculoskeletal service moves to a new service model from 1 April, bringing together two existing teams into one. The service will now be known as the community musculoskeletal physiotherapy service.
- Calderdale CCG are reviewing the adult psychological services they commission. They want to hear from people who have used services to help inform future plans – find out more on our website.

**Successful bid to host new network**

NHS England has appointed us to host a learning disabilities and autism Operational Delivery Network (ODN) for providers across Yorkshire and the Humber.

The two-year contract is worth £200k and includes appointing a clinical lead.

With **all of us** in mind.

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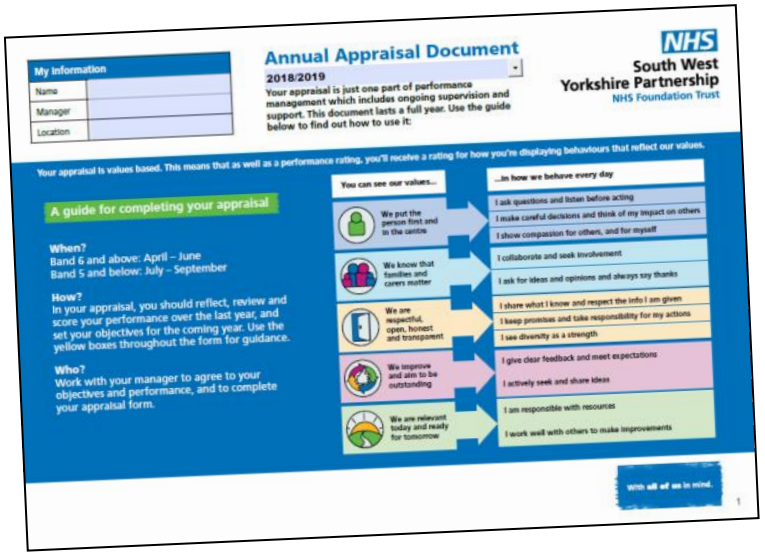
# Focus on:

## Our new values-based appraisal




- Your appraisal is time for you to reflect on the past year with your manager and to set objectives for the year ahead
- Our appraisal rates are high - we exceeded our 95% target this year
- We're now focusing on improving the quality of our appraisals and more explicitly linking them with to values by incorporating our Trust behaviours
- Our new appraisal form is shorter, simpler, and has been developed with staff in response to feedback

**When?**

- Bands 6 and above: before the end of June
- Bands 5 and below: before the end of Sept

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# Focus on:

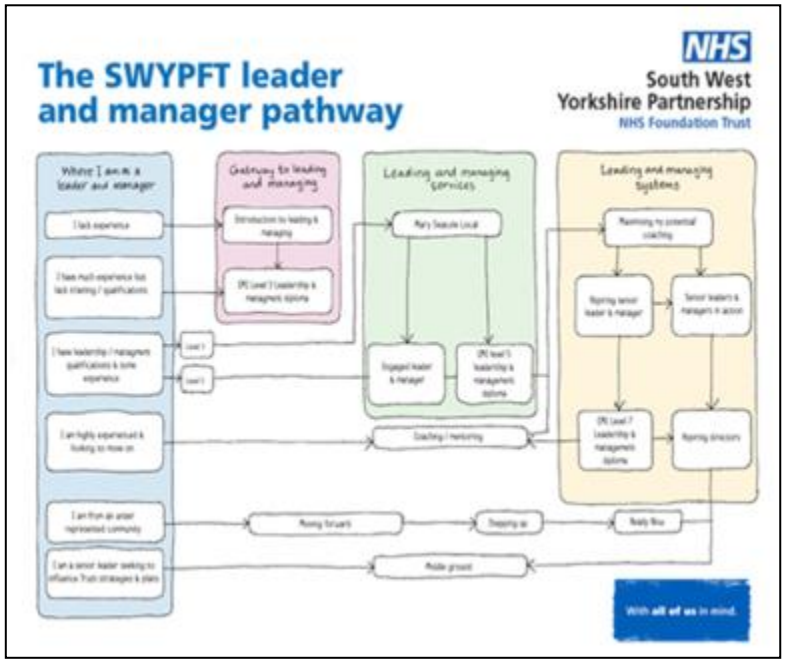
## Our new leadership and management development offer

New values-led programmes are now available to aspiring, new or existing team supervisors and managers:

- Mary Seacole Local - over 6 months, from May, by application
- Apprenticeship Diploma (CMI Levels 3 & 5) - over 15 & 24 months, from June, by application

We also have programmes for new or existing senior leaders and managers:

- Middle Ground 5 Leadership Forum - over 2 days, from May, nomination by deputy director
- Shadow Board (aspiring Directors) - over 6 months, from June, by application




**Find out more and book a place:** Visit the L&D intranet pages, email landd@swyt.nhs.uk, or call 01924 316269

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# Take home messages

We put safety first always, and as a learning organisation we learn from incidents

Thank you to staff who welcomed the CQC – their view of our services gives essential insights

We're achieving the majority of our performance targets and must continue focusing on hotspots

Financially, we may achieve our control total this year – next year it's likely we'll be in deficit

Get updated on our simplified appraisal and prepare for yours and your teams

Whatever role you're in, you can improve quality and our leadership and management offer can help

Vote in the staff governor elections – it's your Trust and they are your representatives

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

With **all of us** in mind.

**29 March 2018**

South West Yorkshire Partnership NHS Foundation Trust

# The Brief

## 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.

## What's happening externally?

### National and local news

- NHS Employers and Trade Unions (with the exception of one) have signed up to an NHS pay deal. It will see wage rises of between 6.5% and 29% over the next three years for over a million health staff in England. Unions will now consult with their members about it. If accepted, it will be introduced this summer, back-dated to April.
- Prime Minister Theresa May has pledged to bring forward a long-term, 10-year funding plan for the NHS in response to growing concerns that key health services are being overwhelmed by rising demand.
- NHS Improvement has launched a consultation on the reporting and investigation of serious incidents and want to hear your views.
- A new Parliamentary and Health Service Ombudsman report found that vulnerable people with mental health conditions are being badly let down by the NHS, causing them and their families needless suffering and distress.
- Jeremy Hunt outlined the seven key principles that will guide the Government's thinking ahead of the social care Green Paper, to be published later in 2018.
- The 'Bercow: Ten Years On' report was published, marking a decade since the publication of The Bercow Report: A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs.
- The West Yorkshire and Harrogate Health and Care Partnership has been awarded £25m to support capital developments in the region.

## What's happening internally?

### Safety and quality

- 1,113 incidents reported in Feb:
  - 977 were rated green (no/low harm)
  - 130 were rated yellow or amber
  - 6 were rated as red
- 4 serious incidents reported in Feb – 3 apparent suicides and 1 self-harm with suicidal intent
- We're reviewing themes in Kirklees from recent apparent suicides of young people
- Our quarter 3 serious incident report went to Trust Board on 27 March and showed:

South West Yorkshire Partnership NHS Foundation Trust

- 2,948 incidents from Oct-Dec 2017, similar to the previous two quarters
- 87% were no or low harm, showing a positive risk management culture
- 'Physical aggression' was the highest reported incident type.

The Care Quality Commission (CQC) carried out unannounced visits to some of our services in February and March, in advance of our well-led review taking place on 9-11 April. We've also responded to over 200 information requests. Our reports will be published in July.

**Quality improvement and innovation**

Our new 3-year Quality Strategy was approved at Trust Board on 27 March. It sets out our aims to improve and be outstanding. To help achieve our aims, our new improvement campaign, #allofusimprove, focuses on three areas of quality - patient safety, operational excellence and experience of care. Find out more on our website.


Together, all of us can improve.
We must get from where we are to where we want to be.
You can do something to make a difference.

**Performance (February)**

- **118%** overall safer staffing fill rate, which helped us to manage increased acuity
- **98%** average registered nurse fill rate, with **4** wards not reaching 80% on days
- **97%** of people recommend our community services, **85%** our mental health services
- **81%** of prone restraint lasted three minutes or less
- **10** confidentiality breaches
- **613** out of area bed days, the highest it's been all year and up from 268 in January
- **1** young person needed to be admitted to an adult ward

In terms of national metrics, overall we're performing well against measures set by NHS Improvement. We narrowly hit out target for people moving to recovery in our IAPT services and out of area beds, which is now reported nationally, remains a challenge.

**Staffing**

- All NHS organisations now publish details on their gender pay gap – read ours
- We've hit our 80% target for staff receiving and recording supervision – thank you
- 900+ staff have been nominated as an NHS70 superstar – read more on our website
- Voting for staff governor elections is now open – cast yours before 20 April
- Don't forget you can buy additional 2018/19 annual leave - details are on the intranet

Our NHS Staff Survey results are now out and a summary can be found in the table below. Thank you to the 1,900 staff who took part and shared your views. The results will be addressed in our Workforce Strategy action plan.

| Better than average results | Worse than average results |
|---|---|
| • Quality of non-mandatory training, learning and development<br>• Trust taking positive action on health and wellbeing<br>• Satisfaction with flexible working opportunities<br>• Numbers of staff working extra hours<br>• Reporting physical violence at work<br>• Reporting harassment and bullying at work | • Witnessing errors, near misses or incident that could hurt staff<br>• Bullying and harassment from service users/carers<br>• Staff motivation at work<br>• Effective team working<br>• Effective use of patient/service user experience feedback<br>• Staff feeling unwell due to work related stress |
| **Positive changes since 2016** | **Negative changes since 2016** |
| • Satisfaction with opportunities for flexible working<br>• Feeling safe in raising concerns about unsafe clinical practice | • Satisfaction with the quality of work and care delivered<br>• Satisfaction with the amount of responsibility<br>• Trust acts fairly with regard to career progression/promotion |

Don't forget to attend a staff listening event in May or June – they'll cover our 2018/19 plans as well as developments in each of our localities. Read more on the intranet and register.

**Month 11 finances (February)**

We had a £0.6m surplus in February, mainly due to the sale of properties – our underlying position was worse than this

We spent £563k on agency, the most we've spent this year – we're now likely to breach our cap for the year of £5.6m set by NHS Improvement

We've saved £6.8m so far this year in cost improvement initiatives, £0.7m less than planned

We have an NHS Improvement financial risk rating of 1 – the highest possible out of 4

Hard work and one-offs this year means we could deliver our financial targets. However, a deficit position next year is likely and we're discussing this with NHS Improvement.

**Infrastructure**

Implementation of our new mental health clinical record system, SystmOne, is underway. Co-design workshops have taken place in forensic and specialist services and more are happening across other services. If you want to champion this change, email to get involved in data testing, co-create the new system, or become a super-user: crsprogramme@swyt.nhs.uk. Read more on the intranet.

Our new Unity Centre at Fieldhead Hospital has won a Chartered Institute of Builders regional award for collaborative working. Thanks to all involved in the project and our partners over at Interserve.

South West Yorkshire Partnership NHS Foundation Trust

**Service change**

- Our diabetes staff in Barnsley transfer to Barnsley Hospital on 1 April. On the same day our smokefree staff in Rotherham transfer to Parkwood Healthcare. Thanks to both groups of staff for your commitment.
- Our Barnsley musculoskeletal service moves to a new service model from 1 April, bringing together two existing teams into one. The service will now be known as the community musculoskeletal physiotherapy service. Read more on our website.
- Calderdale CCG are reviewing the adult psychological services they commission. They want to hear from people who have used services to help inform future plans – find out more.

We've been successful in an NHS England bid to host a learning disabilities and autism Operational Delivery Network (ODN) for providers across Yorkshire and the Humber. The two-year contract is worth £200k and includes appointing a clinical lead.

## Focus on:

**Our new values-based appraisal**

- Your appraisal is time for you to reflect on the past year with your manager and to set objectives for the year ahead.
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Read more on the intranet. If you're a band 6 or above, make sure you've had yours before the end of June. For bands 5 and below it's before the end of September.

**Our new leadership and management development offer**

As part of our new approach to leadership and management development, we've launched the first of our values-led programmes for aspiring, new or existing team supervisors and managers:

- Mary Seacole Local – takes place over 6 months, from May, by application
- Apprenticeship Diploma (CMI Levels 3 & 5) - over 15 & 24 months, from June, by application

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29 March 2018

South West Yorkshire Partnership NHS Foundation Trust

## Take home messages

1. We put safety first always, and as a learning organisation we learn from incidents
2. Thank you to staff who welcomed the CQC – their view of our services gives essential insights
3. We're achieving the majority of our performance targets and must continue focusing on hotspots
4. Financially, we may achieve our control total this year – next year it's likely we'll be in deficit
5. Get updated on our simplified appraisal and prepare for yours and your teams
6. Whatever role you're in, you can improve quality and our leadership and management offer can help
7. Vote in the staff governor elections – it's your Trust and they are your representatives.

**Share your views about The Brief - comms@swyt.nhs.uk**

**The next issue will start on 26 April.**

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 6.1

| | |
|---|---|
| **Title:** | **Strategic Overview of Business and Associated Risks** |
| **Paper prepared by:** | Director of Strategy |
| **Purpose:** | The purpose of this report is to:<br>➢ Support the Trust Board in reviewing the external environment in which the Trust operates.<br>➢ Evaluate the Trust's preparedness, responsiveness and strategic positioning in response to the internal/external environment.<br>➢ Provide assurance of the alignment between the Trust's strategy, priority programmes and risk management |
| **Mission/values:** | The process of analysing the external environment and the Trust's own readiness and capability to respond to those external factors is a key aspect of strategy development, implementation and monitoring process for the Trust.<br>The Trust's strategy supports the achievement of our **mission** to **help people reach their potential and live well in their community.**<br>The way in which we develop strategy in an honest, open and **transparent** manner demonstrates how we live the **values** of the Trust. |
| **Any background papers/ previously considered by:** | This paper continues the updates to the Trust Board in April and October 2017 that reflected PESTLE (Political, Economic, Social, Technological, Legal/Regulatory and Environmental) and SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses aligned with the Trust risk register and priority programmes, where this is possible. |
| **Executive summary:** | The report is presented depicting the links between SWOT, PESTLE, risk and priority programmes.<br>**PESTLE**<br>Key updates in the **PESTLE** summary report include<br>➢ The **review of the Mental Health Act** is likely to bring changes to legislation in the way that care to people under the Act is delivered.<br>➢ A review of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) is underway and could potentially impact on Trust resources and the way in which we work with regards to administration of DoLS.<br>➢ The lifting of the **1% pay cap.** It is yet to be seen if this will further increase financial risk, albeit the pay deal will be Treasury funded.<br>➢ The **review to develop a new NHS estates strategy** to achieve best value from NHS estate; target the sale of surplus or inefficiently used NHS property; release land to build new homes on NHS land; support the realisation of the FYFV and enable clinical transformation to deliver world class care will bring changes to the Trust's estate strategy that is being refreshed. |

| | |
|---|---|
| | ➢ Additions to the entry about the changing landscape of regulation has been made, specifically about the new working arrangements to align **NHSE and NHSI plans** delivered through seven integrated teams; and the proposed **CQC inspection and framework.**<br>➢ Changes in law to **data protection legislation with the introduction of GDPR** will affect how the Trust governs the management and the use of patient data<br><br>**SWOT**<br>A request was made by the Trust Board in the October 2017 update paper that risks should be matched against the opportunities in the SWOT to ensure we are capitalising on these opportunities and there are enough resources in place. The opportunities have been assessed against existing risks and where a relationship was present these have been included in this update.<br><br>Key updates in the **SWOT** summary report include:<br>**Opportunities**<br>➢ Capitalise on opportunities to drive our **strategic aim of co-production** to explore arts and health, sports, and health and wellbeing tender and bid opportunities.<br>➢ Opportunity to build upon the new models of care (forensic, eating disorders etc.) through the **West Yorkshire and Harrogate Health and Care Partnership**<br>➢ Local **integrated care systems** are being developed currently, in Barnsley, Calderdale, and Wakefield which could offer opportunities to strengthen our role within these systems.<br>**Weaknesses**<br>➢ The **sustainability of the Trust** relies on the level of contracted 'business' and loss of any business could affect financial, operational and clinical sustainability<br>➢ Weakness that **lack of engagement with external stakeholders** and the resulting potential misalignment to commissioning intentions may result in non-achievement of the Trust's strategic ambitions<br>**Threats**<br>➢ **Tendering activity,** natural in the provider sector, can have a negative impact on the morale of staff working in the 'tendered' services which could lead to sub-optimal performance and increased staff turnover<br>➢ The **ageing workforce** who are able to retire in the next five years brings a potential loss of knowledge, skills and experience<br>➢ The **impact of universal credit** and the potential for some groups to lose out financially due to reduced benefits income or delays in claims for benefits could have an increased negative affect on people's mental health problems and therefore an increased pressure on Trust resources. |
| **Recommendation:** | **Trust Board is asked to NOTE the content of the report and ADVISE on any further developments required.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# Strategic Overview of Business and Associated Risks

## Trust Board Agenda Item 6.1 – 24 April 2018

**5 April 2018**

Salma Yasmeen, Director of Strategy

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## 1. Purpose of the Report

To provide an update to the Board depicting the links between Trust SWOT and PESTLE analysis, risk and the priority programmes.

## 2. Information and Analysis

As in previous reports to the Board on the business and associated risks it is important to recognise that the purpose and content of the SWOT, PESTLE, risk register and priority programmes should be broadly coherent and aligned but that **strict alignment and correlation of content is not practical and is not to be expected**. This reflects the complex and non-linear nature of the external environment that our PESTLE analysis in particular aims to reflect.

Furthermore the emphasis on alignment with risks should not overshadow the ability of the PESTLE and SWOT to highlight positive and beneficial developments and opportunities for the Trust, as well as ensuring that negative influences are appropriately addressed.

Fields in the PESTLE and SWOT record in the associated summary include:

- The date when the entry was first added to the record.
  Where this date is greater than 1 year this is referenced to help indicate where long term issues may require additional and specific attention.
- The date the record was last updated
  To help ensure the report is kept current and valid.
- Cross reference with the Trust organisational level risk register
  To indicate alignment between the Trust risk register and external environment and highlight which issues are being managed through risk management action plans and resulting mitigation measures.
- For SWOT analysis ‘weaknesses’ and ‘threats’ entries are also cross referenced with the Trust priority programmes.

Updates and additions made since the last report to Trust Board are indicated in Blue text. Entries updated in this report are also indicated with a ‘tick’. Any entries in the record that are suggested to be no longer applicable are indicated with text crossed out.

## 3. PESTLE Analysis

PESTLE analyses the macro environment (external forces) that impact on the Trust's ability to plan and operate. These external forces are summarised under the headings of:

- Political
- Economic
- Sociological
- Technological
- Legal
- Environmental

### 3.1 Frequency of Updating

- There are 50 current entries in the PESTLE record.
- 10 of the 50 entries have been added this time and a further 10 updated.
- 22 of the 50 entries remain unchanged for more than a year. However, there is frequent review of all entries in the record and the 22 records have been checked that they are still current and up to date.

  Items that remain static for long periods will be reviewed for relevance and where it is suggested that they can be removed from the PESTLE analysis they will be 'crossed out' prior to removal from the record.

### 3.2 Alignment to the Trust Risk Register

- 9 of the 50 entries are matched against current risks which are being managed on the Trust's organisational risk register. The matching of risks is against the Trust Risk Register as last reviewed by EMT on 5 April 2018. This matching indicates some correlation between risks and PESTLE issue entries.

  The majority of those issues are being managed within the agreed risk tolerance. This cross referencing is a continual and ongoing exercise to determine alignment between the Trust risk register and the PESTLE analysis.

  Note: Not every entry on the PESTLE analysis constitutes a risk to the Trust and therefore a 100% correlation should not be expected.

## 4. SWOT Analysis

SWOT analyses the external environment and the Trust's strategic objectives and priorities under the headings of:

- Strengths: characteristics of the Trust's services that give it an advantage over others
- Weaknesses: characteristics of the Trust's services that place the Trust at a disadvantage relative to others
- Opportunities: elements in the environment that the Trust could exploit to its advantage
- Threats: elements in the environment that could cause challenge for the Trust

### 4.1 Frequency of Updating

- There are 63 current entries in the record
- 12 of the 63 entries have been added this time and a further 14 updated.
- 7 entries remain unchanged for more than 1 year. These have however been checked that they are still current, valid and up to date.

### 4.2 Alignment to the Trust Risk Register

A request was made by the Trust Board in the October 2017 update paper that risks should be matched against the opportunities in the SWOT to ensure we are capitalising on these opportunities and there are enough resources in place. The opportunities have been assessed against existing risks and where a relationship was present these have been included in this update. For the record - four of the opportunities have been aligned to existing risks in the risk register as a result.

A comparison of 'weaknesses', 'opportunities' and 'threats' indicates that half (24 out of a possible 48) of the entries are matched against risks in the Trust risk register. The matching of risks is against the Trust risk register as last reviewed by EMT on 5th April 2018. This matching includes the four 'opportunities' that have been aligned to risks as described above. The report also shows that most risks are managed within the agreed risk tolerance.

### 4.3 Alignment to Priority Programmes

The report highlights where 'weaknesses' and 'threats' are matched against a priority programme in the Trust's plan.

Generally there is strong alignment, but it also highlights several gaps that will be considered for inclusion in the Trust's forward programme.

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## PESTLE

Below is an analysis of the macro environment (external forces) that impact on the Trust's ability to plan and operate:

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Political** | 1.1 | Public debate regarding social care funding gap and resulting tensions between local and central government related to tax revenue raising powers. Resulting in heightened debate around 'health and care' and increasing openness to challenge assumptions regarding future form and function of the NHS. Investment into social care re flow and delayed transfer of care (DTOC) creates opportunity and tension | Jan-17 | Jan-17 | | | | | |
| **Political** | 1.2 | Public debate regarding 'winter pressures' in urgent care and primary care starting to change expectations on targets, access and personal responsibility. Further highlighted by ongoing political comments on A&E four-hour targets. | Jan-17 | Jan-17 | | | | | |
| **Political** | 1.3 | Integrated care system plans/partnerships require re-alignments with local elected members and Health and Wellbeing Boards. As these partnerships are developed there is potential for confusion and delay. Nine integrated care systems announced as the first wave of integrated care systems and delivery plans are being developed and the control totals and impact are unclear. | Jan-17 | Oct-17 | | 695 | | | |
| **Political** | 1.4 | Impact of continued austerity for councils coupled with perception of strong 'NHS' focus of integrated care system plans/partnerships guidance may make local political alliances with elected members more difficult – may manifest through Health and Wellbeing Boards and Overview and Scrutiny Committees etc. | 1 yr + | Oct-17 | | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Political** | 1.5 | Continued emphasis on collaborative place based approaches to improvement (Vanguards, etc.) and associated changes in organisational form such as integrated care systems and partnerships indicate a subtle shift away from market based drivers of improvement. The Trust is playing a key role in each of the partnerships that are emerging and developing for the places in which we provide services. | 1 yr + | Apr 18 | ✓ | 812 | | | |
| **Political** | 1.6 | Government ministerial changes, which may have unknown impacts on public policy affecting the NHS, and wider social and economic drivers of health, social care and wellbeing. | Jan 17 | Apr 18 | ✓ | | | | |
| **Political** | 1.7 | Uncertainty of the impact of the UK referendum decision on EU membership. Potential to alter previous assumptions regarding the quantum and focus of public spending, which underpin current Five Year Forward View (FYFV) NHS budget projections. Potential to impact on workforce availability. Longer term potential to impact on public procurement and other public law. Initially has at least re-affirmed the importance of the NHS to the public. | 1 yr + | Jul-17 | | | | | |
| **Political** | 1.8 | Increased Treasury influence over the style and emphasis of Department of Health and Social Care and NHS England (NHSE) communications, also impacting on regulatory regime. | Oct-16 | Apr 18 | ✓ | | | | |
| **Political** | 1.9 | Political stance on NHS employment contracts, e.g. Junior Doctors, emphasises potential for continued discontent and disruption. Changes to IR35 and to NHS Improvement expectations on agency use highlight changing political position and public affinity with healthcare professions acting as locums and agency workers | 1 yr + | Jul-17 | | | | | |
| **Political** | 1.10 | The impact of Yorkshire devolution/mayor plans and the devolvement of major powers to the region could move key decision making on government funds to the region. | Apr 18 | Apr 18 | ✓ | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Economic** | 2.1 | Gap between ideal of Five Year Forward View (FYFV) funding shift (prevention, primary care, mental health etc.) and reality of 2017 – 2019 contracts enabled debate with commissioning partners. Collaboration re mental health investment standard helping establish shared intent. | Jan-17 | Jan-17 | | | | | |
| **Economic** | 2.2 | Increased impact on jobs, services and income related to public health prevention services. Pace of change increased significantly, linked to continued austerity in local authorities. | Oct-16 | Oct-17 | | | | | |
| **Economic** | 2.3 | Increased impact of market forces on vulnerabilities in NHS markets for staff and flexible bed capacity. Experienced through agency usage and costs (mitigated by agency cap), and independent sector bed-day prices. NHS Improvement and HMRC interventions beginning to impact | Oct-16 | Jan-17 | | | | | |
| **Economic** | 2.4 | The impact of NHS financial control measures on both commissioners and providers – particularly around control totals, agency caps, etc. There is stronger financial interdependence across health systems through integrated care systems-level control totals, as underlined in the FYFV. | Oct-16 | Apr 18 | ✓ | 812 | | | |
| **Economic** | 2.5 | Impact of current employment market for clinical and IT staff, manifesting in buoyant agency market, driving cost growth for Trusts in excess of plans and 'cap'. | Oct-16 | Oct-17 | | 905 | | | |
| **Economic** | 2.6 | Major Cost Improvement Programme requirements of financially challenged NHS providers leading to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing | Jul-16 | Oct-17 | | 275 | | | |
| **Economic** | | Deleted from record as deemed no longer applicable (October 2017). | | | | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Economic** | 2.8 | The deployment of Sustainability and Transformation Funding (and Clinical Commissioning Group 1%) is (in the short term at least) largely being directed towards improvement of the sustainability of acute care provision. This impacts on the prioritisation of community learning disability and mental health provision in funding terms. However, there have been some opportunities to bid for transformation funding in mental health and bids have been successful in eating disorders, CAMHS T4, perinatal mental health, improving access to psychological therapies (IAPT), mental health liaison and forensic CAMHS services. | Jul-16 | Mar-18 | ✓ | 522 | | | |
| **Economic** | 2.9 | The Government has lifted the 1% pay cap and NHS chiefs and health unions in England have agreed a three-year pay deal pending membership agreement. It is yet to be seen if this will further increase financial risk, albeit the pay deal will be Treasury funded, but it will provide relief on the recruitment and retention of staff that has been experienced since the introduction of the pay cap in 2010. | Sep-17 | Mar-18 | ✓ | | | | |
| **Economic** | 2.10 | The strength, viability and maturity of the third sector to operate fully in the competitive market place impacts on the degree of flexibility that the Trust can partner to provide flexible and diverse services within health enabling us to reach into and benefiting communities. | Apr 18 | April 18 | ✓ | | | | |
| **Socio-Cultural** | 3.1 | High profile campaigns and celebrity endorsement, as well as local action, are all starting to impact on societal attitudes towards mental health increasing recognition of widespread prevalence and relevance in the lives of all. This potentially increases the likelihood of people seeking help, thereby increasing demand, but also potentially increases likelihood of people seeking help earlier increasing opportunities for effective early intervention. | Jan-17 | Jan-17 | | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Socio-Cultural** | 3.2 | Migration trends into the UK show increasingly diverse countries of origin, increasing complexity in service provision, and enriching local communities. Future impact of Brexit on European migration trends not yet fully understood. | Jan-17 | Jan-17 | | | | | |
| **Socio-Cultural** | 3.3 | Impact of demographic change on demand for services and also on workforce age profile | 1 yr + | 1 yr + | | | | | |
| **Socio-Cultural** | 3.4 | Changing expectations of services. Public expect greater personalisation, higher standards of customer service and responsiveness, greater level of co-production. Policy makers and commissioners expect more self-care and emphasis on prevention | 1 yr + | 1 yr + | | | | | |
| **Socio-Cultural** | 3.5 | All the above drive changed workforce requirements – new skills, new roles, new psychological contract at work | 1 yr + | 1 yr + | | | | | |
| **Socio-Cultural** | 3.6 | The national shortage of clinical staff is affecting the Trust's ability to recruit suitably qualified clinical staff which may have an effect on: the safety and quality of our services and the effective delivery of the Trust strategy, particularly in the ability for future development in services. | Feb-18 | Feb-18 | ✓ | 1151 | | | |
| **Socio-Cultural** | 3.7 | Provision of effective health and wellbeing services are a significant contribution to the Big Society agenda and allows people to cope with life situations, have more choices, cope better with anxiety and depression and therefore improve confidence, motivation and wellbeing and sustain engagement in life of those people beyond the boundaries of illness. | Apr 18 | Apr 18 | ✓ | | | | |
| **Socio-Cultural** | 3.8 | The benefits of new health approaches - social prescribing, self-management, co-production, asset based approaches (placing people's skills, networks and community resources alongside their needs to improve care and support) are helping to reduce dependency on health professionals and encourage sustainable development of a community's health. | Apr 18 | Apr 18 | ✓ | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Technological** | 4.1 | Increased threat from cyber-crime impacting on NHS bodies – resulting in additional cost of defence and prevention, and heightened risk of disruption to service provision (mitigated by business continuity plans). | Jan-17 | Jan-17 | | 1080 | | | |
| **Technological** | 4.2 | Digital technologies, and the continued direction of travel in public service towards 'digital by default, are a key enabler for, and driver of change within, the Trust and externally. In addition, 'political will' individuals and communities drive the demand for health and care providers to keep pace with their use of technology as in other aspects of their lives. This has been adopted by the Trust and is central to the digital strategy that has now been approved and initiatives like the ORCHA pilot in CAMHS are enabling that very strategy. The Trust has developed considerable infrastructure to support agile working. | 1 yr + | Apr 18 | ✓ | | | | |
| **Technological** | 4.3 | Inequalities in technology access, competence, and acceptance are slowly being eroded, but persist as a factor impacting on service design and access. In some ways technology inequalities mirror broader socio-economic inequalities, and as such are of relevance to Trust mission and objectives. | Jul-16 | Jul-16 | | | | | |
| **Technological** | 4.4 | Continued growth in use of social media by a wide range of demographic groups, changes the way in which customer experience and service quality is evaluated – becoming more open, faster, and comparable – e.g. Patient Opinion. Supports choice agenda, potentially links to commissioner decision making. | 1 yr + | Jul-16 | | | | | |
| **Technological** | 4.5 | Technology enables improved access and use of data – telehealth monitoring of vital signs, self-reported well-being etc. Creates a different dialogue between service user and healthcare service provider – supports personal control, self-care, and movement towards coaching approaches. | 1 yr + | Jul-16 | | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Technological** | 4.6 | Interoperability of clinical systems, and enhanced analytical functions (data warehouses, big data etc.) support evidence based care at system level and in relation to integrated care planning at an individual level. Creates demand for cross-organisational platforms for integrated working. Progress lags behind the vision. | 1 yr + | Jul-16 | | | | | |
| **Technological** | 4.7 | Platform technology potentially allows Trust's to widen the range of offers available to service users e.g. mobile apps, enables more peer to peer support, promotes innovation and provides data on choice. Also platforms have potential to disrupt traditional 'supply chain' based markets – e.g. Uber, Airbnb, eBay etc. | Jul-16 | Jul-16 | | | | | |
| **Technological** | 4.8 | Increased use of communications technology for consultation – engagement of carers/ Multi-Disciplinary Teams etc. | 1 yr + | Jul-16 | | | | | |
| **Technological** | 4.9 | Technology opens up wider possibilities in terms of 'remote working', operating over a larger geography, and different option for provision of support services including more self-service, more collaboration and traded services between NHS partners and integrated care organisations. | 1 yr + | Mar-18 | ✓ | | | | |
| **Technological** | 4.10 | The provision of agile working (using communications and information technologies to enable staff to work in ways which best suit their needs) offers the capacity to help the Trust become a more responsive, efficient and effective organisation, ultimately improving performance. | Apr 18 | Apr 18 | ✓ | | | | |
| **Legal/ Regulatory** | 5.1 | Increased pace of movement towards new organisational forms and partnership vehicles suitable for place based solutions (e.g. Integrated Care System, Multi-specialty Community Provider), and for service line specific collaboration (e.g. mental health). Gap emerging between regulatory and legal frameworks and the intended future structures for integrated place based care provision. | Jan-17 | Mar 18 | ✓ | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Legal/ Regulatory** | 5.2 | The changing landscape of regulation and approaches from regulators: This includes the NHSE and NHSI plans to establish new working arrangements, delivered through seven integrated teams from September 2018; new CQC inspection and framework around five KLOE from April 2018 (with stronger approach to improvement); NHS Improvement's Single Oversight Framework and alignment with Care Quality Commission; diminished emphasis on previous markers of independence such as Foundation Trust status and more focus on system-wide view of finance, quality and governance. FYFV further underlines the alignment of regulation, and clarifies intent to take a system view. | 1 yr + | Apr 18 | ✓ | | | | |
| **Legal/ Regulatory** | 5.3 | Care Quality Commission visit and subsequent publication of ratings of Trust services confirm regulatory position of the Trust overall and in relation to specific factors – this shapes future regulatory framework and frequency of review for the Trust. | Jul-16 | Jul-16 | | | | | |
| **Legal/ Regulatory** | 5.4 | Some signals of changing commissioner alignment and relationships. In terms of commissioner to commissioner relationships, and also breaking down aspects of purchaser/ provider split. Committees in common in West Yorkshire and South Yorkshire, and provider to provider alliances starting to take shape. | Oct-16 | Oct-16 | | | | | |
| **Legal/ Regulatory** | 5.5 | Mergers and Acquisitions regulation and guidance – legal and regulatory framework unchanged but the anticipated approach to the practical application of this regulatory framework is uncertain in light of shift towards system based solutions. | 1 yr + | 1 yr + | | | | | |
| **Legal/ Regulatory** | 5.6 | Choice agenda in health remains within NHS plans and policy, but pace of implementation has slowed, with far less prominence than previously. | 1 yr + | 1 yr + | | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated this Time? | Cross Ref with Risk Register | Current Risk Level | Risk Appetite | Target Risk Level |
|---|---|---|---|---|---|---|---|---|---|
| **Legal/ Regulatory** | 5.7 | The review of the Mental Health Act 1983 (2007), commenced in May 2017, is likely to brings changes to legislation to change the way that care to people under the Act is delivered. This will mean changes in the way that certain Trust services are delivered and changes in the procedural element of these services as well as wider implications not yet clear. | Mar-18 | Mar-18 | ✓ | | | | |
| **Legal/ Regulatory** | 5.8 | A review of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) is underway and could potentially impact on Trust resources and the way in which we work with regards to administration of DoLS. | Mar-18 | Mar-18 | ✓ | | | | |
| **Legal/ Regulatory** | 5.9 | The review to develop a new NHS estates strategy to achieve best value from NHS estate; target the sale of surplus or inefficiently used NHS property; release land to build new homes on NHS land; support the realisation of the FYFV and enable clinical transformation to deliver world class care will bring changes to the Trust's estate strategy. | Apr 18 | Apr 18 | ✓ | | | | |
| **Legal/ Regulatory** | 5.10 | Changes in law to data protection legislation with the introduction of the EU General Data Protection Regulation (GDPR) from 25th May 2018 will affect how the Trust governs the management and use of patient data and may attract financial penalties if these measures are not met. | Apr 18 | Apr 18 | ✓ | 1216 | | | |
| **Environmental** | 6.1 | Local Economic Partnership areas developing plans linked to local authority housebuilding and development control policy. Likely to increase density of population in some areas and change the environment. | Jan-17 | Jan-17 | | | | | |
| **Environmental** | 6.2 | Change in travel patterns as part of new service models and technological change – e.g. more home based care but fewer trips back to base. More support staff using video conferencing | 1 yr + | 1 yr + | | | | | |
| **Environmental** | 6.3 | Opportunities around renewable energy | 1 yr + | 1 yr + | | | | | |

## SWOT

In the context of an analysis of the external environment and the Trust's strategic objectives and priorities, the following strengths, weaknesses, opportunities and threats are highlighted:

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strength** | 1.1 | Compelling model for alternative capacity – Creative Minds, Recovery Colleges and Altogether Better is well aligned to Five Year Forward View, Sustainability and Transformation Partnership direction etc. and offers opportunities for partnership in local place-based solutions | 1 yr + | Jul-16 | | | | | | |
| **Strength** | 1.2 | Clarity of approach to management of partnerships and contractual relationships with other providers, and track record of integrated teams and multi-agency joint-delivery, is a strength in the formation of integrated care systems. | Jul-16 | Mar-18 | ✓ | | | | | |
| **Strength** | 1.3 | Partnership track record and place based delivery structure underpinned by clear FT governance arrangements including plans to fully engage and mobilise an active public membership – all key for system leadership in emerging Accountable Care Organisations/ Systems. | Oct-16 | Jan-17 | | | | | | |
| **Strength** | 1.4 | Developing partnerships with neighbouring providers of mental health and learning disability services, aligned to achievement of Sustainability and Transformation Partnership/integrated care system aims. | Oct-16 | Mar-18 | ✓ | | | | | |
| **Strength** | 1.5 | Devolved Business Delivery Unit structures offer tried and tested approach to operating as a multi-'place based' provider – increasingly relevant in development of accountable care systems. | 1 yr + | Jan-17 | | | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strength** | 1.6 | 'Centres of excellence' within services recognised internally and externally – e.g. Equipment Store recycling rates, Forensic Child and Adolescent Mental Health Service expertise shaping policy, leading implementation of suicide prevention strategy for West Yorkshire and Harrogate Health and Care Partnership and leading on partnerships, e.g. in the Police Liaison scheme in Calderdale and Kirklees partnership | Jan-17 | Sep-17 | | | | | | |
| **Strength** | 1.7 | Clear commitment to the Trust's mission, good values base, and increased understanding and alignment around strategic priorities within all parts of the Trust. | 1 yr + | Jul-16 | | | | | | |
| **Strength** | 1.8 | Integrated approach to quality improvement ensures quality drives everything we do. The Trust's integrated change framework supports innovation, change and improvement | 1 yr + | Aug-17 | | | | | | |
| **Strength** | 1.9 | What the Care Quality Commission report confirmed about how staff treat people with kindness care and compassion, and that we are respectful and warm has been further confirmed with the Trust being chosen as the winner of the organisation category at the 2017 Kate Granger awards for compassionate care. | Jul-16 | Oct-17 | | | | | | |
| **Strength** | 1.10 | Our Care Quality Commission report highlights the outstanding features of end of life care services provided by the Trust. It also highlights consistent good ratings in most services | Jul-16 | Jul-16 | | | | | | |
| **Strength** | 1.11 | Our Care Quality Commission report highlights that more than 90% of the individual ratings are good or outstanding and our overall rating is Good | Jul-16 | Jul-16 | | | | | | |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strength** | 1.12 | Our culture of supporting those with which we work, Trust's commitment to staff health and wellbeing and our work with and supporting service users and carers makes us different to many other Trusts. This is seen as a major organisational strength and it inspires staff and offers potential for building external relationships and engaging with commissioners more effectively. | Jul-16 | Mar-18 | ✓ | | | | | |
| **Strength** | 1.13 | Our partnership relationships and the way in which we conduct ourselves when working collaboratively and co-producing with others demonstrates a real focus on the needs of the people who use our services. | Jul-16 | Mar-18 | ✓ | | | | | |
| **Strength** | 1.14 | The additional external responsibilities taken on by our Chief Executive in relation to leadership roles in Sustainability and Transformation Partnerships and on national bodies ensure we have high level connections and influence at a strategic level. | Jul-16 | Jul-16 | | | | | | |
| **Strength** | 1.15 | Our stakeholder survey indicates partners consider the Trust to be well led with an important role to play in the formation and delivery of local place based plans. | Jan-17 | Jan-17 | | | | | | |
| **Weakness** | 2.1 | Some elements of data quality undersell the true quality and contribution made by the Trust. Also examples of poor use of data that undermine stakeholder confidence and therefore impacts on reputation and sustainability. | 1 yr + | Sep-17 | | | | | | Data driven improvements and innovation |
| **Weakness** | 2.2 | There are some Trust services where access to help can be too slow and needs to improve. This requires changes within services as well as improvements supported by commissioners to achieve the right level of capacity. | 1 yr + | Apr 18 | ✓ | 1078 | | | | West Yorkshire work – Tier 4 CAMHS Improving Autism and ADHD |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Weakness** | 2.3 | We need to better recruit, retain, motivate and value the health and wellbeing of our staff. In common with other Trusts we experience difficulties in ensuring that we have the right workforce in some hot spots. e.g. staff grade doctors, ward based nursing staff, Psychological Wellbeing Practitioners in Improving Access to Psychological Therapies. Opportunity to re-think models of care and roles. | 1 yr + | Oct-17 | | 905 | | | | Operational Excellence<br>Health and wellbeing programmes (staff)<br>Workforce and agency spend |
| **Weakness** | 2.4 | Our IT systems don't always support the desired agile style of working, particularly for those working in community services and non-SWYPFT locations, where connectivity or access to systems is not effective. | 1 yr + | Oct-17 | | | | | | Clinical Record System<br>Digitally Health |
| **Weakness** | 2.5 | Our most recent CQC report from January 2017 highlights that there is a requirement to improve our community learning disability services and our acute adult mental health inpatient services. And overall we need to improve our 'Responsiveness'. | Jul-16 | Apr 18 | ✓ | | | | | Quality Counts<br>Safety First |
| **Weakness** | 2.6 | Sometimes we act in silos, with particular need to address gaps between operations and corporate support, and between strong local identities. | Jul-16 | Sep-17 | | | | | | Operational Excellence<br>Change and Quality Improvements<br>Leadership Development |
| **Weakness** | 2.7 | There is a gap between our brand and offer as we would like it to be – 'integrated holistic care' and the perceptions of many of our stakeholders, who often see us as focused on mental health alone | Oct-16 | Jan-17 | | | | | | Joined up care |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Weakness** | 2.8 | Sometimes our approach is too bureaucratic, and colleagues and partners would like us to be faster in making decisions | Jul-16 | Aug-17 | | | | | | Operational excellence Quality Counts, Safety First |
| **Weakness** | 2.9 | Our approach to change takes too long, and is not always as engaging as it needs to be | Jul-16 | Sep-17 | | 695 | | | | Change and Quality Improvements |
| **Weakness** | 2.10 | We have made improvements but we continue to make unnecessary and avoidable Information Governance breaches which undermine service user, commissioner, and regulator confidence and trust. | | | | 852 | | | | |
| **Weakness** | 2.11 | In our place based/integrated care system discussions with partners our broad geography can be portrayed as a lack of 'belonging' to each specific place and community | Apr-17 | Mar-18 | ✓ | | | | | Joined up care Supporting Place Based Plans |
| **Weakness** | 2.12 | Our clinical record system (RiO) has not been reliable, resilient nor robust since November 2015, due in most part to how the system has been developed by the vendor, which impacts on effectiveness and the morale of staff using the system. | Oct-17 | Oct-17 | | | | | | Digital by Default Clinical Record System |
| **Weakness** | 2.13 | The sustainability of the Trust relies on the level of contracted 'business' and the loss of any business could affect financial, operational and clinical sustainability | Feb-18 | Feb-18 | ✓ | 1077 | | | | |
| **Weakness** | 2.14 | A lack of engagement with external stakeholders and the resulting potential misalignment to commissioning intentions may result in non-achievement of the Trust's strategic ambition as set out in the Trust strategy | Feb-18 | Feb-18 | ✓ | 773 | | | | Joined up care Place based plans |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Opportunity** | | Deleted from record as deemed no longer applicable (October 2017). | | | | | | | | |
| **Opportunity** | 3.2 | Through the development of integrated care partnerships we have opportunities to provide integrated joined up care and engage local populations in their health. Integrated care developments in Barnsley, Alliance developments in Wakefield and Calderdale Cares have the opportunity to demonstrate this. | Jul-16 | Mar-18 | ✓ | | | | | Joined up care<br>Place based plans |
| **Opportunity** | 3.3 | We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health | Jan-17 | Sep-17 | | | | | | Quality Counts<br>Safety First<br>Forensic developments |
| **Opportunity** | 3.4 | The integrated nature of our organisation, with reach into several localities across many different services, means we are well placed to play a leading role in the changing shape of health and care provision, in which further integration is anticipated, of both a place based and a service-specific nature. | 1 yr + | Sep-17 | | | | | | Joined up care |
| **Opportunity** | 3.5 | We can forge stronger collaboration and promote the delivery and growth of innovation through our connectivity to integrated care partnerships. In particular we have an opportunity to make a bigger contribution to the South Yorkshire ICS/, e.g. in the mental health workstream, to secure sustainable pathways and West Yorkshire and Harrogate Health and Care Partnership developments in new models of care. | Jul-16 | Mar-18 | ✓ | 1114 | | | | Joined up care & Quality counts safety first |
| **Opportunity** | 3.6 | By fully rolling out our devolved approach to leadership we can empower and inspire more people – becoming an employer of choice and delivering great results in partnership with our service users. | Jan-17 | Mar-18 | ✓ | 1151 | | | | Leadership development |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Opportunity** | 3.7 | We can use the learning from our stakeholder engagement work on brand and strategy to forge excellent relationships with primary care as the bed rock of place based care systems. | Jan-17 | Mar-18 | ✓ | 1214 | | | | Joined up care<br>Place based plans |
| **Opportunity** | 3.8 | We can use our skills in health and wellbeing and health coaching to support our revised workforce strategy with a focus on retention and wellbeing | Jan-17 | Mar-18 | ✓ | 1151 | | | | Operational Excellence<br>Workforce |
| **Opportunity** | 3.9 | We can use the replacement of our clinical records IT system for mental health as an opportunity to improve quality, safety, and efficiency; and to create a system fit for the integrated place based systems of care envisaged in our integrated care partnerships and integrated care system plans. | Jan-17 | Mar-18 | ✓ | | | | | Digital by Default |
| **Opportunity** | 3.10 | We have an opportunity to transform the approach to the delivery of our services through innovation that makes greater use of our unique approaches, e.g. creative minds, recovery colleges, altogether better. | Jan-17 | Aug-17 | | | | | | |
| **Opportunity** | 3.11 | Additional investment in social care to address flow and reduce delayed transfers of care (DTOC) offers an opportunity for innovative collaboration with partners, taking a system view using the Better Care Fund mechanism. | Apr-17 | Apr-17 | | | | | | |
| **Opportunity** | 3.12 | The positive result of our Care Quality Commission revisit provides opportunities to improve from good to outstanding and also positions the Trust well in relation to partnership and growth, supports an enhanced regulatory relationship and allows support to other system partners. | Apr-17 | Aug-17 | | | | | | Quality counts safety first |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Opportunity** | 3.13 | We can use our strategic aim of co-production to explore arts and health, sports, and health and wellbeing tender and bid opportunities. | Mar-18 | Mar-18 | ✓ | | | | | |
| **Threat** | 4.1 | Loss of autonomy arising from failure to achieve key financial and service delivery measures – resulting in increased regulatory attention, and diversion of effort away from progressive activities. | Jan-17 | Jan-17 | | | | | | Operational Excellence |
| **Threat** | 4.2 | If place based 'integrated care' systems are developed which result in significant loss of contracts for the Trust this would be a de-stabilising factor requiring a step change reduction in organisational cost base, and therefore a threat to viability. | Jan-17 | Mar-18 | ✓ | 812 | | | | Joined up care Operational Excellence |
| **Threat** | 4.3 | NHS sustainability agenda focuses primarily on the highly visible challenges to the viability of acute hospital model, which may marginalise the needs of community, learning disability, and mental health services in terms of funding and support. | 1 yr + | Sep-17 | | | | | | Joined up care Operational Excellence |
| **Threat** | 4.4 | Focus on one or two particular issues could be a distraction to ensuring that all key performance metrics are given sufficient and appropriate focus and time. | Oct-16 | Oct-17 | | 1078 | | | | People and Communities First Quality priorities Operational Excellence |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Threat** | 4.5 | It is possible that well-developed infrastructure around service delivery and gaps between corporate support and operations may lead to a lack of agility to respond to changing priorities quickly enough. | 1 yr + | Sep-17 | | | | | | Leadership Development Quality/change improvement Operational Excellence |
| **Threat** | 4.6 | Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g. as a result of benefit restrictions). | 1 yr + | Oct-17 | | 275 | | | | Joined up care Operational Excellence |
| **Threat** | 4.7 | Threat of decommissioning of services may result in loss of services and financial income. | Jan-17 | Apr 18 | | | | | | Joined up care |
| **Threat** | 4.8 | Data quality and information governance issues may lead to regulatory action and reputational damage. | 1 yr + | Sep-17 | | 852 | | | | Data Driven Improvements and Innovation Digital by Default |
| **Threat** | 4.9 | Deleted from record as deemed no longer applicable (October 2017). | | | | | | | | |
| **Threat** | 4.10 | Threat that the under-delivery of cost improvements reduces funding available for investment in required capital schemes including IM&T | Jan-17 | Sep-17 | | 1076 | | | | Operational Excellence |
| **Threat** | 4.11 | Threat that the under-delivery of cost improvements impacts negatively on cash flow, necessitating undesirable urgent cost control measures, and negatively impacting on key operating measures that trigger regulatory action | Apr-17 | Oct-17 | | 1114 | | | | Operational Excellence Effective use of supplies and resources |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Threat** | 4.12 | Threat of cyber-attack impacting on operational continuity and stakeholder confidence | Apr-17 | Sep-17 | | 1080 | | | | Digital by Default Safety First |
| **Threat** | 4.13 | Deleted from record as deemed no longer applicable (April 2018). | | | | | | | | |
| **Threat** | 4.14 | The development of an Accountable Care System for South Yorkshire may lead to the Trust sharing accountability for achievement of a system wide control total. The detailed implications of this are not currently understood | Apr-17 | Oct-17 | | 812 | | | | Joined up care |
| **Threat** | 4.15 | There is a threat of a sub-optimal implementation of the clinical record system (SystmOne), selected to replace our existing RiO system. | Oct-16 | Oct-17 | | | | | | Digital by Default Clinical Record System |
| **Threat** | 4.16 | There is a threat that the Trust's reputation could be adversely affected by long waiting lists delaying treatment and recovery | Feb-18 | Feb-18 | ✓ | 1132 | | | | Operational Excellence |
| **Threat** | 4.17 | Threat that the local tendering of services could increase, impacting on Trust financial viability. | Feb-18 | Feb-18 | ✓ | 1214 | | | | Supporting Place Based Plans |
| **Threat** | 4.18 | Threat likely to the safety and quality of current services, ability for future development in services, and the effective delivery of the Trust strategy due to national shortages in clinical staff affecting ability to recruit suitably qualified clinical staff. | Feb-18 | Feb-18 | ✓ | 1151 | | | | Supporting Place Based Plans |
| **Threat** | 4.19 | The constant level of tendering activity, natural in the provider sector, can have a negative impact on the morale of staff working in the 'tendered' services which could lead to sub-optimal performance and increased staff turnover. | Feb-18 | Feb-18 | ✓ | 1212 | | | | Supporting Place Based Plans |

| Category | Ref. | Description | Date First Added | Date Last Updated | Updated This Time? | Cross Ref. with Risk Register | Current Risk Level | Risk Appetite | Target Risk level | Link to Strategic Priorities and Programmes |
|---|---|---|---|---|---|---|---|---|---|---|
| **Threat** | 4.20 | Non submission, or late submission of statutory returns could result in non-compliance with constitution and licence | Feb-18 | Feb-18 | ✓ | 164 | | | | Supporting Place Based Plans |
| **Threat** | 4.21 | The ageing workforce who are able to retire in the next five years brings a potential loss of knowledge, skills and experience | Mar-18 | Mar-18 | ✓ | 1153 | | | | Leadership Development |
| **Threat** | 4.22 | The impact of universal credit and the potential for some groups to lose out financially due to reduced benefits income or delays in claims for benefits could have an increased negative affect on people's mental health problems and therefore an increased pressure on Trust resources | Mar-18 | Mar-18 | ✓ | | | | | Joined up care Supporting Place Based Plans Operational Excellence |
| **Threat** | 4.23 | Cuts to Citizens Advice (CAB) funding is reducing the numbers of people that CAB can help with problems such as debt, benefits, housing and employment worries therefore potentially increasing people's mental health problems, the knock on affect to mental health services. | Mar-18 | Mar-18 | ✓ | | | | | Joined up care Supporting Place Based Plans |
| **Threat** | 4.24 | Cuts in local authority budgets, and social care budgets specifically, could adversely affecting health services, particularly in delays in discharges from hospital, due to problems accessing social care services. | Mar-18 | Mar-18 | ✓ | | | | | Joined up care Supporting Place Based Plans |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 6.2

| | |
|---|---|
| **Title:** | **Assurance Framework Quarter 4 2017/18** |
| **Paper prepared by:** | Director of Finance and Resources |
| **Purpose:** | For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives. |
| **Mission / values:** | The assurance framework is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values. |
| **Any background papers/ previously considered by:** | Previous quarterly reports to Trust Board. |
| **Executive summary:** | **Assurance Framework 2017/18**<br>The Board assurance framework provides the Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's strategic objectives. In respect of the assurance framework for 2017/18, the principal high level risks to delivery of the Trust's strategic objectives have been identified and, for each of these, the framework sets out:<br>➢ key controls and / or systems the Trust has in place to support the delivery of the objectives<br>➢ assurance on controls – where the Trust Board will obtain assurance<br>➢ positive assurances received by Trust Board, its Committees or the Executive Management Team (EMT) confirming that controls are in place to manage the identified risks and these are working effectively to enable objectives to be met<br>➢ gaps in control (if the assurance is found not to be effective or in place)<br>➢ gaps in assurance (if the assurance does not specifically control the specified risks or no form of assurance has yet been received or identified), which are reflected on the risk register.<br><br>A schematic of the assurance framework process is set out as an attachment.<br><br>The assurance framework is used by the Board in the formulation of the Board agenda and in the management of risk and by the Chief Executive to support his review meetings with Directors. This will ensure Directors are delivering against agreed objectives and action plans are in place to address any areas of risk identified.<br><br>In line with the organisational risk register, the assurance framework has been aligned to the strategic priorities for 2017/18: |

| Our six strategic priorities for 2017/18 | | |
|---|---|---|
| **Improving health** | **Improving Care** | **Improving resources** |
| **People at the centre**<br><br>**Joined up care** | **Quality counts, safety first**<br><br>**Compassionate leadership** | **Operational excellence**<br><br>**Digital by default** |

Following discussion of the assurance framework during Q4, EMT indicated an overall current assurance level of 'yellow'. The rationale and the individual risk RAG ratings are set out in the attached report. Further work will be carried out during quarter 1 to update the assurance framework if necessary so as to ensure it remains fully up-to-date and relevant with regard to meeting 2018/19 objectives.

Overview of current assurance level:

| Strategic objective | Strategic risk (abbreviated) | Assurance level Q1 | Assurance level Q2 | Assurance level Q3 | Assurance level Q4 |
|---|---|---|---|---|---|
| Improving health (people at the centre, joined up care) | 1.1 Differences in published local priorities could lead to service inequalities across the footprint | A | A | A | A |
| | 1.2 Trust plans for service transformation not aligned to a stakeholder requirements | Y | Y | Y | Y |
| | 1.3 Differences in the services may result in inequitable services offers across the Trust | Y | Y | Y | Y |
| Improving care (quality counts, safety first, compassionate leadership) | 2.1 Lack of suitable and robust information systems leading to lack of high quality management and clinical information | Y | Y | Y | Y |
| | 2.2 Inability to recruit and retain skilled workforce leading to poor service user experience | Y | Y | Y | Y |
| | 2.3 Failure to create learning environment leading to repeat incidents | Y | Y | Y | Y |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | 2.4 Failure to embed mission, vision and values | G | G | G | G |
| | Improving resources (operational excellence, digital by default) | 3.1 Deterioration in financial performance leading to unsustainable organisation and inability to deliver capital programme | Y | Y | A | A |
| | | 3.2 Failure to develop commissioner relationships to develop services | Y | Y | Y | A |
| | | 3.3 Failure to deliver efficiency improvements / CIPs | A | A | A | A |
| | | 3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives | Y | Y | Y | Y |
| **Recommendation:** | **Trust Board is asked to NOTE the controls and assurances against the Trust's strategic objectives for Q4 2017/18 and AGREE to an ongoing target for addressing gaps in control given the nature of the gaps and risks identified.** | | | | | |
| **Private session:** | Not applicable. | | | | | |

# ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust

**Our mission**: we help people reach their potential and live well in their community.

**The Operational Context of the Board Assurance Framework (BAF)**
**Purpose:** to provide a comprehensive method for the effective and focused management of the principal risks to achieving the corporate delivery objectives.
**Provides direct evidence for:** Annual Governance Statement and the Head of Internal Audit Opinion

**Strategic direction:** Strategic objectives And priorities as set out in our Annual Plan, underpinned by our values and linked to wider health economy and regulatory requirements.

**Strategic Objectives**

Approved by Trust Board and reviewed regularly

**Controls**
- Accountability
- Regular performance measures
- Operational plans
- Policy and procedure
- Systems and structures

**Assurances**
- Audit (including clinical audit) reports and opinions
- Actual performance measurement
- External and internal reports

**Gaps**
- Audit report, opinion and recommendations to be implemented
- Poor performance management and related actions

Principal risks linked to strategic objectives

Controls in respect of risks and strategic objectives

Assurances in respect of the controls and strategic objectives

Gaps in controls and assurances and actions required to address the gaps

Strategic level risks (15+) into organisational risk register, mitigated in accordance with Trust risk appetite statement. Summary reports into relevant risk committee of the Board where the risk is above the Trusts risk appetite.

Risks at directorate and local level identified and scored through DATIX in line with risk management strategy and procedure. These **may** include gaps identified in the BAF

Exec Management Team

Individual director/BDU assurance arrangements

Trust Board Committees

TRUST BOARD

**Closure of gaps**
- Time bound responsibilities identified plus lead

**Corporate review of the Assurance Framework**
- Trust Board quarterly review of the BAF in terms of the adequacy of assurance processes and the effectiveness of the management of principal risks and gaps
- Audit Committee review of process for development of BAF annually

With **all of us** in mind.

## Assurance Framework 2017/18 Quarter 4

**KEY**: CEO=Chief Executive Officer, DFR=Director of Finance and Resources, DHR=Director of HR, OD and Estates, DMCE= Director of Marketing, Communication and Engagement, DNQ=Director of Nursing and Quality, MD=Medical Director, DS=Director of Strategy, DD= Director of Delivery, BDU=Business Delivery Unit Directors

AC=Audit Committee, EF-Estates Forum, EMT=Executive Management Team, CGCS=Clinical Governance & Clinical Safety Committee, MHA=Mental Health Act Committee, RTSC=Remuneration and Terms of Service Committee. OMG= Operational Management Group. MC=Members Council. ORR=Organisational Risk Register.

| RAG ratings | |
|---|---|
| | On target to deliver within agreed timescales |
| | On trajectory but concerns on ability / confidence to deliver actions within agreed timescales |
| | Off trajectory and concerns on ability / capacity to deliver actions within agreed timescales |
| | Actions will not be delivered within agreed timescales |
| | Action complete |

| Strategic Objective: | Lead Director(s) | Key Board or Committee | Current Assurance Level | | | |
|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 |
| **1. Improving health (people at the centre, joined up care)** | As noted below | EF, EMT, CGCS, MHA | Y | Y | Y | Y |

| Strategic Risks that need to be controlled and consequence of non-controlling and current assessment | | RAG Rating |
|---|---|---|
| 1.1 | Differences in published local priorities could lead to service inequalities across the footprint. | A |
| 1.2 | Trust plans for service transformation are not aligned to a multiplicity of stakeholder requirements. | Y |
| 1.3 | Differences in the services provided due to unnecessary internal variation in practice, may result in inequitable service offers across the whole Trust. | Y |

| Controls – systems and processes (what are we currently doing about the Strategic Risks?) | | Strategic risks | Director lead |
|---|---|---|---|
| C.1 | Senior representation on local partnership boards, building relationships, ensuring transparency of agenda's and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction | 1.1, 1.2 | DS |
| C.2 | Annual Business planning guidance in place standardising process and ensuring consistency of approach across the Trust, standardised process in place for producing businesses cases with full benefits realisation | 1.1, 1.2 | DFR |
| C.3 | Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services | 1.1 | DFR |
| C.4 | Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. | 1.1 | DD |
| C.5 | Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board | 1.1, 1.2 | DFR |
| C.6 | Cross-BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas | 1.1, 1.3 | DD |
| C.7 | Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT | 1.1, 1.3 | BDU |
| C.8 | Project Boards for transformation work streams established, with appropriate membership skills and competencies, PIDs, Project Plans, project governance, risk registers for key projects in place | 1.2, 1.3 | DS |
| C.9 | Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity | 1.2 | DHR |
| C.10 | Further round of Middleground leadership programme being developed, delivered and evaluated linked to organisational and individual resilience to support staff, prepare for change and transition and to support new ways of working | 1.2 | DHR |

| | | | |
|---|---|---|---|
| C.11 | Partnership Fora established with staff side organisations to facilitate necessary change | 1.2 | DHR |
| C.12 | Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon | 1.2, 1.3 | DNQ |
| C.13 | Communication, Engagement and Involvement Strategy in place for service users/carers, staff and stakeholders/partners , engagement events gaining insight and feedback, including identification of themes and reporting on how feedback been used | 1.2 | DMCE |
| C.14 | Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval | 1.1 | DNQ |
| C.15 | Governors engagement and involvement on Members' Council and on working groups, holding Non-Executive Directors (NEDs) to account | 1.2, 1.3 | DFR |
| C.16 | Strategic Priority no. 1 and no. 2 (people at the centre and joined up care) and underpinning programmes supported through robust programme management approach | 1.2, 1.3 | DS |

| | | Report Title/Date |
|---|---|---|
| A.1 | Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement (DFR) | Updates to operational plans for 2018/19 noted at Trust Board March 2018. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. Draft plan submitted March 2018. Final plan due 30 April 2018. |
| A.2 | Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan (DFR) | Audit Committee and Trust Board – April 2017.<br>Audit Committee and Trust Board – April 2018. |
| A.3 | Transformation plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Transformation Boards and IPR (DS, BDU) | Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re. quality impact. |
| A.4 | Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO) | Monthly / bi-monthly 1:1s, annual appraisal and mid-year reviews with each Director – key points and issues summarised following each review. |
| A.5 | Business cases for expansion/change of services approved by Executive Management Team (EMT) and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework (BDU) | Contracting risks, bids & tenders update standing item on delivery EMT agenda. Report to Board bi-annually. |
| A.6 | Integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken (DFR) | IPR reported monthly to OMG, EMT and Trust Board. |
| A.7 | Independent PLACE audits undertaken and results and actions to be taken reported to Executive Management Team (EMT), Members' Council and Trust Board (DHR) | Governors and Directors involved in assessments.<br>Outcome report to CG&CS Committee September 2017. |
| A.8 | Rolling programme of staff, stakeholder and service user/carer engagement and consultation events (DHR, DS, DMCEC) | Communication, engagement and involvement strategy 2016-2019 (approved October 2016). Weekly and monthly engagement with staff (huddles, the Headlines, the View and the Brief) plus staff listening events June 2017, monthly engagement with stakeholders (the Focus), various SU & carer engagement events across the year plus Annual Members' Meeting September 2017. |
| A.9 | Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities (DNQ) | Clinical audit and practice effectiveness (CAPE) annual plan CG&CS Committee April 2017. |
| A.10 | Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives (CEO) | Quarterly Board strategic meetings. |
| A.11 | Service user survey results reported annually to Trust Board and action plans produced as applicable (DNQ) | NHS Mental Health Service User Survey Results will be report to Trust Board when available. |

| | | |
|---|---|---|
| A.12 | Care Quality Commission (CQC) registration in place and assurance provided that Trust complies with its registration (DNQ) | The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – quarterly engagement meetings between DNQ & CQC. |
| A.13 | Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board , CG&CS and MC (DNQ) | Unannounced and planned visits programme in place – report to CG&CS Committee April 2017 and included in annual report to Board April 2017. Visits taking place March 2018<br>Annual report to CG&CS Committee and MC - April 2018. |
| A.14 | Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken. Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DFR) | Quarterly BAF and risk register reports to Board. Triangulation of risk, performance and governance present to each Committee. |
| A.15 | Staff wellbeing survey results reported to Trust Board and/or Remuneration and Terms of Service Committee and action plans produced as applicable (DHR) | Staff wellbeing and work results – RTSC July 2017.<br>NHS staff survey results reported to Trust Board - January 2018 (initial) and March 2018 and RTSC - March 2018 (initial). |
| A.16 | Annual Safeguarding report to Clinical Governance & Clinical Safety Committee (CG&CS), Members' Council and Trust Board (DNQ) | Safeguarding adults and children reports to CG&CS April 2017 and<br>included in annual report to Board April 2017. |
| A.17 | Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR (DS) | Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). |

| Gaps in control and what do we need to do to address these and by when | Date |
|---|---|
| • Loss of business impacting on sustainability considered as part of business planning<br>• Impact on services as a result of local authority cuts – actions identified on the Organisational Risk Register<br>• Impact of local place based solutions and STP initiatives – recognition that some of this is out of our control and ensure engagement takes place in each area impacted | Ongoing<br>Ongoing<br>Ongoing |

| Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when | Date |
|---|---|
| • Strategic workforce plans in development to be presented by the Executive Management Team (EMT).<br>• Internal audit reports with partial assurance (see below) management actions agreed by lead Director. | Quarter 4<br>As per audit report |

**Rationale for current assurance level**

- Effective and involved members of the Board.
- Health & Wellbeing Board place based plans – contributed to through board discussions and commented on.
- Monitor Independent well-led review assessed the Trust as Green in two areas and amber/green in eight areas with action plan in place to move towards green.
- In the main, positive Friends and Family Test feedback from service users and staff with the exception of Child and Adolescent Mental Health Services (CAMHS) (being addressed through joint action plan with commissioners).
- Strong and robust partnership working with local partners, such as Locala to deliver the Care Closer to Home contract and establishment of Programme Board.
- Establishment of locality Recovery Colleges and production of co-produced prospectus.
- Increasing capacity of Creative Minds and Spirit in Mind through partnership development.
- Regular Board-to-Board and/or Exec-to Exec meetings with partners.
- Trust involved in local Vanguards and STPs.
- Involved in development of Accountable Care Organisation in Barnsley and MCP in Wakefield.
- Changes in Local Authority Commissioning arrangements for Smoking Cessation Contracts e.g. Loss of smoking cessation service in Kirklees and impact on our more vulnerable groups.
- Stakeholder survey results and resulting action plan.

- Care Quality Commission (CQC) revisit overall rating of good, number of areas rated good or outstanding 90%, action plan to address remaining requirement notices.
- Integrated Performance Report (IPR) summary metrics re improving people's health and reduce inequalities – IPR Month 8 out of area beds – red, Improving Access to Psychological Therapies (IAPT) – green, % service users followed up within 7 days green (M3), 1 child/young person accommodated on an Inpatient ward
- Strategic Priorities (1 and 2) and underpinning Programmes RAG rating all green re governance, all green for scoping phase with exception of 1.4 Physical and Mental Health yellow.
- Transformation and priority programmes, including the measurement and impact on strategic risks, reported to Trust Board through the Integrated Performance Report (IPR), Clinical Governance & Clinical Safety Committee, and Audit Committee through the triangulation report.
- Internal audit reports: Delivering service change and clinical record keeping - partial assurance with improvements required, Corporate governance arrangements – significant assurance, Data quality performance metrics - significant assurance with minor improvement opportunities.

| **Strategic Objective:**<br>**2. Improving care (quality counts, safety first, compassionate leadership)** | **Lead Director(s)** | **Key Board or Committee** | **Current Assurance Level** | | | |
|---|---|---|---|---|---|---|
| | | | **Q1** | **Q2** | **Q3** | **Q4** |
| | As noted below | EMT, R&TSC, IM&T Forum, CGCS | **Y** | **Y** | **Y** | **Y** |

| **Strategic Risks that need to be controlled and consequence of non-controlling and current assessment** | | **RAG Rating** |
|---|---|---|
| 2.1 | Lack of suitable and robust, performance and clinical information systems leading to lack of timely high quality management and clinical information to enable improved decision-making | **Y** |
| 2.2 | Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience | **Y** |
| 2.3 | Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation | **Y** |

| | | |
|---|---|---|
| 2.4 | Failure to create and communicate a coherent articulation of Trust Mission, Vision and Values leading to inability for staff to identify with and deliver against Trust Strategic objectives | **G** |

| Controls – systems and processes (what are we currently doing about the Strategic Risks?) | | Strategic risks | Director Lead |
|---|---|---|---|
| C.1 | Digital strategy in place and quarterly report to Executive Management Team (EMT) and half yearly report Trust Board in place. | 2.1 | DFR |
| C.2 | Development of data warehouse and business intelligence tool supporting improved decision making | 2.1 | DFR |
| C.3 | Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity | 2.2 | DHR |
| C.4 | A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme | 2.2 | DHR |
| C.5 | Human Resources processes in place ensuring defined job description, roles and competencies to meet needs of service, pre-employment checks done re qualifications, DBS, work permits | 2.2 | DHR |
| C.6 | Trust Board sets the Trust vision and corporate objectives as the strategic framework within which the Trust works | 2.4 | CEO |
| C.7 | Performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board | 2.1, 2.2, 2.3 | DFR |
| C.8 | Executive Management Team (EMT) ensures alignment of developing strategies with Trust vision and strategic objectives | 2.4 | DS |
| C.9 | Weekly serious incident summaries to Executive Management Team (EMT) supported by quarterly and annual reports to EMT, Clinical Governance & Clinical Safety Committee and Trust Board | 2.3 | DNQ |
| C.10 | Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services | 2.2, 2.3 | BDU |
| C.11 | Trust Board approved strategic objectives supporting delivery of Trust mission, vision and values monitored through appraisal process down through director to team and individual team member | 2.4 | CEO |
| C.12 | Risk assessment and action plan for delivery of CQUIN indicators in place | 2.1 | DNQ |
| C.13 | Risk assessment and action plan for data quality assurance in place | 2.1 | DFR |
| C.14 | Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs) | 2.2, 2.4 | DHR |
| C.15 | Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures | 2.2, 2.4 | DHR |
| C.16 | Mandatory clinical supervision and training standards set and monitored for service lines | 2.2 | DHR |
| C.17 | Communication, Engagement and Involvement Strategy approved by Board and action plan in place | 2.2 | DMCE |
| C.18 | Medical Leadership Programme in place with external facilitation | 2.2 | MD |
| C.19 | Organisational Development Framework and plan re support objectives “the how” in place with underpinning delivery plan, Strategic Priority no. 1 and no. 2 ( People First and Joining up Care) and underpinning programmes supported through robust programme management approach | 2.2 | DHR |
| C.20 | Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training | 2.3 | DFR |
| C.21 | Strategic Priority no. 3 and no.4 (Quality counts, safety first and compassionate leadership) and underpinning programmes supported through robust programme management approach | 2.2, 2.4 | DNQ |
| C.22 | Programme established for implementing new clinical record system. | 2.1 | DS |
| C.23 | Learning lessons reports, BDUs, post incident reviews. | 2.3 | DNQ |

| Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external) | | Report title/Date |
|---|---|---|
| A.1 | Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO) | Monthly / bi-monthly 1:1s, annual appraisal and mid-year reviews with each Director – key points and issues summarised following each review. |
| A.2 | Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives (CEO) | Quarterly Board strategic meeting. |

| Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external) | | Report title/Date |
|---|---|---|
| A.3 | CQC registration in place and assurance provided that Trust complies with its registration (DNQ) | The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – quarterly engagement meetings between DNQ & CQC. |
| A.4 | Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans (DNQ) | Unannounced and planned visits programme in place. |
| A.5 | Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken (DFR) | Quarterly BAF and risk register reports to Board. Triangulation of risk, performance and governance present to each Committee. |
| A.6 | Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DFR) | Quarterly triangulation of risk report to Audit Committee. |
| A.7 | Assurance reports to Clinical Governance and Clinical Safety Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place (DNQ) | Quarterly report to CG&CS Committee of risks aligned to the committee for review. |
| A.8 | Integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken (DFR) | IPR reported monthly to OMG, EMT and Trust Board. |
| A.9 | Annual report to Trust Board to risk assess changes in compliance requirements and achievement of performance targets, in year updates as applicable (DFR) | IPR monthly to EMT and Trust Board.<br>Quarterly quality performance/exception reporting to Trust Board. |
| A.10 | Nursing and Medical staff revalidation in place evidenced through report to Trust Board (DNQ, MD) | Annual report to Trust Board - July 2017. |
| A.11 | Data quality improvement plan monitored through Executive Management Team (EMT) deviations identified and remedial plans requested (DFR) | Included in monthly IPR to EMT and Trust Board.<br>Regular reports to CG&CS Committee. |
| A.12 | Serious incidents from across the organisation reviewed through the Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation (DNQ) | Process in place with outcome reported through quarterly serious incident reporting including lessons learned to EMT, Clinical Governance & Clinical Safety Committee and Trust Board. |
| A.13 | Annual appraisal, objective setting and PDPs to be completed in Q1 of financial year for staff in Bands 6 and above and in Quarter 2 for all other staff, performance managed by Executive Management Team (EMT) (DHR). | Included as part of the IPR to EMT and Trust Board. |
| A.14 | Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board, Clinical Governance & Clinical Safety Committee (CGCS and Members' Council (DNQ) | Unannounced and planned visits programme in place – report to CG&CS Committee April 2017 and included in annual report to Board April 2017.<br>Annual report to CGCS and MC in April 2018. |
| A.15 | Information Governance (IG) Toolkit provides assurance and evidence that systems and processes in place at the applicable level, reported through Improving Clinical Information Group, deviations identified and remedial plans requested receive, performance monitored against plans (DFR) | Internal Audit of IG Toolkit Phase 2 report to Audit Committee - July 2017. |
| A.16 | Monitoring of organisational development plan through Executive Management Team (EMT), deviations identified and remedial plans requested (DHR) | |
| A.17 | Health Watch undertake unannounced visits to services providing external assurance on standards and quality of care (BDU) | |
| A.18 | Independent Care Quality Commission (CQC) reports to Mental Health Act Committee provided assurance on compliance with Mental Health Act (DNQ) | Quarterly update report to MHA Committee on independent CQC visits. |
| A.19 | Annual Patient Safety Strategy progress report to Clinical Governance & Clinical Safety Committee (CGCS) (DNQ) | |
| A.20 | Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR (DS) | Monthly priority programmes item schedule for EMT.<br>Included as part of the IPR to EMT and Trust Board. |

| Gaps in control and what do we need to do to address these and by when | Date |
|---|---|
| • Impact of waiting lists leading to a delay in access to services / treatment (in BDUs / CAMHS / ASD). | Ongoing |
| • Forensic BDU locks out of patent. | March 2019 |
| • Untimely risk reporting through management reporting system for forensic CAMHS, Wetherby. | Ongoing |
| • Impact of national funding arrangements (e.g. CCG allocation, Better Care Fund) and local re-tendering. | Ongoing |
| • Liability for any harm caused by drugs stored at temperatures above 25 degrees. | Ongoing |
| • Potential delay in implementation or achievement of transformation change due to lack of engagement with external stakeholders. | Ongoing |
| • Reliance on the use of bank and agency staff to ensure wards are adequately staffed to meet safer staffing requirements. | Ongoing |
| • Risk of arson, | Ongoing |

| Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when | Date |
|---|---|
| • Workforce retention plans under development. | Quarter 4 |
| • Further updates to Clinical Governance & Clinical Safety Committee and Audit Committees on capture of clinical information and impact on data quality. | Quarter 3 |
| • Mandatory training standards not being delivered in all areas, routine reports to teams identifying individuals out of compliance. | Quarter 2 |
| • Appraisal targets not being met, routine reporting to Executive Management Team (EMT) and Remuneration & Terms of Service Committee. | Quarter 2 |
| • Internal audit reports with partial assurance (see below) management actions agreed by lead Director. | As per audit report |

| Rationale for current assurance level |
|---|
| • Monitor well-led review undertaken by independent reviewer demonstrated through stakeholder engagement that the Trust's mission and values were clearly embedded through the organisation. |
| • Staff 'living the values' as evidenced through values into excellence awards. |
| • In the main, positive Friends and Family Test feedback from service users and staff with the exception of CAMHS (being addressed through joint action plan with commissioners). |
| • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. |
| • Strong and robust partnership working with local partners, such as Locala to deliver the Care Close to Home contract and establishment of Programme Board. |
| • Care Quality Commission (CQC) revisit overall rating of good, number of areas rated good or outstanding 90%, action plan to address remaining requirement notices |
| • Internal audit reports –Patient property follow up, Patients bank, Agile working, IT capability, Delivering service change, Sickness absence, Clinical record keeping - partial assurance with improvements required, Information Governance (IG) Toolkit - significant assurance, Significant and serious untoward incidents - significant assurance with minor improvement opportunities |
| • CQUIN targets not achieved in full. |
| • Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 11 shows: F&F Test MH green, F&F Test Community yellow, safer staff fill rates green, IG confidentiality breaches yellow. |
| • Strategic Priorities (3 and 4) and underpinning Programmes rag rating all green for governance and scoping phase. |

| Strategic Objective:<br>3. Improving resources (operational excellence, digital by default) | Lead Director(s) | Key Board or Committee | Current Assurance Level | | | |
|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 |
| | As noted | AC, EMTR&TSC | Y | Y | Y | A |

| Strategic Risks that need to be controlled and consequence of non-controlling and current assessment | | RAG Rating |
|---|---|---|
| 3.1 | Deterioration in financial performance leading to unsustainable organisation and insufficient cash to deliver capital programme | A |
| 3.2 | Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being lost, reduction in income | A |
| 3.3 | Failure to deliver efficiency Improvements/CIPs | A |
| 3.4 | Capacity and resources not prioritised leading to failure to meet strategic objectives. | Y |

| Controls – systems and processes (what are we currently doing about the Strategic Risks?) | | Strategic risks | Director Lead |
|---|---|---|---|
| C.1 | Independent survey of stakeholders perceptions of the organisation and resulting action plans (3.2) | 3.2 | DMCE |
| C.2 | Annual financial planning process CIP and QIA process (3.1, 3.3) | 3.1, 3.3 | DFR, |
| C.3 | Financial control and financial reporting processes (3.1, 3.3) | 3.1, 3.3 | DFR |
| C.4 | Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks (3.4) | 3.4 | DFR |
| C.5 | Strategic Business and Risk Report including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power ( 3.2 ) | 3.2 | DS |
| C.6 | Weekly Operational management Group chaired by DD providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks (3.1, 3.3) | 3.1, 3.3 | DD |
| C.7 | Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities (3.1 ) | 3.1 | DFR |
| C.8 | Performance management system in place with Key Performance Indicators (KPIs) covering national and local priorities reviewed by EMT and Trust Board (3.1) | 3.1 | DFR |
| C.9 | Project Management office in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities ( 3.4 ) | 3.4 | DS |
| C.10 | Standardised process in place for producing businesses cases with full benefits realisation ( 3.1 ) | 3.1 | DFR |
| C.11 | Innovation Framework in place to deliver service change and innovation (3.4 ) | 3.4 | DS |
| C.12 | Service line reporting/ service line management approach (3.1) | 3.1 | DFR |
| C.13 | Human Resources (HR) and Finance managers aligned to BDUs acting as integral part of local management teams(3.1, ) | 3.1 | DHR |
| C.14 | Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (3.4 ) | 3.4 | DHR |
| C.15 | Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. (3.3) | 3.3 | DD |
| C.16 | Annual Business planning guidance in place standardising process, ensuring consistency of approach, standardised process for producing businesses cases with full benefits realisation ( 3.1 ) | 3.1 | DFR |

| | | | |
|---|---|---|---|
| C.17 | Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services (3.2) | 3.2 | DFR |
| C.18 | Regular formal contract review meetings with clinical commissioning and specialist commissioning groups (3.4) | 3.4 | DFR |
| C.19 | Strategic Priority no. 5 and no.6 (Operational excellence and digital by default) and underpinning programmes supported through robust programme management approach (3.1, 3.3) | 3.1, 3.3 | DS |
| C.20 | Wellbeing plans in place | 3.4 | DHR |
| C.21 | Quality Impact Assessment (QIA) process in place | 3.2, 3.3 | DNQ |

| **Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)** | | **Report Title/Date** |
|---|---|---|
| A.1 | Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO) | Objectives for 2017/18 set for all Directors.<br>Monthly one to one meetings between Chief Executive and Directors. |
| A.2 | Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken (DFR) | Monthly IPR to Executive Management Team (EMT) and Trust Board. |
| A.3 | Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources (DFR) | Trust Constitution (including Standing Order) and Scheme of Delegation reviewed by Audit Committee in January 2017 prior to approval by Trust Board and Members' Council.<br>Further update to Scheme of Delegation reviewed by Audit Committee on April 2017 prior to approval by Trust Board and Members' Council. |
| A.4 | Quarterly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity (DFR) | Monthly bids and tenders report to Executive Management Team (EMT).<br>In April 2017, Trust Board agreed for the Investment Appraisal report to be received six monthly. |
| A.5 | Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited (DFR) | Annual Governance Statement 2017/18 reviewed by Trust Board and approved under delegation by Audit Committee in May 2017. |
| A.6 | Quarterly strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats (DS) | In April 2017, Trust Board agreed for the Investment Appraisal report to be received six monthly. |
| A.7 | CQUIN performance monitored through Operational Management Group (OMG) and Executive Management Team (EMT), deviations identified and remedial plans requested (DD) | Monthly Integrated Performance reporting (IPR) to OMG, EMT and Trust Board. |
| A.8 | Remuneration and Terms of Service Committee receive HR Performance Reports, monitor compliance against plans and receive assurance from reports around staff development, workforce resilience (DHR) | Standing item at Remuneration and Terms of Service Committee. |
| A.9 | Benchmarking of services and action plans in place to address variation (DFR) | Benchmarking reports are received by Executive Management Team (EMT) and any action required identified. |
| A.10 | Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by Monitor (DFR, DS) | Operational plan for 2017/18-2018/19 approved by Trust Board in December 2016 and submitted to NHS Improvement in accordance with required timescales.<br>Monitored monthly through the IPR to EMT and Trust Board. |
| A.11 | Business cases for expansion/change of services approved by Executive Management Team (EMT) | Bids and tenders report monthly to EMT. |

| Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external) | | Report Title/Date |
|---|---|---|
| | and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework (BDU) | |
| A.12 | Attendance of NHS Improvement/Monitor at Executive Management Team (EMT) and feedback on performance against targets (DFR) | NHS Improvement hold Quarterly Review Meetings with EMT. |
| A.13 | Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DFR) | Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. |
| A.14 | Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through the Integrated Performance Report (IPR) (DS) | Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board. |

| Gaps in control and what do we need to do to address these and by when | Date |
|---|---|
| • Risk of loss of business impacting on financial, operational and clinical sustainability | Ongoing |
| • Risk of cyber –attack defeating NHS and Trust defences | Ongoing |
| • Risk of inability to achieve transitions identified in our plan | Ongoing |
| • Trust has a history of not fully achieving its recurrent CIP targets | March 2018 |
| • Inability to recruit to qualified clinical staff vacancies | Ongoing |
| • Reduction in Local Authority budgets negatively impacting on financial resource available to commission staff / deploy social care resource | Ongoing |
| • Lack of growth in Clinical Commissioning Group (CCG) budgets combined with other local healthcare financial pressures leading to Mental Health and Community funding not increasing in line with demand for our services | Ongoing |
| • Potential loss of knowledge, skills and experience due to ageing workforce | Ongoing |
| • Impact of pay restraint and new terms and conditions on staff morale and potential for increased industrial action | Ongoing |
| • Increased risk of redundancy / lack of ability to redeploy if services are decommissioned at short notice | March 2018 |
| • Workforce is not sufficiently diverse and representative of local population, failing to meet EDS2 and WRES | Ongoing |
| • Over reliance on temporary staff in some areas | Ongoing |
| • Clinical record system upgrade affecting ability to deliver services | January 2019 |
| • Requirement for succession planning / business continuity plans should individuals holding key information be absent from work | Ongoing |
| • Record keeping / inappropriate destruction of records may lead to loss of information / data | Ongoing |
| • Risk our engagement strategy is not effectively implemented | Ongoing |

| Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when | Date |
|---|---|
| • Completion of review of decision-making framework (Scheme of Delegation) to inform delegated authority at all levels (to Audit Committee) | Quarter 2 |
| • CIP delivery is currently behind plan and there is an overspend in relation to out of area bed placements | Quarter 4 |
| • Internal audit reports with partial assurance management actions agreed by lead Director | As per Audit report |
| • Delivery of 17/18 financial control total has only been achieved through a range of non-recurrent means. | Quarter 4 |
| • Some history of Information Governance (IG) breaches | Ongoing |
| • Cash position is largely dependent on us delivering a surplus | Ongoing |
| • Balanced financial plan for 2018/19 not yet in place | Ongoing |

| Rationale for current assurance level |
| --- |
| • Positive well-led results following CQC review.<br>• Holding some income steams with local authorities in the current climate will generate risk.<br>• Contracts agreed with commissioners.<br>• NHS Improvement Single Oversight Framework rating of 2 – targeted support<br>• Integrated Performance Report hot spots e.g. out of area placements<br>• Impact of non-delivery of CIPs and out of area placements on financial year end outturn.<br>• Underlying profitability after adjusting for non-recurrent measures being taken.<br>• STP and place based driven change may impact on our additional pay spend and service portfolio.<br>• Internal audit reports – General Data Protection Regulations readiness – limited assurance, Integrity of the General Ledger and Financial Reporting, Data Quality Framework, Quality Governance, Risk Management, Payroll – significant assurance.<br>• Integrated Performance Report (IPR) summary metrics provide assurance on majority of our performance and clearly identify where improvement is required.<br>• Introduction of enhanced programme management process.<br>• Income reducing year on year. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 6.3

| | |
|---|---|
| **Title:** | **Organisational risk register quarter 4 2017/18** |
| **Paper prepared by:** | Director of Finance and Resources |
| **Purpose:** | For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives. |
| **Mission / values:** | The risk register is part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its mission and adhere to its values. |
| **Any background papers / previously considered by:** | Previous quarterly reports to Trust Board. |
| **Executive summary:** | **Organisational risk register**<br>The organisational risk register records high level risks in the organisation and the controls in place to manage and mitigate the risks. The risk register is reviewed by the Executive Management Team (EMT), risks are re-assessed based on current knowledge and proposals made in relation to this assessment, including the addition of any high level risks from BDUs, corporate or project specific risks and the removal of risks from the register.<br>The organisational level risks are aligned to the Trust's priorities for 2017/18 and to one of the sub Committees for the Trust Board for review and to ensure that the Committee is assured the current risk level is appropriate. |

| Our six strategic priorities for 2017/18 | | |
|---|---|---|
| **Improving health** | **Improving care** | **Improving resources** |
| **People at the centre**<br>**Joined up care** | **Quality counts, safety first**<br>**Compassionate leadership** | **Operational excellence**<br>**Digital by default** |

The organisational risk register contains the following **15+ risks**:

| | Risk ID | Description |
|---|---|---|
| | 1080 | Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data. |
| | 1212 | Risk that the amount of tendering activity taking place has a negative impact on staff morale which leads to sub-optimal performance and increased staff turnover. |

The following changes have been made to the risk register since the last Board report in January 2018:

| | Risk ID | Description | Status | Update (what changed, why, assurance) |
|---|---|---|---|---|
| | 1078 | Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment. | Risk level reduced | Risk likelihood reduced from 'likely (4)' to 'possible (3)' following discussion at EMT regarding mitigating action in place re. assessment of each individual. Risk level reduced from 16 to 12. |
| | 1119 | Risk that Forensic BDU locks are now out of patent. | Risk level reduced | Risk likelihood reduced from 'possible (3)' to 'rare (1)' following discussion at EMT regarding systems in place to manage work programme. Risk level reduced from 15 to 5. |
| | 1132 | Risks to the Trust's reputation caused by long waiting lists delaying treatment and recovery. | Risk level reduced | Risk likelihood reduced from 'likely (4)' to 'possible (3)' following discussion at EMT due to the controls in place. Risk level reduced from 16 to 12. |
| | 1214 | Risk that local tendering of services will increase, impacting on Trust financial viability. | Risk level reduced | Risk consequence reduced from 'major (4)' to 'moderate (3)' following discussion at EMT due to financial recovery plan in place. Risk level reduced from 16 to 12. |
| | 1077 | Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective. | Risk level reduced | Risk consequence reduced from 'major (4)' to 'moderate (3)' following discussion at EMT due to strategies in place. Risk level reduced from 16 to 12. |
| | 1114 | Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan. | Risk level reduced | Risk consequence reduced from 'catastrophic (5)' to 'moderate (3)' following discussion at EMT regarding director role to focus on operations and financial sustainability plan. Risk level reduced from 15 to 9. |
| | 1151 | Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development. | Risk level reduced | Risk consequence reduced from 'major (4)' to 'moderate (3)' following discussion at EMT regarding workforce strategy implementation plan. Risk level reduced from 16 to 12. |

<table>
<tr><td></td><td>
The full detail for all current organisational level risks is included in the attached risk report. Further detail regarding the status of risks is also provided in the attached risk profile.<br><br>
Following review at both EMT and Audit Committee a further risk will be added to the risk register in respect of Out of Area bed usage:
<table>
<tr><td>Risk ID</td><td>Description</td></tr>
<tr><td>TBC</td><td>Use of out of area beds poses a risk to quality of care and reduces opportunities to retain family and community links which is against the values of the Trust. In addition, it has a significant negative impact Trust finances and its reputation. Out of area bed use is monitored through the Operational Management Group, Executive Management team and is reported monthly to the Board through the Integrated Performance Report.</td></tr>
</table>
One additional risk is included for discussion in the private session of the Trust Board.<br><br>
Risk appetite<br>
The organisational risk register supports the Trust in providing safe, high quality services within available resources, in line with the Trust's Risk Appetite Statement.
</td></tr>
<tr><td>Recommendation:</td><td>Trust Board is asked to NOTE the key risks for the organisation subject to any changes / additions arising from papers discussed at the Board meeting around performance, compliance and governance, and to DISCUSS if the target risk levels that fall outside of the risk appetite are acceptable or whether they require review.</td></tr>
<tr><td>Private session:</td><td>Not applicable.</td></tr>
</table>

# ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

| **Risk appetite:** | |
|---|---|
| **Strategic risks:**<br>Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans. | |
| **Clinical risks:**<br>Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks. | |
| **Financial or commercial risks:**<br>Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income, inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation. | |
| **Compliance risks:**<br>Failure to comply with its licence, CQC registration standards or failure to meet statutory duties, such as compliance with health and safety legislation. | |
| | |
| **Risk appetite** | **Application** |
| Avoid / none (nil) | • Risk of breakdown in financial controls, loss of assets with significant financial value. |
| Minimal / low (1-3) | • Risk to service user, public or staff safety<br>• Risks to meeting statutory and mandatory training requirements, within limits set by the Board<br>• Risk of failing to comply with Monitor requirements impacting on license<br>• Risk of failing to comply with CQC standards and potential of compliance action<br>• Risk of failing to comply with health and safety legislation<br>• Meeting its statutory duties of maintaining expenditure within limits agreed by the Board |
| Cautious / moderate (4-6) | • Reputational risks, negative impact on perceptions of service users, staff, commissioners<br>• Risks to recruiting and retaining the best staff |
| Open / high (8-12) | • Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work<br>• Developing partnerships that enhance the Trusts current and future services<br>• Financial risk associated with plans for existing / new services as the benefits for patient care may justify the investment |
| Seek / extreme (15-20) | • Innovating and safely changing practices |

| Consequence | Likelihood | | | | |
|---|---|---|---|---|---|
| | 1 Rare | 2 Unlikely | 3 Possible | 4 Likely | 5 Almost certain |
| 5 Catastrophic | 5 | 10 | 15 | 20 | 25 |
| 4 Major | 4 | 8 | 12 | 16 | 20 |
| 3 Moderate | 3 | 6 | 9 | 12 | 15 |
| 2 Minor | 2 | 4 | 6 | 8 | 10 |
| 1 Negligible | 1 | 2 | 3 | 4 | 5 |

| | | |
|---|---|---|
| Green | 1 – 3 | Low risk |
| Yellow | 4 – 6 | Moderate risk |
| Amber | 8 – 12 | High risk |
| Red | 15 – 25 | Extreme / SUI risk |

| Our six strategic priorities for 2017/18 | | |
|---|---|---|
| **Improving health** | **Improving care** | **Improving resources** |
| People at the centre<br>Joined up care | Quality counts, safety first<br>Compassionate leadership | Operational excellence<br>Digital by default |

**KEY**: CEO=Chief Executive Officer, DFR=Director of Finance and Resources, DHR=Director of HR, OD and Estates, DMCE= Director of Marketing, Communication and Engagement, DNQ=Director of Nursing and Quality, MD=Medical Director, DS=Director of Strategy, DD= Director of Delivery, BWBDU=Barnsley & Wakefield Business Delivery Unit Director, CKFSBDU=Calderdale, Kirklees, Forensic & Specialist Services Business Delivery Unit Director

## Trust Board (business & risk) – 24 April 2018

## Risk level 15+

| Risk ID | Description of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get To Target Risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1080 | Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data. | ➢ McAfee anti-virus software in place including additional email security and data loss prevention.<br>➢ Security patching regime covering all servers, client machines and key network devices.<br>➢ Annual infrastructure, server and client penetration testing.<br>➢ Appropriately skilled and experienced staff who regularly attend cyber security events.<br>➢ Disaster recovery and business continuity plans which are tested annually.<br>➢ Data retention policy with regular back-ups and off-site storage.<br>➢ NHS Digital Care Cert advisories reviewed on an on-going basis & where applicable applied to Trust infrastructure.<br>➢ Key messages and communications issued to staff regarding potential cyber security risks.<br>➢ Microsoft software licensing strategic roadmap in place. | 5 Catastrophic | 3 Possible | 15 Red / extreme / SUI risk (15-25) | Minimal low (1-3) | ➢ Explore potential to install Intrusion Detection and Intrusion Prevention. (DFR)<br>➢ Implementation of three year (data Centre) infrastructure plan including security and firewall rules for key network and computer devices, and IT services business continuity and disaster recovery (DFR)<br>➢ Daisy currently drafting a cyber-security overview to include recommendations for improvement (DFR)<br>➢ Increased training for information asset owners and managers.<br>➢ Internal assurance report for the Trust controls and mechanisms in relation to the recent WannaCry Ransomware cyber-attack being finalised (DFR)<br><br>Actions in green are completed or ongoing by their nature. | DFR | Ongoing | IM&T Managers Meeting (Monthly)<br><br>EMT Monthly (bi-Monthly)<br><br>Audit Committee (Quarterly)<br><br>IT Services Department service management meetings (Trust/ Daisy) (Monthly) | 5 Yellow / moderate (4-6) | AC | Risk appetite: Financial risk target 1 – 3<br><br>Links to BAF, SO 2 & 3<br><br>The Trust were not impacted by the recent WannaCry Ransomware cyber-attack on 12 May 2017 as experienced within the NHS and private industry | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get To Target Risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1212 | Risk that the amount of tendering activity taking place has a negative impact on staff morale which leads to sub-optimal performance and increased staff turnover. | ➢ Business Development and tendering process.<br>➢ Staff engagement processes.<br>➢ Performance management processes.<br>➢ Wakefield and Barnsley Staff Partnership Forum briefings.<br>➢ Staff retention plan.<br>➢ Staff health and wellbeing offer. | 4 Major | 4 Likely | 16<br><br>Red / extreme / SUI risk (15-25) | Cautious / moderate<br><br>(4-6) | ➢ Horizon scanning for potential tender activity and work with staff in relevant services (DFR / DS)<br>➢ Lessons learned from tenders being systematically actioned (e.g. Barnsley IAPT service) (DFR)<br>➢ Implementation of workforce strategy action plan (DHR)<br>➢ Development of provider alliance in Barnsley (BWBDU)<br>➢ Implementation of staff survey action plans (DHR) | CEO | Ongoing | Staff Partnership Forum briefings<br><br>Regular updates to EMT<br><br>Board context report | 9<br><br>Amber / High (8-12) | AC | Risk appetite: Commercial risk 4 – 6<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |

**Risk level <15 - risks outside the risk appetite (unless stated)**

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 275 | Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding. | ➢ Agreed joint arrangements for management and monitoring delivery of integrated teams.<br>➢ Monthly review through Delivery EMT of key indicators and regular review at OMG.<br>➢ Weekly risk scan by Director of Nursing and Medical Director.<br>➢ BDU / commissioner forums – monitoring of performance.<br>➢ In all geographic areas the Trust is a partner in developing integrated working to reduce overall costs in the system.<br>➢ Maintenance of good strategic partnerships through maintenance of positive relationships with Local Authority staff through EMT and operational contacts. Positive engagement of overview and scrutiny transformation boards.<br>➢ Monthly review through performance monitoring governance structure of key indicators, which would indicate if issues arose regarding delivery, such as delayed transfers of care, waiting times and service users in settled accommodation.<br>➢ At least monthly review of bids management in relation to services commissioned by local authorities.<br>➢ Regular ongoing review of contracts with local authorities.<br>➢ Decision tree process in place to review bids through EMT. | 4 Major | 3 Possible | 12<br><br>Amber / high (8-12) | Minimal low (1-3) | ➢ Joint working in Calderdale is captured in the Calderdale Cares document and delivery is overseen through the Health and Wellbeing Board and Vanguard Board. Updates are provided to EMT and to Board via the Health and Wellbeing Board minutes.(CKFSBDU)<br>➢ Opportunity to look at a Trustwide approach to review across all areas. (BWBDU / CKFSBDU)<br>➢ Continues to be monitored through BDU/commissioner forums. Given ongoing financial austerity review of planned activity is reflected in annual plan submission. (BWBDU / DD / CKFSBDU)<br>➢ Part of the Integration Board (chaired by Locala and includes Local Authority) to develop wider system integration of Care Closer to Home and 0-19 services in Kirklees (CKFSBDU / DD)<br>➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation plans/CEO leads the West Yorkshire STP. (CEO / DHR)<br>➢ Further support for the transfer and redeployment of staff. (DHR)<br>➢ Creation of alternate delivery of services and mitigate financial risks. (BWBDU / DD / CKFSBDU)<br><br>Actions in green completed or ongoing by their nature. | BW BDU | Ongoing risk given external influence outside our control | BDU (monthly)<br><br>EMT (monthly)<br><br>OMG (regular)<br><br>Trust Board (each meeting through integrated performance report)<br><br>Annual review of contracts and annual plan at EMT and Trust Board | 12<br><br>Amber / High (8-12) | CG&CS<br><br>AC | Risk appetite: Clinical risk target 1 – 3<br><br>Links to BAF, SO1, 2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 695 | Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy. | ➢ Governance arrangements for the integrated change framework for OMG, transformation project board and EMT.<br>➢ Service quality metrics in place highlighting potential hotspots and areas for action to be taken as appropriate.<br>➢ Post implementation review process.<br>➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation Plans (STP) / CEO leads the West Yorkshire STP.<br>➢ Regular review and update of the strategy by Trust Board.<br>➢ Review by the CG&CS Committee on QIAs updated at gateway review stages of the integrated change framework process. | 4 Major | 3 Possible | 12 Amber / high (8-12) | Minimal low (1-3) | ➢ Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives. (DS / CKFSBDU / BWBDU)<br>➢ Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. (DS)<br>➢ Active engagement in place based plans. (DS / CKFSBDU / BWBDU)<br>➢ Update Trust business plan and actions in light of updated planning assumptions and system intelligence. (DFR)<br>➢ Place based plans that impact on clinical services will be governed and managed through the Trust-wide integrated change process at EMT and discussed at Trust Board. (DS / CKFSBDU / BWBDU)<br><br>Actions in green are completed or ongoing by their nature. | DS | As per strategic priority delivery timetables. | EMT (monthly)<br><br>Transformation board (monthly)<br><br>OMG (weekly)<br><br>Trust Board (quarterly) | 8 Amber / high (8-12) | CG&CS | Risk appetite: Clinical risk target 1 – 3<br><br>Links to BAF, SO1 & 2 | Every three months prior to business and risk Trust Board – April 2018 |
| 812 | Risk that Trust's sustainability will be adversely impacted by the creation of local place based solutions which change clinical pathways and financial flows. For example integrated care system implementation. | ➢ Progress on system and service transformation reviewed by Board and EMT.<br>➢ Quality Impact Assessment process for CIP and QIPP savings in place.<br>➢ Alignment of contracting and business development functions to support a pro-active approach to retention of contract income and growth of new income streams.<br>➢ EMT monthly and Trust Board investment appraisal report.<br>➢ Regular review and update of strategy by Trust Board.<br>➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation Plans (STP) / CEO leads the West Yorkshire STP.<br>➢ Financial control process to maximise contribution. | 3 Moderate | 3 Possible | 9 Amber / high (8-12) | Open / high (8-12) | ➢ Trusts pro-active involvement and influence in system transformation programmes, which are led by commissioners and includes new models of care. (BWBDU / CKFSBDU)<br>➢ Alignment of our plans with CCGs commissioning intentions. (BWBDU / CKFSBDU)<br>➢ Horizon scanning for new business opportunities. (DS / DFR)<br>➢ Developing communications and engagement into a more systematic approach in stakeholder engagement. (DMCE)<br>➢ Review of CQUIN income attainment by EMT & OMG with action plan to improve. (DFR)<br>➢ Review of commissioning intentions by EMT and contract negotiation stances and meetings in place to progress agreements of contracts for 2018/19. (DFR)<br>➢ Trust strategy approved at Trust Board in January 2018 (DS)<br>➢ Communication of the strategy to the public in place by March 2018 (DMCE)<br>➢ Developing clear service strategies to engage commissioners and service users on the value of services delivered. (DS)<br>➢ Place based plans and other system transformation programmes developing and ensuring Trust participation. (DS)<br>➢ Management process including additional skills building an increase in joint bids with partners (DFR)<br>➢ Ongoing development of capability. (DS)<br><br>Actions in green are completed or ongoing by their nature. | DS | Currently October 2017 | EMT (monthly)<br><br>Trust Board business and risk (half-yearly) | 8 Amber / high (8-12) | AC | Risk appetite: Commercial risk target 8 – 12<br><br>Links to BAF, SO 1 & 3 | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
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| 522 | Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements. | ➢ Participation in system transformation programmes.<br>➢ Progress on Transformation reviewed by Trust Board and EMT.<br>➢ Robust CIP planning and implementation process.<br>➢ Trust is proactive in national discussions and forums to have positive influence on upholding concept of "parity of esteem" for mental health and learning disabilities.<br>➢ Secure 5YFV MH funding. | 3 Moderate | 3 Possible | 9 Amber / high (8-12) | Cautious / moderate (4-6) | ➢ The Trust is developing external engagement and communications to explain the benefits of mental health transformation for external stakeholders. (DMCE)<br>➢ Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR)<br><br>Actions in green are completed or ongoing by their nature. | DFR | Ongoing.<br><br>Review annually. | EMT (monthly)<br><br>Trust Board | 6 Yellow / moderate (4-6) | AC | Risk appetite: Financial risk target 4 – 6<br><br>Links to BAF, SO1, 2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 773 | Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition. | ➢ Transformation projects required to include engagement with external partners to ensure alignment.<br>➢ Use of workshops with external stakeholders to co-produce changes as part of the transformation programme.<br>➢ Communications through contract meetings and other working groups to ensure appropriate sharing of information.<br>➢ Regular team-to-team meetings with commissioner organisations to ensure strategic alignment.<br>➢ Quarterly Partnership Board meetings<br>➢ Integrated change governance framework ensuring engagement of all transformation programmes<br>➢ Active participation at all levels in Vanguards, STPs and other place based planning initiatives.<br>➢ Communication, engagement and involvement strategy. | 4 Major | 3 Possible | 12 Amber / high (8-12) | Cautious / moderate (4-6) | ➢ Forging stronger links with national bodies to influence local and national systems thinking in relation to mental health and community services. (ALL)<br>➢ Pro-active programme of discussion with OSCs regarding transformation proposals. (DS / CKFSBDU / BWBDU)<br>➢ Proactive customer relationship management (CRM) approach with CCG clinical leads, relevant commissioning managers, and other key stakeholders to ensure that community service, learning disability and mental health commissioning intentions are relevant and appropriate. (DMCE)<br>➢ Proactive development of relationships with GP Federations to identify opportunities for collaboration and alignment. (CKFSBDU / BWBDU)<br>➢ Alignment of Trust transformation plans for all services with commissioner's plans as set out in local STP place based plans. (DS / CKFSBDU / BWBDU)<br><br>Actions in green are completed or ongoing by their nature. | DS / DMCE | Annual plan | Bi-monthly focus by EMT on transformation<br><br>Trust Board reports as appropriate<br><br>Business cases approved by Calderdale, Kirklees and Wakefield commissioners | 6 Yellow / moderate (4-6) | CG&CS | Risk appetite: Commercial risk target 4 – 6<br><br>Links to BAF, SO 1 & 2 | Every three months prior to business and risk Trust Board – April 2018 |
| 905 | Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications. | ➢ Safer staffing project manager in place with appropriate medium and longer term plans including recruitment drive and centralisation of the bank.<br>➢ Safer staffing project manager is currently implementing appropriate actions. | 3 Moderate | 3 Possible | 9 Amber / high (8-12) | Cautious / moderate (4-6) | ➢ There are action plans are in place and monitored from Board to ward level. (CKFSBDU / BWBDU)<br>➢ Safer staffing group meets on a monthly basis. (DHR)<br>➢ Recruitment drive ongoing (DHR)<br><br>Actions in green are completed or ongoing by their nature. | BW BDU CK FS BDU | Ongoing | EMT (monthly) | 6 Yellow / moderate (4-6) | CG&CS | Risk appetite: Clinical risk target 4 – 6<br><br>Links to BAF, SO 2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1078 | Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment. | ➢ Emergency response process in place for those on the waiting list.<br>➢ Demand management process with commissioners to manage ASD waiting list within available resource.<br>➢ Commissioners have established an ASD Board and local commissioning plans are in | 4 Major | 3 Possible | 12 Amber / High risk (8-12) | Minimal low (1-3) | ➢ Work is ongoing to implement care pathways and consistent recording of activity and outcome data (CKFSBDU).<br>➢ The team is working with commissioners to implement additional solutions for people waiting for ASD assessment and treatment (CKFSBDU).<br>➢ The team is contributing to the locality plans and | CK FS BDU | Review every three months | Performance reporting to EMT - monthly<br><br>Assurance report to | 6 Yellow / moderate (4-6) | CG&CS | Risk appetite: Clinical risk target 1 – 3<br><br>Links to BAF, SO 2 | Every three months prior to business and risk Trust |

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
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| | | place to start to address backlog for ASD.<br>➢ Future in Mind investments are in place to support the whole CAMHS system<br>➢ Healthwatch Barnsley and Wakefield have carried out monitoring visits and are supporting local teams with the action plans.<br>➢ CAMHS performance dashboard for each district | | | | | reviewing the impact of the Future in Mind investments on demand for specialist CAMHS. (CKFSBDU)<br>➢ Investment into FPOC has demonstrated a positive impact on access and demand in Kirklees. The learning from this is being applied to other areas (CKFSBDU).<br>➢ Ongoing dialogue with people on the waiting list to keep in touch and to carry out well-being checks (CKFSBDU)<br>➢ Active participation in STP CAMHS initiative (CKFSBDU)<br>➢ Recruitment to new waiting list initiative (CKFSBDU)<br>➢ Recruitment to vacant positions is underway to increase capacity. This includes the consideration of new roles to improve opportunities to recruit. (CKFSBDU)<br>➢ Extensive work, supported by the PMO, is underway to develop the care pathways and agree consistent recording and monitoring of activity and outcome data (CKFSBDU)<br><br>Actions in green are completed or ongoing by their nature. | | | Clinical Governance Committee<br><br>Individual district performance reports reviewed by BDU | | | | Board – April 2018 |
| 1099 | Risk of untimely risk reports through management reporting system for forensic CAMHS in Wetherby leading to a failure to act upon and learn from incidents. | ➢ Staff with access to the Leeds Community Trust were able to log on to Datix to complete the reports.<br>➢ Verbal and email reporting was in place through management reporting systems.<br>➢ Support for staff is arranged via management systems.<br>➢ List of staff has been supplied to Leeds Community Healthcare so that Datix can be accessed via their system.<br>➢ Meeting held with Patient Safety Team, SWYPFT to agree reporting from LCH system to SWYPFT (commenced April 2017).<br>➢ Reports have now started to come through the governance system. | 4 Major | 3 Possible | 12 Amber / High (8-12) | Minimal low (1-3) | ➢ Explore potential to install Intrusion Detection and Intrusion Prevention. (DFR)<br>➢ Implementation of 3 year infrastructure plan including security and firewall rules for key network and computer devices. (DFR)<br>➢ Daisy currently drafting a cyber-security overview which will include recommendations for improvement. (DFR)<br>➢ As reports are now being made available, the risk will be reviewed by the BDU and the Patient Safety Team in January 2018 with a view to removing the risk if assurance is satisfactory. (CKFSBDU / BWBDU)<br><br>Actions in green are completed or ongoing by their nature. | CK FS BDU | | EMT monthly | 6 Yellow / moderate (4-6) | CG&CS | Risk appetite: Clinical risk target 1 – 3<br><br>Links to BAF, SO2 | Every three months prior to business and risk Trust Board – April 2018 |
| 1119 | Risk that Forensic BDU locks are now out of patent. | ➢ Protected airlocks and procedures controlling the issue and return of keys.<br>➢ Controlled access and egress from the unit.<br>➢ Procedures re care and control of keys.<br>➢ Full induction support specifically addressing care and control of keys for all staff who work in the service. | 5 Catastrophic | 1 Rare | 5 Yellow / moderate risk (4-6) | Minimal low (1-3) | ➢ There is an agreed programme of work from 2017 to 2019 to renew all the locks (CKFSBDU / DHR)<br><br>Actions in green are completed or ongoing by their nature. | CK FS BDU | Review of progress work March 2018. Expected completion March 2019. | EMT monthly.<br><br>Progress report March 2018. | 5 Yellow / moderate (4-6) | CG&CS | Risk appetite: Clinical risk target 1 – 3<br><br>Links to BAF, SO 2 | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
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| 1132 | Risks to the Trust's reputation caused by long waiting lists delaying treatment and recovery. | ➢ There is a common understanding of the issues with relevant commissioners.<br>➢ Waiting lists are reported through the BDU business meetings.<br>➢ Alternative services are offered as appropriate.<br>➢ People waiting are offered contact information if they need to contact someone urgently.<br>➢ Individual bespoke arrangements are in place within services and reported through the BDU business meetings.<br>➢ Bespoke arrangements to review pathways in individual services. | 4 Major | 3 Possible | 12 Amber / high risk (8-12) | Minimal low (1-3 | ➢ Waiting list information being developed with P&I and reported to EMT on the IPR. (BWBDU / CKFSBDU / DFR)<br>➢ Further work on reviewing the pathways and the impact of this to be monitored in the BDU management meetings (BWBDU / CKFSBDU).<br>➢ Maintaining communication with commissioners to push for waiting list initiatives where demand has exceeded an optimal service supply. (BWBDU / CKFSBDU)<br>➢ The risks at BDU level will be monitored in BDU meetings (BWBDU / CKFSBDU).<br>➢ Work ongoing with the commissioners to agree additional capacity in specific services. (BWBDU / CKFSBDU)<br><br>Actions in green are completed or ongoing by their nature. | BW BDU CK FS BDU | Ongoing | Performance reporting to OMG and EMT monthly.<br><br>Assurance report to CG&CS Committee (CAMHS).<br><br>Individual district performance reports reviewed by BDU. | 6 Yellow / moderate (4-6) | CG&CS | Risk appetite: Clinical risk target 1 – 3<br><br>Links to BAF, SO 2 | Every three months prior to business and risk Trust Board – April 2018 |
| 1159 | Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity. | ➢ Fire Safety Advisor produces monthly / quarterly Fire Report via DATIX and Operational Fire/Unwanted Fire Activation for Head of Estates and Facilities for review/action by EFM Senior Managers.<br>➢ Quarterly review undertaken by Estates TAG.<br>➢ Weekly risk scan are completed by the trusts Fire Safety Advisor and any issues or concerns raised directly with the Head of Estates and Facilities and Head of Estates Operations with the Director of HR, OD and Estates been briefed and action undertaken accordingly<br>➢ In line with regulations the Trust is complying with the following:<br>o The allocation and definition of responsibilities and standards for the provision, installation, testing and planned maintenance of fire safety equipment, devices, alarm and extinguishing systems;<br>o The identification of standards for the control of combustible, flammable or explosive materials;<br>o The allocation of responsibilities for the implementation of fire emergency plans including evacuation procedures, first-aid firefighting, contacting the emergency services, emergency co-ordination and staff training;<br>o The allocation of responsibilities and duties of staff for monitoring and auditing all fire safety management systems and procedures; | 4 Major | 3 Possible | 12 Amber / high (8-12) | Cautious / moderate (4-6) | ➢ Re-enforce Trust smoking polices during annual fire training sessions. Investigate reported incidents on Datix in liaison with local managers and provided quarterly statistics to the Head of Estates and Facilities for tabling at the trusts Estates TAG meetings where fire related incidents and contravention to the trusts policies can be evaluated and any increase in risk action accordingly. (DHR)<br>➢ Smoking group established to review the smoking policy (DHR) | DHR | Ongoing | EFM (weekly and monthly)<br><br>Estates TAG (quarterly) | 6 Yellow / moderate (4-6) | CG&CS | Risk appetite: Clinical risk target 4 – 6<br><br>Links to BAF, SO2 & 3<br><br>Note - A failure to effectively manage compliance with the Trust Fire/Smoking policies will expose the Trust to an increased risk of fire within patient care areas. This would result in injury to service users and damage to Trust property and buildings | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequen -ce (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
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| | | ○ The development and delivery of suitable staff training in fire safety awareness;<br>○ The development and implementation of emergency procedures to ensure early recovery from unforeseen incident involving fire in order to maximise safety, minimise problems and enable the core business structure to continue. | | | | | | | | | | | | |
| 1214 | Risk that local tendering of services will increase, impacting on Trust financial viability. | ➢ Clear service strategy to engage commissioners and service users on the value of services delivered.<br>➢ Participation in system transformation programmes.<br>➢ Robust process of stakeholder engagement and management in place through EMT.<br>➢ Progress on Transformation reviewed by Trust Board and EMT.<br>➢ Robust CIP planning and implementation process.<br>➢ Trust is proactive in engaging leadership of key leaders across the service footprint.<br>➢ Active role in STPs. | 3 Moderate | 4 Likely | 9 Amber / high (8-12) | Cautious / moderate (4-6) | ➢ The Trust leadership is developing productive partnerships with other organisations to develop joint bids and shared services in preparation for integration of services. (DFR / DS / CKFSBDU / BWBDU)<br>➢ The Trust is developing external engagement and communications to explain the benefits of mental health transformation for external stakeholders. (DS / DMCE)<br>➢ Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR)<br>➢ Financial recovery plan to the satisfaction of the regulators (DFR)<br>➢ Commercial strategy development (DFR)<br>➢ Development and maintenance of longer term financial sustainability plan (DFR)<br><br>Actions in green are completed or ongoing by their nature. | DFR | Ongoing.<br><br>Review annually. | EMT (monthly)<br><br>Trust Board | 6 Yellow / moderate (4-6) | AC | Risk appetite: Financial risk target 4 – 6<br><br>Links to BAF, SO1, 2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 164 | Risk of non-submission of statutory returns resulting in non-compliance with constitution and licence. | ➢ Procedure notes are in place to cover majority of returns therefore another individual should be able to complete the return.<br>➢ Staff trained.<br>➢ Detailed year end time lines.<br>➢ Systems utilised to facilitate data for submission.<br>➢ Monthly timetable of NHS I returns | 4 Major | 1 Rare | 4 Yellow / moderate (4-6) | Minimal low (1-3) | ➢ Recruitment plans in P & I to ensure sufficiently trained resource in place. (DFR)<br><br>Actions in green are completed or ongoing by their nature. | DFR | TBC | EMT (monthly) | 4 Yellow / moderate (4-6) | AC | Risk appetite: Compliance risk target 1 – 3<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |
| 852 | Risk of information governance breach leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk. | ➢ Trust maintains access to information governance training for all staff and has track record of achieving the mandatory training target of 95%<br>➢ Trust employs appropriate skills and capacity to advise on policies, procedures and training for Information Governance.<br>➢ Trust has appropriate polices and procedures in place.<br>➢ Trust has good track record for recording incidents and all incidents are reviewed weekly with investigations carried out where needed and action plans put in | 4 Major | 3 Possible | 12 Amber / high (8-12) | Minimal low (1-3) | ➢ Further review of guidance and policies to ensure they comply with best practice (DFR).<br>➢ Targeted approach to advice and support from IG Manager through proactive monitoring of incidents and 'hot-spot- areas (DFR).<br>➢ IG awareness raising sessions through an updated communications plan (DFR)<br>➢ Rebranded materials and advice to increase awareness in staff and reduce incidents (DFR)<br>➢ Increase in training available to teams including additional e-learning and face-to-face training (DFR)<br>➢ Implement recommendations from ICO audit (DFR) | DFR | ICO external monitoring of progress by external evidence / desk based reviews | Progress monitored through EMT and weekly risk scans | 4 Yellow / moderate (4-6) | AC | Risk appetite: Financial risk target 1 – 3<br><br>Links to BAF, SO2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
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| | | place.<br>➢ Improving Clinical Information and Governance group in place which is the governance group with oversight of IG issues.<br>➢ Monthly report of IG issues to EMT.<br>➢ Internal audit perform annual review of IG as part of IG Toolkit. | | | | | ➢ GDPR implementation plan (DFR)<br><br>Actions in green are completed or ongoing by their nature. | | | | | | | |
| 1004 | Risk that a decentralised model for health records results in inconsistent application of standards and / or loss of health records. | ➢ Guidance issued through regular comms not to destroy paper.<br>➢ IG and Records Staff supporting teams .<br>➢ Guidance on document upload, paperlight, scanning, records retention and transporting records issued.<br>➢ Policies and procedures in place. | 4 Major | 3 Possible | 12 Amber / high (8-12) | Minimal low (1-3) | ➢ A guide on "how to move records securely" and further advice on records management / paper light to be issued. (DFR)<br>- Data scanning implementation<br>- Data Quality Improvement Programme<br>➢ Implement recommendation from ICO audit. (DFR) | DFR | | ICIG<br><br>EMT (monthly) | 4 Yellow / moderate (4-6) | AC | Risk appetite: Commercial risk target 1 – 3<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1076 | Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support. | ➢ Financial planning process includes detailed two year projection of cash flows.<br>➢ Working capital management process including credit control and creditor payments to ensure income is collected on time and creditors paid appropriately.<br>➢ Capital prioritisation process to ensure capital is funded where the organisation most needs it.<br>➢ Stated aim of development of financial plans that achieve at least a small surplus position.<br>➢ Estates strategy with the intent of selling surplus buildings.<br>➢ CIP identification and review process. | 4 Major | 3 Possible | 12 Amber / high (8-12) | Minimal low (1-3) | ➢ Increased focus on prioritisation of capital expenditure (DHR / DFR)<br>➢ Increased focus on raising of invoices to ensure timely payment (DFR)<br>➢ Increased focus on robust financial management via training (DFR)<br>➢ Increased robustness of CIP and expenditure management (DFR)<br>➢ Collaborative working within West Yorkshire STP (DFR / CEO / BWBDU)<br><br>Actions in green are completed or ongoing by their nature. | DFR | 31/03/17 | EMT (monthly)<br><br>Board (monthly) | 6 Yellow / moderate (4-6) | AC | Risk appetite: Financial risk target 1 – 3<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1077 | Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective. | ➢ Systematic and integrated monitoring of contract performance, changes in specification and commissioning intentions to identify and quantify contract risks.<br>➢ Regular reporting of contract risks to EMT and Trust Board.<br>➢ Play full role in STPs in both West and South Yorkshire.<br>➢ Communication, engagement and involvement strategy.<br>➢ Updated Trust strategy in place.<br>➢ Liaison with regulators | 3 Moderate | 4 Likely | 12 Amber / high (8-12) | Minimal low (1-3) | ➢ Formulation and delivery of proactive contract risk management plans for specific services (BWBDU / CKFSBDU).<br>➢ Development and maintenance of longer term financial sustainability plan (DFR).<br>➢ Development of targeted programme of business growth focused on specific services and markets and aligned to strategy (BWBDU / DD / CKFSBDU).<br>➢ Scenario planning in Operational Plan and Strategy regarding place based developments, where this could result in step-changes in income in either direction (DS / BWBDU / CKFSBDU).<br>➢ Develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care (BWBDU / CKFSBDU).<br>➢ Implement actions from stakeholder survey (DMCE). | DFR | Ongoing | EMT (monthly)<br><br>Board (monthly) | 6 Yellow / moderate (4-6) | AC | Risk appetite: Financial risk target 1 – 3<br><br>Links to BAF, SO 1 & 3 | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
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| | | | | | | | ➢ Ongoing response to the rapidly changing operating environment and the role the Trust plays in each place (DS).<br>➢ Commercial strategy development (DFR).<br><br>Actions in green are completed or ongoing by their nature. | | | | | | | |
| 1114 | Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan. | ➢Board and EMT oversight of progress made against transformation schemes.<br>➢Active engagement in West Yorkshire and South Yorkshire STPs / CEO leads the West Yorkshire STP.<br>➢Active engagement on place based plans.<br>➢Enhanced management of CIP programme .<br>➢Updated integrated change management processes.<br>➢Director role focussing on delivery of operational excellence. | 3 Moderate | 3 Possible | 9<br><br>Amber / high (8-12) | Minimal low (1-3) | ➢ Increased use of service line management information by directorates (DFR)<br>➢ Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services (DS)<br>➢ Update five year forward plan in light of updated planning assumptions and system intelligence (DFR)<br>➢ Devise plans based on NHS I benchmarking data (DFR)<br>➢ Development of longer term financial sustainability plan (DFR)<br><br>Actions in green are completed or ongoing by their nature. | DFR | Annual review | EMT (monthly)<br><br>Trust Board (quarterly) | 8<br><br>Amber / high (8-12) | AC | Risk appetite: Financial risk target 1 – 3<br><br>Links to BAF, SO 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1151 | Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development. | ➢Safer staffing levels for inpatient services agreed and monitored.<br>➢Agreed turnover and stability rates part of IPR<br>➢Weekly risk scan by Director of Nursing and Medical Director to identify any emerging issues, reported weekly to EMT.<br>➢Reporting to the Board through IPR<br>➢Datix reporting on staffing levels.<br>➢Strong links with universities<br>➢New students supported whilst on placement<br>➢Regular advertising<br>➢Development of Associate Practitioner<br>➢Workforce plans incorporated into new business cases<br>➢Workforce strategy implementation | 3 Moderate | 4 Likely | 12<br><br>Amber / high (8-12) | Cautious / moderate (4-6) | ➢ Workforce plans linked to annual business plans (DHR)<br>➢ Develop new roles e.g. Advanced Nurse Practitioner (DNQ / DHR / MD)<br>➢ Safer staffing reviewing establishment levels (DNQ)<br>➢ Working in partnership across W Yorks on international recruitment. (DHR)<br>➢ Development of Physician Associate role (DHR / MD)<br>➢ Retention plan being developed (DHR)<br>➢ Marketing of the Trust as an employer of choice (DHR)<br>➢ Implementation of workforce strategy action plan (DHR) | DHR | Ongoing given external influence outside our control | BDU (weekly)<br><br>EMT (monthly)<br><br>Trust Board (each meeting through integrated performance report) | 6<br><br>Yellow / moderate (4-6) | CG&CS | Risk appetite: Financial / commercial risk target 4 – 6<br><br>Links to BAF, SO 2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1153 | Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years. | ➢Monitoring turnover rates monthly<br>➢Exit interviews<br>➢Flexible working guidance<br>➢Flexible working arrangements promoted<br>➢Investment in health and well-being services<br>➢Retire and return options<br>➢Apprenticeship scheme balancing the age profile | 3 Moderate | 4 Likely | 12<br><br>Amber / High (8-12) | Cautious / moderate (4-6) | ➢ Workforce planning includes age profile (DHR)<br>➢ Better development and career opportunities (DHR) | DHR | Ongoing | EMT and Trust Board reporting through IPR (monthly)<br><br>RTSC exception reports | 6<br><br>Yellow / moderate (4-6) | RTSC | Risk appetite: Financial / commercial risk target 4 – 6<br><br>Links to BAF, SO2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1154 | Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc. | ➢ Absence management policy<br>➢ Occupational Health service<br>➢ Trust Board reporting<br>➢ Health and well-being survey<br>➢ Enhanced occupational health service<br>➢ Well-being at Work Partnership Group<br>➢ Health trainers<br>➢ Well-being action plans<br>➢ Core skills training on absence management<br>➢ Extend use of e-rostering | 3 Moderate | 3 Possible | 9 Amber / High (8-12) | Cautious / moderate (4-6) | ➢ Workforce plans (DHR)<br>➢ Staff Engagement events (DHR / DMCE)<br>➢ Retention plan developed with NHS I support (DHR) | DHR | 31/08/18 | BDU (weekly)<br>EMT (monthly)<br>Trust Board | 6 Yellow / moderate (4-6) | RTSC | Risk appetite: Financial / commercial risk target 4 – 6<br>Links to BAF, SO2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1155 | Risk that pay restraint and new terms and conditions could cause increased industrial action and impact on morale. | ➢ Implementation of terms and conditions monitored through EMT<br>➢ Staff Partnership Forum and negotiation<br>➢ Business continuity plans in place<br>➢ Strong partnership working with Staff Side<br>➢ Staff Partnership Forums to engage on key issues<br>➢ Implement as far as possible changes in an open and transparent way<br>➢ Reinforce Trust values | 3 Moderate | 3 Possible | 9 Amber / High (8-12) | Cautious / moderate (4-6) | ➢ Pay and conditions part of the well-being and engagement survey (DHR) | DHR | Ongoing | Reports to EMT as and when | 6 Yellow / moderate (4-6) | RTSC | Risk appetite: Financial / commercial risk target 4 – 6<br>Links to BAF, SO2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1156 | Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy. | ➢ Contracting risks, bids and tenders report to delivery EMT<br>➢ Investment appraisal report to business and risk Trust Board (private session)<br>➢ Business development report reviewed by EMT and Board<br>➢ Early discussions with Staff Side on service changes | 3 Moderate | 3 Possible | 9 Amber / High (8-12) | Cautious / moderate (4-6) | ➢ Revised organisational change policy with clear at risk and redeployment process (DHR)<br>➢ Develop formal view of tenders (DFR)<br>➢ Stakeholder engagement plans (DMCE)<br>➢ Influence over place based plans to reduce the likelihood of tendering (DS) | DHR | Ongoing | EMT (monthly)<br>Board (monthly) | 6 Yellow / moderate (4-6) | RTSC | Risk appetite: Financial / commercial risk target 4 – 6<br>Links to BAF, SO2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1157 | Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2 and WRES. | ➢ Annual Equality Report<br>➢ Equality and Inclusion Form<br>➢ Equality Impact Assessment<br>➢ Staff Partnership Forum<br>➢ Development of joint WRES and EDS2 action plan<br>➢ Targeted career promotion in Schools<br>➢ Focus development programmes<br>➢ Support to develop staff disability network | 3 Moderate | 3 Possible | 9 Amber / High (8-12) | Cautious / moderate (4-6) | ➢ Links with Universities on widening access (DHR / DNQ)<br>➢ Review of recruitment with staff networks (DHR) | DHR | Ongoing | EMT (quarterly)<br>E&I Forum (quarterly) | 6 Yellow / moderate (4-6) | RTSC<br>E&I Forum | Risk appetite: Financial / commercial risk target 4 – 6<br>Links to BAF, SO2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequence (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1158 | Risk of over reliance on agency staff which could impact on quality and finances. | ➢ Board self-assessment<br>➢ Reporting through IPR<br>➢ Safer Staffing Reports<br>➢ Agency induction policy<br>➢ Authorisation levels for approval of agency staff now at a senior level<br>➢ Restrictions on Administration and Clerical Staff<br>➢ Extension of the Staff Bank<br>➢ Development of Medical Bank<br>➢ OMG to Overview<br>➢ Director of Delivery supporting reduction in agency usage | 3 Moderate | 3 Possible | 9 Amber / High (8-12) | Cautious / moderate (4-6) | ➢ Recruitment to Consultant Roles (DHR / MD)<br>➢ Development of new roles e.g. Advanced Clinical Nurse Practitioners to reduce the need for medical locum (DHR)<br>➢ Retention programme (DHR) | DHR | 31/03/18 | EMT (monthly)<br><br>Board (monthly) | 6 Yellow / moderate (4-6) | RTSC | Risk appetite: Financial / commercial risk target 4 – 6<br><br>Links to BAF, SO2 & 3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1169 | Risk that improvements in performance against the metrics covering open referrals, invalidated progress notes and un-outcomed appointments are not made leading to clinical risk and poor outcomes for service users. | ➢ Information is available daily at HCP, team, BDU and Trust level.<br>➢ A regular summary is reviewed at Operational Management Group (OMG) to track progress | 3 Moderate | 3 Possible | 9 Amber / high (8-12) | Minimal low (1-3) | ➢ Track movement in performance (DFR) | DFR | Ongoing | ICIG<br><br>OMG | 3 Green / low (1-3) | CG&CS | Risk appetite: Financial risk target 1 - 3<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1196 | Risk that the use of multi-functional devices for scanning and printing patient identifiable information leads to a breach in information governance. | ➢ Communications plan.<br>➢ Asset security plan.<br>➢ Policies and procedures in place.<br>➢ Training of staff | 2 Minor | 3 Possible | 6 Yellow / moderate (4-6) | Cautious / moderate (4-6) | ➢ Undertake a formal risk assessment of using MFDs for confidential and sensitive information and identify mitigation. (DFR)<br>➢ Change MFD to the scanning resolution 300dpi and ensure that all scanned and copied items are either instantly deleted or are automatically cleared from the machine memory daily. (DFR)<br>➢ Future procurement for MFDs includes meeting health record standards. (DFR) | DFR | 31/03/17 | ICIG | 6 Yellow / moderate (4-6) | AC | Risk appetite: Financial risk target 4 – 6<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1213 | Risk that the sub-optimal transition from Rio to SystmOne will result in significant loss or ineffective use of data resulting in the inability share information and produce reports | ➢ Implementation plan<br>➢ Agreed contract<br>➢ Dedicated implementation team<br>➢ Programme governance on progress reporting and risk management through the Clinical Record System programme board; Transformation Board; and EMT<br>➢ Non Exec (RC) on programme board | 4 Major | 3 Possible | 12 Amber / High (8-12) | Open / high (8 – 12) | ➢ Regular reports to EMT and Trust Board (DS)<br>➢ Risk management oversight through Audit Committee (DS)<br>➢ Learning from other mental health SystmOne implementations (DS)<br>➢ Report to CG&CS Committee re. quality aspects (DS) | DS | November 2018 | Regular reports to EMT, CG&CS Committee and Trust Board | 9 Amber / High (8-12) | AC | Risk appetite: Strategic risk 8 – 12<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |

| Risk ID | Description Of risk | Current control measures | Consequen -ce (current) | Likelihood (current) | Risk level (current) | Risk appetite | Summary of Risk action Plan to get to Target risk Level and individual risk owners | Overall Risk owner | Expected Date of completion | Assurance & monitoring | Risk level (target) | Nominated Committee | Comments | Risk review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1215 | Risk of scanning records on to the clinical system and destroying paper records without paper light accreditation. | ➢Policies and procedures in place.<br>➢Regular communication.<br>➢IG and records staff support. | 4 Major | 3 Possib le | 12<br><br>Amber / high (8-12) | Minimal low (1-3) | ➢A guide on "how to move records securely" and further advice on records management / paper light to be issued. (DFR)<br>- Data scanning implementation<br>- Data Quality Improvement Programme<br>➢Implement recommendation from ICO audit. (DFR) | DFR | | ICIG<br><br>EMT (monthly) | 4<br><br>Yellow / moder ate (4-6) | AC | Risk appetite: Commercial risk target 1 – 3<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1216 | Risk that the impact of General Data Protection Regulations (GDPR) results in additional requirements placed on the Trust that are not met or result in a financial penalty. | ➢Implementation plan<br>➢Existing data protection policies<br>➢Attendance at Yorkshire & Humber IG meetings<br>➢Internal audit completed on readiness<br>➢Training provided by Deloitte to Board members | 4 Major | 3 Possib le | 12<br><br>Amber / high (8-12) | Cautious / modera te<br><br>(4-6) | ➢Implementation plan monitored by ICIG group which includes the update of policies and staff awareness training (DFR / DNQ)<br>➢React to national guidance when provided (DFR / DNQ)<br>➢Ongoing actions to complete internal audit recommendations (DFR / DNQ)<br>➢Progress updates at EMT and Audit Committee (DFR / DNQ) | DFR DNQ | Impleme ntation plan – May 2019 | Regular reports to ICIG group<br><br>Reports to Audit Committee | 6<br><br>Yellow / moder ate (4-6) | AC | Risk appetite: Reputational risk 4 – 6<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |
| 1217 | Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives. | ➢Programme prioritisation processes<br>➢Overall priority progress reports via monthly IPR<br>➢Individual priority programmes via governance groups of transformation board, OMG and EMT<br>➢Resources established aligned to programmes<br>➢Annual planning process | 4 Major | 3 Possib le | 12<br><br>Amber / high (8-12) | Open / high (8 – 12) | ➢Wider staff training (DHR)<br>➢Agree resource availability to support system-wide programmes of work (ALL)<br>➢Fully establish Integrated Change Network (DS)<br>➢Agree Quality strategy with integrated change application embedded (DNQ / DS)<br>➢Leadership framework to build capability and to include change competencies (DHR / DS)<br>➢Review prioritisation and include stopping some activities based on risk assessment (DS)<br>➢Build capability to enhance capacity through programmes including Change Acceleration Programme (CAP) and other development programmes (DS)<br>➢Establish change network to develop critical mass across the organisation (DS) | DS | Ongoing | Regular reports to transformati on board, OMG and EMT | 9<br><br>Amber / High (8-12) | AC | Risk appetite: Strategic risk 8 – 12<br><br>Links to BAF, SO3 | Every three months prior to business and risk Trust Board – April 2018 |

## Organisational level risks within the risk appetite

| Risk ID | Description of risk | Risk level (current / pre-mitigation) | Risk appetite | Risk level (target) |
|---|---|---|---|---|
| 279 | Risk that trust may not be competitive in its offer to secure Any Qualifies Provider status for services selected by Cluster Commissioners. | Yellow/ Moderate (4-6) | Cautious / moderate (4-6) | Yellow/ Moderate (4-6) |

# Risk profile – Trust Board 24 April 2018

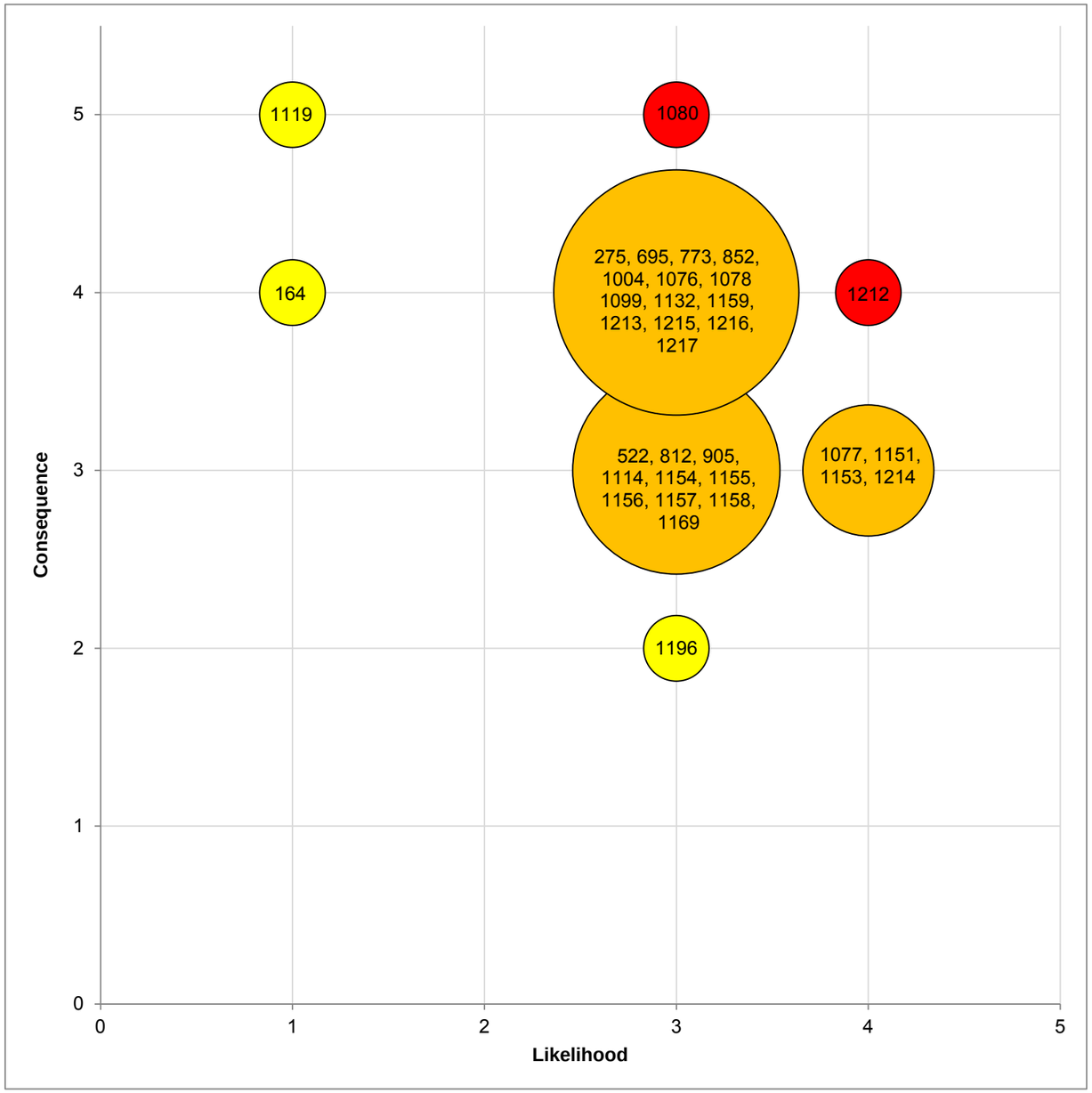
South West Yorkshire Partnership NHS Foundation Trust

| Consequence (impact / severity) | Likelihood (frequency) | | | | |
|---|---|---|---|---|---|
| | Rare (1) | Unlikely (2) | Possible (3) | Likely (4) | Almost certain (5) |
| Catastrophic (5) | < Risk that Forensic BDU locks are now out of patent. (1119) | | = Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data. (1080) | | |
| Major (4) | = Risk of non-submission of statutory returns resulting in non-compliance with constitution and licence. (164) | | = Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding. (275)<br>= Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy. (695)<br>= Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition. (773)<br>= Risk of information governance breach leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk. (852)<br>= Risk that decentralised model for health records results in inconsistent application of standards and / or loss of health records. (1004)<br>= Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support. (1076)<br>< Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment. (1078)<br>= Risk of untimely risk reports through management reporting system for forensic CAMHS in Wetherby leading to a failure to act upon and learn from incidents. (1099)<br>< Risks to the Trust's reputation caused by long waiting lists delaying treatment and recovery. (1132)<br>= Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity. (1159)<br>= Risk of sub-optimal transition from Rio to SystmOne will result in significant loss or ineffective use of data resulting in the inability share information and produce reports (1213)<br>= Risk of scanning records on to the clinical system and destroying paper records without paper light accreditation. (1215)<br>= Risk that the impact of General Data Protection Regulations (GDPR) results in additional requirements placed on the Trust that are not met or result in a financial penalty. (1216)<br>= Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives. (1217) | = Risk that the amount of tendering activity taking place has a negative impact on staff morale which leads to sub-optimal performance and increased staff turnover. (1212) | |
| Moderate (3) | | | = Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements. (522)<br>= Risk that Trust's sustainability will be adversely impacted by the creation of local place based solutions which change clinical pathways and financial flows. For example ACO implementation. (812)<br>= Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications. (905)<br>< Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan. (1114)<br>= Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc. (1154)<br>= Risk that pay restraint and new terms and conditions could cause increased industrial action and impact on morale. (1155)<br>= Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy. (1156)<br>= Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2 and WRES. (1157)<br>= Risk of over reliance on agency staff which could impact on quality and finances. (1158)<br>= Risk that improvements in performance against the metrics covering open referrals, invalidated progress notes and un-outcomed appointments are not made leading to clinical risk and poor outcomes for service users. (1169) | < Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective. (1077)<br>< Risk that the Trust is unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development. (1151)<br>= Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years. (1153)<br>< Risk that local tendering of services will increase, impacting on Trust financial viability. (1214) | |
| Minor (2) | | | = Risk that the use of multi-functional devices for scanning and printing patient identifiable information leads to a breach in information governance. (1196)<br><br>RA (522), (773), (905), (1151), (1153), (1154), (1155), (1156), (1157), (1158), (1159), (1196), (1212), (1214) | RA (812), (1213) | |
| Negligible (1) | | | RA (164), (275), (695), (852), (1004), (1076), (1077), (1078), (1080), (1099), (1114), (1119), (1132), (1169) (1215), (1216), (1217) | | |

| | | | | | |
|---|---|---|---|---|---|
| = | same risk assessment as last quarter | < | decreased risk rating since last quarter | RA | risk appetite |
| ! | new risk since last quarter | > | increased risk rating since last quarter | | |

With **all of us** in mind.

# Risk profile – Trust Board 24 April 2018




| Average risk level 2017/18 | | | |
|---|---|---|---|
| **Q1** (31 risks) | **Q2** (31 risks) | **Q3** (35 risks) | **Q4** (35 risks) |
| **14** | **11** | **12** | **9** |

| | | |
|---|---|---|
| | 164 | Risk of non-submission of statutory returns resulting in non-compliance with constitution and licence. |
| | 275 | Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding. |
| | 522 | Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements. |
| | 695 | Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy. |
| | 773 | Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition. |
| | 812 | Risk that Trust's sustainability will be adversely impacted by the creation of local place based solutions which change clinical pathways and financial flows. For example ACO implementation. |
| | 852 | Risk of information governance breach leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk. |
| | 905 | Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications. |
| | 1004 | Risk that decentralised model for health records results in inconsistent application of standards and / or loss of health records. |
| | 1076 | Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support. |
| | 1077 | Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective. |
| | 1078 | Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment. |
| | 1080 | Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data. |
| | 1099 | Risk of untimely risk reports through management reporting system for forensic CAMHS in Wetherby leading to a failure to act upon and learn from incidents. |
| | 1114 | Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan. |
| | 1119 | Risk that Forensic BDU locks are now out of patent. |
| | 1132 | Risks to the Trust's reputation caused by long waiting lists delaying treatment and recovery. |
| | 1151 | Risk that the Trust is unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development. |
| | 1153 | Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years. |
| | 1154 | Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc. |
| | 1155 | Risk that pay restraint and new terms and conditions could cause increased industrial action and impact on morale. |
| | 1156 | Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy. |
| | 1157 | Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2 and WRES. |
| | 1158 | Risk of over reliance on agency staff which could impact on quality and finances. |
| | 1159 | Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity. |
| | 1169 | Risk that improvements in performance against the metrics covering open referrals, invalidated progress notes and un-outcomed appointments are not made leading to clinical risk and poor outcomes for service users. |
| | 1196 | Risk that the use of multi-functional devices for scanning and printing patient identifiable information leads to a breach in information governance. |
| | 1212 | Risk that the amount of tendering activity taking place has a negative impact on staff morale which leads to sub-optimal performance and increased staff turnover. |
| | 1213 | Risk of sub-optimal transition from Rio to SystmOne will result in significant loss or ineffective use of data resulting in the inability share information and produce reports |
| | 1214 | Risk that local tendering of services will increase, impacting on Trust financial viability |
| | 1215 | Risk of scanning records on to the clinical system and destroying paper records without paper light accreditation. |
| | 1216 | Risk that the impact of General Data Protection Regulations (GDPR) results in additional requirements placed on the Trust that are not met or result in a financial penalty. |
| | 1217 | Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 6.4

| | |
|---|---|
| **Title:** | **Review of the Risk Appetite Statement** |
| **Paper prepared by:** | Director of Finance and Resources<br>Company Secretary |
| **Purpose:** | To review the risk appetite statement which outlines the level of risk Trust Board is prepared to tolerate. |
| **Mission/values:** | Supports the Trust in delivering safe, effective and efficient services which underpins the Trust's mission of helping people reach their potential and live well in their community. Supporting delivery of a key value around improvement and the aim to be outstanding as a Trust. |
| **Any background papers/ previously considered by:** | Risk Management Strategy (including Risk Appetite Statement) approved by Trust Board.<br>Corporate/Organisational Risk Register received quarterly by Trust Board.<br>Risk Appetite discussion at Trust Board strategic in February 2018 and paper in March 2018.<br>Executive Management Team meeting 5 April 2018.<br>Audit Committee 10 April 2018. |
| **Executive summary:** | **Background**<br>The Trust aims to provide high quality, safe services which help people reach their potential and live well in their community. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and determines its approach and its appetite for risk to suit the circumstances at the time.<br>Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. The Risk Appetite Statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Strategy.<br>The statement of risk appetite is by its nature dynamic and its drafting will be an iterative process that reflects the challenging environment facing the Trust and the wider NHS. Under the Risk Management Strategy, the Trust should review its risk appetite at least annually.<br>**Review**<br>The Trust first introduced its Risk Appetite Statement in 2016. Since then, through discussions at Board and sub-committees it was noted that there was a flaw in the scoring methodology. For example, where there was a risk appetite of 1-3 (Minimal /Low), that if the 'consequence' score |

| | |
|---|---|
| | of a risk was 4 (Major) or 5 (Catastrophic) even if it had a 'likelihood' of 1 (Rare – This will probably never happen / reoccur) with an overall score of 5 for the risk it could never be within the risk appetite level. At the strategic session of Trust Board in February 2018, the Board discussed possible options for changes to the Risk Appetite Statement and supported that the levels be reviewed. At the Trust Board meeting in March 2018, it was agreed that the Executive Management Team (EMT) would discuss this further and make a recommendation on what the revised risk appetite by category should be with any proposed changes be reviewed by the Audit Committee prior to approval by the Trust Board in April 2018. This review has taken place and the attach paper provides an updated Risk Appetite Statement for approval which continues to be aligned to the *'Good Governance Institute risk appetite for NHS Organisations'* matrix. Further development will take place over the next twelve months.<br>**Risk appetite**<br>The Risk Appetite Statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Strategy. Where risks cannot be managed within the risk appetite of the Trust, they are subject to scrutiny by the relevant sub-committee as identified within the committee Terms of Reference. |
| **Recommendation:** | **Trust Board is asked to REVIEW and APPROVE the update to the Trust's Risk Appetite Statement.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018

## Review of the Risk Appetite Statement

### Introduction

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. The Risk Appetite Statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Strategy.

The statement of risk appetite is by its nature dynamic and its drafting will be an iterative process that reflects the challenging environment facing the Trust and the wider NHS. Under the Risk Management Strategy, the Trust should review its Risk Appetite at least annually.

It is recognised that the Trust may have limited influence on external factors that can impact on the Trusts ability to manage a risk down to the risk target. The risk target is just that: a target the Trust is trying to manage down to; however, on occasions, it may have to revise that target to the best achievable option.

The Executive Management Team (EMT), through its monthly review of the corporate/organisational risk register, consider if there is a likelihood of a risk not being managed down to the right level. Risks are aligned to relevant sub-committee or forum of Trust Board for further overview of the controls in place and actions being taken to mitigate the risk. Exception reports may be requested in order to provide further assurance to the Trust Board.

### Review

The Trust first introduced its Risk Appetite Statement in 2016. Since then, through discussions at Board and sub-committees it was noted that there was a flaw in the scoring methodology. For example, where there was a risk appetite of 1-3 (Minimal /Low), if a 'consequence' score (see attached definitions) of a risk was 4 (Major) or 5 (Catastrophic) with a 'likelihood' of 1 (Rare – This will probably never happen / reoccur) the overall score of the risk would be 5 and it could never be within the risk appetite level. At the strategic session of Trust Board in February 2018, the Board discussed possible options for changes to the Risk Appetite Statement and supported that the levels be reviewed. At the Trust Board meeting in March 2018, it was agreed that the Executive Management Team (EMT) would discuss this further and make a recommendation on what the revised risk appetite by category should be with any proposed changes be reviewed by the Audit Committee prior to approval by the Trust Board in April 2018.

The Risk Appetite Statement has been reviewed and continues to be aligned to the *'Good Governance Institute risk appetite for NHS Organisations'* matrix. In our application, the risk appetite scores of 1-3 (Minimal / Low) and 4-6 (Cautious / Moderate) will be accumulated, 8-12 (Open / High) remains unchanged, and 15-20 (Seek / Extreme) and 25 (Mature / Extreme) will be accumulated. It is also recommended that the risk category for Financial and Commercial risks be split into two separate categories.

This will result in the five broad areas of risk scored as:

| Risk appetite level | Risk appetite score | Risk category |
|---|---|---|
| *Avoid/None* | *Nil* | *Nil* |
| **Minimal/Low - Cautious/Moderate** | **1-6** | **Clinical risks** |
| | | **Compliance risks** |
| | | **Financial risks** |
| **Open/High** | **8-12** | **Commercial risks** |
| | | **Strategic risks** |
| *Seek/Extreme-Mature/Extreme* | *15-25* | *Nil* |

The updated Risk Appetite Statement is attached.

Further development will take place over the over the next 12 months including a review of the Risk Management Strategy and procedures to ensure they reflect the risk management process including consideration of whether a risks should go through a formal risk acceptance process if the controls and actions do not mitigate the risks in line with the risk appetite.

## Recommendation

**Trust Board is asked to REVIEW and APPROVE the update to the Trust's Risk Appetite Statement.**

**Consequence score (severity levels) and examples of descriptors**

| Domains | 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic |
|---|---|---|---|---|---|
| **Impact on the safety of patients, staff or public (physical / psychological harm)** | • Minimal injury requiring no / minimal intervention or treatment.<br>• No time off work. | • Minor injury or illness, requiring minor intervention.<br>• Requiring time off work for < 3 days.<br>• Increase in length of hospital stay by 1 – 3 days. | • Moderate injury requiring professional intervention.<br>• Requiring time of work for 4 – 14 days.<br>• Increase in length of hospital stay by 4 – 15 days.<br>• RIDDOR / agency reportable incident.<br>• An event which impacts on a small number of patients. | • Major injury leading to long-term incapacity / disability.<br>• Requiring time of work for >14 days.<br>• Increase in length of hospital stay by >15 days.<br>• Mismanagement of patient care with long-term effects. | • Incident leading to death.<br>• Multiple permanent injuries or irreversible health effects.<br>• An event which impacts on a large number of patients. |
| **Quality / complaints / audit** | • Peripheral element of treatment or service suboptimal.<br>• Informal complaint / inquiry. | • Overall treatment or service suboptimal.<br>• Formal complaint (stage 1).<br>• Local resolution.<br>• Single failure to meet internal standards.<br>• Minor implications for patient safety if unresolved.<br>• Reduced performance rating if unresolved. | • Treatment or service has significantly reduced effectiveness.<br>• Formal complaint (stage 2).<br>• Local resolution (with potential to go to independent review).<br>• Repeated failure to meet internal standards.<br>• Major patient safety implications if findings are not acted on. | • Non-compliance with national standards with significant risk to patients if unresolved.<br>• Multiple complaints / independent review.<br>• Low performance rating.<br>• Critical report. | • Totally unacceptable level or quality of treatment / service.<br>• Gross failure of patient safety if findings not acted on.<br>• Inquest / ombudsman inquiry.<br>• Gross failure to meet national standards. |
| **Human resource / organisational development / staffing / competence** | • Short-term low staffing level that temporarily reduces service quality (< 1 day). | • Low staffing level that reduces the service quality. | • Late delivery of key objective / service due to lack of staff.<br>• Unsafe staffing level of competence (< 1 day)<br>• Low staff morale<br>• Poor staff attendance for mandatory / key training. | • Uncertain delivery of key objective / service due to lack of staff.<br>• Unsafe staffing level of competence (> 5 days).<br>• Loss of key staff.<br>• Very low staff morale.<br>• No staff attending mandatory / key training. | • Non-delivery of key objective / service due to lack of staff.<br>• Ongoing unsafe staffing levels or competence.<br>• Loss of several key staff.<br>• No staff attending mandatory / key training on an ongoing basis. |

| Domains | 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic |
|---|---|---|---|---|---|
| **Statutory duty / inspections** | • No or minimal impact or breech of guidance / statutory duty. | • Breach of statutory legislation.<br>• Reduced performance rating if unresolved. | • Single breech in statutory duty.<br>• Challenging external recommendations / improvement notice. | • Enforcement action.<br>• Multiple breeches in statutory duty.<br>• Improvement notices.<br>• Low performance rating.<br>• Critical report. | • Multiple breeches in statutory duty.<br>• Prosecution.<br>• Complete systems change required.<br>• Zero performance rating.<br>• Severely critical report. |
| **Adverse publicity / reputation** | • Rumours.<br>• Potential for public concern. | • Local media coverage – short-term reduction in public confidence.<br>• Elements of public expectation not being met. | • Local media coverage – long-term reduction in public confidence. | • National media coverage with < 3 days service well below reasonable public expectation. | • National media coverage with > 3 days service well below reasonable public expectation.<br>• MP concerned (questions in the House)<br>• Total loss of public confidence) |
| **Business objectives / projects** | • Insignificant cost increase / schedule slippage. | • < 5 % over project budget.<br>• Schedule slippage. | • 5 – 10% over project budget.<br>• Schedule slippage. | • Non-compliance with national 10 – 25% over project budget.<br>• Schedule slippage.<br>• Key objectives not met. | • Incident leading to >25% over project budget.<br>• Schedule slippage.<br>• Key objectives not met. |
| **Finance including claims** | • Small loss.<br>• Risk of claim remote. | • Loss of 0.1 – 0.25% of budget.<br>• Claim less than £10k | • Loss of 0.25 – 0.5% of budget.<br>• Claim(s) between £10k - £100k. | • Uncertain delivery of key objective / loss of 0.5 – 1% of budget.<br>• Claim(s) between £100k - £1m.<br>• Purchasers failing to pay on time. | • Non-delivery of key objective / loss of > 1% of budget.<br>• Failure to meet specification / slippage.<br>• Loss of contract / payment by results/<br>• Claim (s) > £1m. |
| **Service / business interruption. Environmental impact** | • Loss / interruption of > 1 hour.<br>• Minimal or no impact on the environment. | • Loss / interruption of > 8 hours.<br>• Minor impact on environment. | • Loss / interruption > 1 day.<br>• Moderate impact on environment. | • Loss / interruption of > 1 week.<br>• Major impact on environment. | • Permanent loss of service or facility.<br>• Catastrophic impact on environment. |

South West Yorkshire Partnership NHS Foundation Trust

**Trust Board 24 April 2018**

**Trust Board Risk Appetite Statement**

## Background

As an NHS foundation trust, the Trust Board acts as custodian of the interests of our current and future service users, our staff and our members.

*Our Mission: We help people reach their potential and live well in their community.*

*Our strategic objectives are to:*
1. *improve the health*
2. *improve care*
3. *improve resources*

We must deliver our Mission and strategic objectives in a manner which ensures as far as reasonably possible that this is done safely. We therefore seek a prudent position for our risk appetite that could compromise the delivery of high quality, safe services. Acknowledging that the outcomes may, on occasions, result in a negative impact on our reputation or in a lower level of financial return.

## Risk appetite target scores

We have defined our risk appetite in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix as shown in the table below.

*Note: The target score is that after the risk has been mitigated through relevant action plans.*

| **Good Governance Institute matrix** | **Risk appetite level** | **Risk target score (range)** |
|---|---|---|
| **Avoid:** Avoidance of risk and uncertainty is a key organisational objective | **None** | **Nil** |
| **Minimal:** (ALARP: As low as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential | **Low** | **1-3** |
| **Cautious:** Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward. | **Moderate** | **4-6** |
| **Open:** Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward (and VFM) | **High** | **8-12** |
| **Seek:** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk) | **Extreme** | **15-20** |
| **Mature:** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust. | **Extreme** | **25** |

## Application

Within our Risk Management Strategy, we have defined the following four broad areas of risk which have been used to frame the Trust's risk appetite statement. *Note: The risk appetite and risk targets noted are indicative and for discussion at Trust Board.*

| **Clinical risks: Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.** | **Risk appetite Minimal/low-Cautious/moderate** | **Risk target 1-6** |
|---|---|---|
| • Risks to service user/public safety.<br>• Risks to staff safety<br>• Risks to meeting statutory and mandatory training requirements, within limits set by the Board. | | |

| **Commercial risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.** | **Risk appetite Open/high** | **Risk target 8-12** |
|---|---|---|
| • Reputational risks, negative impact on perceptions of service users, staff, commissioners.<br>• Risks to recruiting and retaining the best staff. | | |

| **Compliance risks: Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.** | **Risk appetite Minimal/low-Cautious/moderate** | **Risk target 1-6** |
|---|---|---|
| • Risk of failing to comply with Monitor requirements impacting on license<br>• Risk of failing to comply with CQC standards and potential of compliance action.<br>• Risk of failing to comply with health and safety legislation<br>• Meeting its statutory duties of maintain expenditure within limits agreed by the Board. | | |

| **Financial risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.** | **Risk appetite Minimal/low-Cautious/moderate** | **Risk target 1-6** |
|---|---|---|
| • Financial risk associated with plans for existing/new services as the benefits for patient care may justify the investment<br>• Risk of breakdown in financial controls, loss of assets with significant financial value. | | |

| **Strategic risks: Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.** | **Risk appetite Open/High** | **Risk target 8-12** |
|---|---|---|
| • Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work.<br>• Developing partnerships that enhance Trusts current and future services. | | |

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 7.1

| | |
|---|---|
| **Title:** | **South Yorkshire and Bassetlaw Shadow Integrated Care System (SYBsICS): Update on Engagement on the Hospital Services Review for South Yorkshire, Bassetlaw, North Derbyshire and Mid Yorkshire** |
| **Paper prepared by:** | Director of Strategy and Director of Human Resources, OD and Estates |
| **Purpose:** | The purpose of this paper is to update the Trust Board on the development of the South Yorkshire and Bassetlaw shadow Integrated Care System (sICS). |
| **Mission/values:** | 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.<br>It is therefore important that the Trust plays an active role in the South Yorkshire and Bassetlaw sICS. |
| **Any background papers/ previously considered by:** | The Trust Board have received regular updates on the progress and developments in the SYB sICS (formerly Sustainability and Transformation Partnership). |
| **Executive summary:** | The South Yorkshire and Bassetlaw sICS Collaborative Partnership Board met on the 13th April 2018 and there were an number of key issues discussed:<br>➢ **Planning Guidance**<br>There continue to be negotiations with NHS England and NHS Improvement on the application of the planning guidance 'Refreshing NHS Plans for 2018/19' in order to maximise the benefits of being designated as a shadow Integrated Care System for 2018/19.<br>➢ **North of England ICS/STP leaders meeting**<br>Leads from the North of England joined Richard Barker, Regional Director for NHS England (North) and Warren Brown, Regional Winter Director for NHS Improvement, on 5 April. The session focused on discussions on sICS developments and system control totals, as well as an update on plans for joint working between NHSE and NHSI.<br>➢ **Hospital Services Review update**<br>The Hospital Services Review report is now in its final development stages, following recent final rounds of engagement with clinicians and the public.<br><br>The formal publication date of the Hospital Services Review report is Tuesday 8 May, with communications planned in advance to raise awareness of the headlines with staff, stakeholders and those people who have been involved in ongoing engagement around the review. |

A communications plan is in development and will follow a similar approach to the launch of the Hospital Services Review. Further details are given below.

- **Capital bids to NHS England – first stage**
  The sICS have submitted an outline of the potential capital bid to NHS England as part of a £1.6b pot available nationally. It includes bids for primary care, transformation and potential reconfiguration of services as well as backlog maintenance. Bids will be assessed against six criteria:
  - Deliverability
  - Patient benefit and demand management
  - Service need and transformation
  - Financial sustainability
  - Value for money
  - Strength of estates strategy

  Business cases will be worked up and prioritised prior to submitting the final bids by the national deadline of 16 July.

- **sICS governance**
  To date, SYB sICS governance has worked within programme governance. The Oversight and Assurance Group, Collaborative Partnership Board, Executive Steering Group and programme boards have worked well and will continue whilst a review of the governance arrangements takes place over the next three months.

  The approach will be to simplify and use statutory governance arrangements in our organisations, place and system; a reflection of what advanced systems are doing. Draft proposals of how this might be done, using the Committees in Common (CiC) and Joint Committee of Clinical Commissioning Groups (JCCCG), will be explored in more detail at the Chief Executive and Accountable Officer workshop next week.

- sICS response to the Health Education England (HEE) Draft Work Strategy.

  The sICS has put a response back to HEE on their draft Workforce Strategy for England which is attached.

  The response recognises that there are a number of Workforce challenges facing the sICS and NHS as a whole and highlighted:
  - The importance of ensuring the strategic alignment of business and service goals for Health and Social Care with a work programme for the Workforce.
  - That it is crucial there is clarity and agreement of what is best to be done a national, what could be at sICS level and what should be done locally.
  - The importance of planning for a workforce to meet the future service needs and models.
  - The Social Care workforce is key to achieving the business and service goals.

| | |
|---|---|
| | - The need to ensure that staff are trained to understand the interplay between physical and mental health.<br>**Risk Appetite**<br>This update supports the risk appetite identified in the Trust's organisational risk register. |
| | **Trust Board is asked to NOTE the update from the SYB sICS Collaborative Partnership Board.** |
| **Private session:** | Not applicable. |

**South Yorkshire and Bassetlaw Shadow Integrated Care System**
PMO Office: 722 Prince of Wales Road
Sheffield
S9 4EU
0114 305 4487

23 March 2018

Professor Cumming OBE
Chief Executive
Health Education England
1st Floor
Blenheim House
Duncombe Street
Leeds
LS1 4PL

Dear Professor Cumming OBE,

1. We are grateful for the opportunity to comment on the draft **Workforce Strategy - Facing the Facts, Shaping the Future**. The attached response includes:

    a. our overview on some major points which need to be considered
    b. summary of the findings of our own work in summer 2017
    c. our response to your specific questions
    d. a copy our own Workforce Framework which we developed on summer 2017 which covers much of the same ground and which we are sure you will find helpful

**Background**

2. In putting this response together, we have consulted widely across the 'patch' and we also did a comprehensive piece of 'strategy' work led by our Local Workforce Action Board (LWAB). This is response, therefore, represents a summary of views and ideas. Individual SYB organisations may have sent their own responses in parallel.

3. As you will appreciate South Yorkshire and Bassetlaw is one of the leading groups who are developing as an Integrated Care System (ICS). We comprise 5 'places' and we directly employ over 48,000 staff who give care and treatment to meet the needs of 1.5 million people. Many more people work in health and care in our area employed through small scale private sector providers in social care, the voluntary sector and as volunteers.

4. As a leading ICS, we fully appreciate the importance of our workforce locally; we see it as **the key enabler** to help us answer the quality, efficiency and safety challenges and improving the patient and service user experience. We think it is a good thing that workforce is also now attracting national level attention through this strategy and in other ways and we hope this leads to some concrete action to improve coherence and resource flow to support ICS/STP development and work on front line development.

**Major Points**

5. Some major points we'd like to make in overview are:

    a. **Strategic Alignment** – clear strategic alignment will be essential in the final version of the strategy. We should ensure that the business goals of health and care are underpinned by a clear ambition, direction, and work programme for the workforce. If our overall goals are about integrated and high-quality services our approach to workforce, from planning demand to supporting retirement, need to be suitably aligned.

    We recognise the existing document *'. is unashamedly broad in its inclusiveness …. And detail …'* but the final document could be helpfully more directive and focussed on what the priorities are, what needs to happen, when, and to assign responsibilities for delivery. Being clear on purpose – what are the business goals we are trying to achieve – will be important. This in turn should guide clear workforce priorities.

    b. **Fragmentation** – following on from a) above, we think that the workforce landscape, particularly at national level is fragmented and, therefore, potentially duplicative, and wasteful and can hard to access for support. The diagram on page 17 is a helpful start on mapping some of this but this strategy provides a real opportunity to review roles and responsibilities and provide an 'umbrella' under which (at the very least) we can assign clear strategic roles deliverables to ALBs (HEE, BSA, NHSE, NHSI etc etc) and other national bodies such as NHS Employer, Skills for Care etc all of whom receive public funding support.

    c. **Workforce Resources** – whilst we appreciate that there are some things which are best done at scale and at a national level, we do think there is also an opportunity presented by this strategy to review what resource responsibility could be delegated to ICS/STP level to ensure greater localisation of budgets and resource management, e.g. on commissioning of clinical training places or initiative/pilot monies for trialling new ways of working. We should ask the question about

        i. what <u>needs</u> doing nationally,
        ii. what <u>could</u> be done at STP/ICS level
        iii. what <u>should</u> be done at local organisational level.

We have already taken the decision in SYB to establish our own Workforce Hub, which working under the oversight of LWAB, will take a lead on workforce issues locally. This model is likely to be welcomed by other ICS/STP areas also but will need support resource.

d. **Planning for the future not the past** – much of the current strategy and the workforce infrastructure is based on the past way of organising things from organisational structures to service delivery models. This strategy is a real opportunity to look ahead and organise based on STPs/ICS as planning vehicles, building better more integrated community-based services and capacity, and concentrating acute sector services appropriately. So how are we training the highly skilled community and social care nurses we might need in the future? How are curricula being adapted now to prepare our staff for the future?

   'Double running and transition costs' – if ICS/STPs are to effect real and last service changes from one model of delivery to another, then there will be periods of 'double running' or 'transition' required. Given that much of the cost will be workforce cost, this needs to be factored in to planning and resourcing decisions. For example, if our ambitions are to run more services in primary, community and social care settings then we need to invest in building capacity in those areas as a dependency on being able to move services from other settings.

e. **Management Data and data burden** – good quality data is essential for making good quality management decisions and for predicting future patterns, trends, and outcomes. When we developed our own strategic framework in the summer we found data sources to be mixed both in terms of the data quality and completeness and often caveated with accuracy warnings and at odds with local organisation data. This meant it was hard to make any clear managerial judgements from the Management Information (MI) available.

   Our own Workforce Hub will try and take pre-existing data and triage it with (qualitative) intelligence from employers. In this way we are hopeful that we can make informed decisions about priorities.

   Often systems are established for specific purposes or collections made by one organisation for its own reasons. This can be duplicative of effort and burdensome on front line providers (disproportionately for small providers). Existing systems include workforce planning, ESR and some attached payroll, NHS Pensions, NHS Jobs, National Minimum Workforce Data Set (Social care) and so on. An urgent review of data sources and how they can become '*Management Information*' to support front line decision making would be helpful.

f. **Social Care** – the social care workforce has some huge challenges with recruitment and retention. Turnover is high, pay levels are low and there is a constant battle to recruit and retain care assistants (inc domiciliary care), registered managers and social care nurses. It is essential that this capacity grows, and that staff are appropriately developed for a career in the sector as opposed to just 'jobs'. This should include investment in digital skills also.

   We also note that DH recently launched a consultation on social care workforce strategy and wonder why this is separate if our goal is to be integrated?

g. **Mental Health** - The need to train staff to understand Parity of Esteem and how they personally impact on the interplay between physical and mental health conditions should be an expectation across the wider NHS. Each professional body, group and organisation should ensure this is a key professional expectation. Training on prevention and early intervention and an ability to recognise the interplay between physical health and mental health should be built into the skill development of all professionals. Embedding mental health professionals into MDTs is a vital step towards integrating a holistic mental and physical health approach within primary and secondary care.

   Staff must also have the support to look after their own mental and physical health. All staff with staff management responsibilities should receive mandatory Mental Health First Aid evidenced based training. The Mental Health sector will be working to achieve 6,000 FTE staff retention savings by 2020, and all mental health trusts will be required to produce detailed improvement programmes on how they plan to address their high leaver rates. This strategy should acknowledge the reasons why people leave the sector: lack of historical investment in mental health services compared to other areas; one of the most pressured environments; and resources which don't match demands. The decline in mental health, community and learning disabilities nursing numbers is of huge concern and needs urgent attention.

**South Yorkshire and Bassetlaw – The Workforce Framework**

6. In 2017, SYB ICS undertook work to identify the local work force challenges and provide recommendations for the way forward. These are summarised in the table below – further full detail is available in the full framework. This work was inclusive and involved a range of stakeholders including senior managers and senior clinicians, HR Directors amongst other.

7. As well as looking at the generic workforce challenges across the board, the work also looked at each service workstream in the STP/ICS and place and identified the workforce issues in each.

**South Yorkshire and Bassetlaw – The Workforce Framework**

1. **Local Workforce Action Board (LWAB) –** has established work programmes which focus on building capacity in Primary Care, the Excellence Centre leads work to recruit and retain the non-registered workforce and apprentices and, the Faculty of Advanced Practice which aims to develop further clinical support capacity through Advanced Practice roles. These need to be set-up formally as work programmes on behalf of the ACS/ACP with resources and demand led targets.

   LWAB should be confirmed as the executive leadership function on behalf of SYB ACS and its existing and new work programmes should be actively supported as central planks in the delivery of the region's workforce strategy.

2. **SYB ACS Clinical Service Programmes** – whilst many are at the early stages of development, all recognise workforce as a key enabler to the delivery of success and are starting to outline the workforce requirements and challenges. They should be encouraged to develop clear workforce plans.

3. **Place Based Accountable Care Partnership (ACPs) and Organisational Level –** there is already a lot of work underway in 'places' and in individual organisations which aims to tackle the workforce challenges of recruitment and retention and developing skills of the future. This includes increasing collaboration between health organisations and local authorities.

   Each 'Place' should develop a local workforce plan/strategy which addresses the specific needs of the locality (Accountable Care Partnership (ACP)) in health and care, including any specific recruitment or retention needs of employers in the area. These strategies should align with the wider ACS clinical and workforce priorities and take account of neighbouring ACP plans/strategies.

4. **ICS/LWAB Workforce Intelligence Function -** LWAB and the system more widely needs to be supported by a 'Workforce Intelligence Function' which is employer led and which has an overview of the workforce supply and demand intelligence. This function should have a problem solving and initiating role on behalf of the system, leading responses to identified challenges and, crucially, supporting ICS clinical programmes to develop workforce strategies. Its role needs to be developed and it will need resourcing.

5. **Efficiency -** there is a need to build on the existing streamlining work to enable appropriate functions to be delivered at regional level on behalf of constituent organisations e.g. recruitment campaigns, support functions, systems procurement.

6. Given that the **primary, community and social care workforces** are crucial to the delivery of ICS ambition, greater emphasis and investment is required in this these critical areas. Investment here will ultimately be more cost effective and higher quality care across the system and is a critical dependency for the delivery of many other ambitions.

7. **Retention -** Specifically, at organisational and place levels, there is a need to focus on retention best practice to ensure the existing workforce is retained and developed. Linked to this, and to ensure flexibility, it may be appropriate to consider flexible employment models which enable workforce mobility

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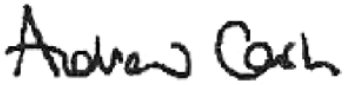
| and development across the local health and care workforce economy. |
| |

Yours sincerely



**Sir Andrew Cash**
**SYB Shadow ICS Lead**

**Annex A**

**HEE Consultation questions:**

1. **<u>Do you support the six principles proposed to support better workforce planning; and, in particular, aligning financial, policy, best practice and service planning in the future?</u> Areas to explore may include:**

• What more can be done to help staff work across organisations and sectors more easily?

• What data do we need to ensure we can plan effectively, and how do we align across workforce, finance and service planning?

• For what sort of measures/plans/proposals should the Workforce Impact Assessment be used?

*The 6 Principles – the 6 principles are good and capture all the key workforce themes, though they don't seem to touch social care employers explicitly. This needs to be considered. They are generic workforce themes or organising principles and arguably need to be more focussed and linked to the purpose (the so what) of the strategy (assuming the strategy is explicitly linked to achieving business goals as per 5a) of our general narrative.*

*We would strongly endorse the need to align finance, service, and workforce planning. Workforce is THE most expensive part of running a service and so for it not be considered as an integral part does not make sense. In some cases, we have seen service plans developed first and workforce implications added later and in others we have seen service plans driven by workforce shortages or workforce availability. Neither is right. Care Group based workforce planning at national level has worked well in the past and is a possibility going forwards*

*Workforce Impact Assessments should be more standardised in their usage. This should start at national policy level in DH and NHS England.*

*We support joint training and development opportunities across health and social care, and across mental and physical health services. Joint training and development and short-term secondments along with opportunities to 'rotate' between roles. In addition, placements and rotations across MH provision and physical health provision at the start of any placement (e.g. junior doctors on acute wards). This approach should also be applied to General Practitioners during their training period.*

2. **<u>What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?</u> Areas to explore may include:**

• Are there fresh ideas for attracting more people to work in the NHS, either as new recruits or returners?

• What scope is there to extend workforce flexibility using ideas such as credentialing, transferable qualifications, scope of practice and others?

*Retention and vacancies – many areas are experiencing vacancies with different staff groups including: general and specialist nurses, middle grade doctors and consultants in many specialties, GPs, social care nurses, mental health support staff and so on. (See our local assessment). Recruitment is obviously one way of resolving this, but a far more cost-effective way is via* ***retention*** *mechanisms and we think that the strategy needs to focus more strongly in this area and help provide national level support and locally adaptable tools. Retention, retention, retention!*

*Why do people stay? The answer to this leads to modern employment practice, being treated well at work, being engaged, and involved in decision making, having a career path, supported training. It means having managers who are good at what they do managerially and who get the best out of people; it also means being flexible with employment patterns to help people stay and balance their individual needs. Don't underestimate our public service values and ethos which are very strong, but equally don't stretch goodwill based on it too far.*

*We also need a wider than traditional view about people's careers. If they leave one employer to join a different health and care employer, this is not an overall loss to the system and perhaps if we understood why they wanted to move we might be able to offer it and retain them. We were struck by stories of paramedics who wanted primary care experience and left accordingly and once the local ambulance service realised this they put in place a rotational arrangement which meant the paramedics didn't need to leave to gain the experience.*

*Flexible employment models are becoming increasingly crucial if we are to enable flexible deployment of the workforce across traditional boundaries in a world where STPs/ICS. What are these technical employment models which enable the movement between organisations without necessarily having to give up employment with one employer to take up employment with another NHS (or social care) employer?*

*In building our mental health workforce we might consider the targeted recruitment of psychology graduates who achieve below a First-Class Honours Degree in their*

*undergraduate degrees who are then unlikely in a competitive market to secure psychology assistant posts in order to go onto to Clinical Psychology training. This is an untapped resource and lost skill base. New bespoke roles could be developed which provide attractive development opportunities for both psychology and other graduates wishing to pursue a career in the NHS.*

3. **How can we ensure the system more effectively trains, educates and invests in the new and current workforce? Areas to explore may include:**

• Are there any specific areas of curricula change or new techniques such as gamification or new cross cutting subjects like leadership, public health or quality improvement science taught to all clinicians?

• How does the system ensure it spends what is needed on individual CPD and gets the most effective outcomes from it?

*Strategic Alignment – clear strategic alignment will be essential in the final version of the strategy. We should ensure that the business goals of health and care are underpinned by a clear ambition, direction, and work programme for the workforce. If our overall goals are about integrated and high-quality services our approach to workforce, from planning demand through training to supporting retirement, need to be suitably aligned.*

*So, we need to be planning for future service models and this strategy is a real opportunity to look ahead and organise, train, and prepare the workforce for a system based on STPs/ICS as the 'new' planning vehicles, building better more integrated community-based services/capacity, and concentrating acute sector services appropriately. This will impact virtually every curriculum going forward but there is a real danger that even by the time we start to make the changes it could be too late given the lead times involved. These changes will be in part about behaviours and attitudes of key staff groups and members and, therefore, this new system thinking needs to be built into training as a priority. All clinical training should include some element of system specific training, by which we mean the interaction between physical and mental healthcare, secondary and primary care and health and social care.*

*Advanced Communication skills should be taught to all front line clinical staff: (e.g. the use of simple augmentative communication tools) linked to the Accessible Communication Standards.*

*Digital Skills – digital skills are obviously of increasing importance both in terms of high end technical health care developments but also in managing routine business such as record keeping (and sharing) and patient and drug administration. We need to be skilling*

*our staff to be ahead of and not behind this curve and, therefore, the strategy needs to major on this area.*

4. **<u>What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?</u> Areas to explore may include:**

• What more can be done to create careers not jobs for all staff, regardless of qualifications, entry level and current skills?

• What reforms are required to medical education and training to deliver the doctors the system needs in the future but also supports the needs of the system now?

*A clear simple to understand career ladder which spans health and care will help. It should cover all the pay bands and include (and normalise) the Assistant Practitioner and Advanced Practitioner roles. It needs to be used uniformly and recognised as the only "ladder" / "framework" and should be discussed consistently.*

*Being valued and having opportunities to progress and develop are essential flexible working practices/ career breaks/ sabbaticals/ personal development opportunities/ good employment policies and practices. Having opportunities for short experiential learning based secondments/ job swaps across primary, secondary and community physical and mental health services. Ensuring that all roles in the NHS have a demonstrable career structure, with opportunities provided to enhance individuals skill base (i.e. on-the-job professional qualifications).*

*There is a need for a greater focus on apprenticeships and school leavers to be introduced into health and care careers and, where possible should span both sectors. There are existing examples, including in Leeds, but these initiatives need to be done on a more 'industrial' scale to have a real impact.*

*All education, but particularly Medical education, needs to look ahead to other new models of service where greater work is done in community settings. Mandatory time spent in Mental Health and General Practice and include leadership and health economics in the undergraduate curriculum as well as equality and diversity training.*

5. **<u>How can we better ensure the health system meets the needs and aspirations of all communities in England</u>? Areas to explore may include:**

• What more can be done to attract staff from non-traditional backgrounds, including where we train and how we train?

• How we better support carers, self-carers and volunteers?

*This question is linked to how to make the NHS and social care sector more attractive as employers. Additionally, we have to consider whether training fees are appropriate, and whether there is greater flexibility to assist those who want to train but can't afford to do so. We also need to challenge preconceptions about things like nursing being a degree level occupation, especially at a time where we are experiencing (and will experience) chronic vacancy rates, particularly in areas such as mental health.*

*NHS organisations should be set targets for increasing employment of people from the 9 protected characteristic groups as identified under the Equality Duty. Improved Equality and Diversity Training for all staff with specific focus on delivering "reasonable adjustments" required through equality legislation. Staff need to really understand both their legal duties, but also to be given practical guidance on how to apply this.*

**6. <u>What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?</u> Areas to explore may include:**

• What more would make it more attractive to work or stay in the NHS as you progress through different careers stages?

• What should the system do to ensure it is flexible and adaptable to new ways of working and differing expectations of generations?

*Being a model employer means doing the sorts of things explained at paragraph 2 above. The key thing is also to further create a sense of pride about working in health and care. It is unique, and to build a sense of belonging which picks up people's public service ethos is important. All too often we hear negative stories about threats to staff from reorganisations, privatisations, and redundancy when we should be turning these stories around to talk about job security, permanence, job, and career opportunities. Our employees are our best ambassadors, so if they have a positive work experience they are more likely to encourage family, friends etc. to work for the NHS.*

*One definition of being a modern, model employer is to enshrine the concept of developing staff so that they are equipped to move onto new roles but through providing such opportunities ensure that they want to stay <u>within the NHS</u>. Retention and continuous development should be the cornerstones of what it means to be a model employer*

7. **Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England? Areas to explore may include:**

- What opportunities are there for making a difference through skill mix changes, staff working flexibly across traditional boundaries, and enabling staff to work at the top of their professional competence?

- What more can be done to deploy staff effectively and reduce further the use of agency staff?

- What more should we do to help staff focus on the health and wellbeing of patients and their families?

- What are the most productive other areas to explore around management and leadership, technology and infrastructure?

*We do need to enable staff to work across traditional boundaries. The introduction of Assistant and Advanced Practitioner roles is a positive step in this direction and a benefit to staff. But, how can we industrialise the scale at which these roles are introduced into service?*

*Digital Skills – digital skills are obviously of increasing importance both in terms of high end technical health care developments but also in managing routine business such as record keeping (and sharing) and patient and drug administration. We need to be skilling our staff to be ahead of and not behind this curve and, therefore, the strategy needs to major on this area.*

*Embedding a real understanding and explicit expectation on organisations and individual staff relating to how they address Parity of Esteem in their delivery of care (in both directions across mental and physical health services). A move of staff from secondary care into early intervention and prevention service models within primary care would also assist to help build more integrated services.*

8. What policy options could most effectively address the current and future challenges for the adult social care workforce?

*Social Care – the social care workforce has some huge challenges with recruitment and retention. Turnover is high, pay levels are low and there is a constant battle to recruit and retain care assistants (inc dom care), registered managers and social care nurses. It is essential that this capacity grows. The first thing to say here is that we need to view the service as ONE service not two. Too many people still refer to "AND social care". Social care services are integral to breaking the cycle of many NHS challenges resolving which*

*are fundamental to its success. Greater cross-sector working, and training will help but some of this will have to be mandated into curricula. There is the ongoing "elephant in the room" of social care pay levels which also need to be tackled and which mean social care employers are competing with lowish paid retail sector jobs.*

*We also note that DH recently launched a consultation on social care workforce strategy and wonder why this is separate if our goal is to be integrated? Any national workforce strategy for health and/ or social care should include the views of both sectors or ideally should be coproduced.*

Annex B

**The HEE six principles** underpinning workforce planning for the future are:

1. Securing the supply of staff that the health and care system needs to deliver high quality care in the future. Since the NHS began patients have been well served by staff from around the world. However, maximising the self-supply of our workforce is critical. It cannot be right for the NHS to draw staff from other countries in large numbers just because we have failed to plan and invest.

2. Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff. Individual NHS professions have distinct roles but there is scope for more blending of clinical responsibilities between professions. This flexibility is rewarding for staff and can provide the NHS with more choice in how we organise our services.

3. Providing broad pathways for careers in the NHS, and the opportunity for staff to contribute more, and earn more, by developing their skills and experience. Structured career opportunities which enable staff to progress both within and between professions will enhance retention and make the health and care system more resilient and attractive in the face of changing demands from staff.

4. Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare. This enshrines the public duty to provide equal opportunity for all and will ensure the NHS workforce of the future more closely reflects the populations it serves. If delivered successfully it will increase the pool of people available to be recruited into the NHS.

5. Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures and rewards. These need to support staff and reflect the way people live now and the changing expectations of all the generations who work in the NHS. To retain dedicated staff now and in the future requires employment models that sustain the values which drive health professionals every day whilst protecting against burnout, disillusionment or impossible choices between work and home life.

6. Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested. This will help ensure the NHS gets the best for patients from all its resources. Aligning service and workforce planning fosters realism alongside creativity in considering what the workforce in all the relevant groups can best contribute to a new or changing service. This will also increase the resilience of workforce planning and

ensure the NHS workforce is rightly seen as an enabler of improved services, not as a constraint.

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# Trust Board 24 April 2018
# Agenda item 8.1

| | |
|---|---|
| **Title:** | **Integrated Performance Report** |
| **Paper prepared by:** | Director of Finance & Resources and Director of Quality & Nursing |
| **Purpose:** | To provide the Board with the Integrated Performance Report (IPR) for March 2018. |
| **Mission/values/objectives** | All Trust objectives |
| **Any background papers/ previously considered by:** | ➢ IPR is reviewed at Trust Board each month<br>➢ IPR is reviewed at Executive Management Team Meeting on a monthly basis |
| **Executive summary:** | **Quality**<br>➢ The CQC have now completed their well-led review and we await draft reports during late May<br>➢ Safer staffing levels remain positive overall, however some significant local pressures remain<br>➢ Restraint incident reporting has increased and is subject to further analysis<br>➢ Internal audit of our mortality review policy implementation receives significant assurance<br>➢ Under 18 admissions to acute wards remains a concern<br>➢ Quality improvement plan to support quality strategy finalised<br><br>**NHSI Indicators**<br>➢ The Trust continues to perform well against the vast majority of nationally reported measures.<br>➢ Improving Access to Psychological Therapies – provisionally the proportion of people moving to recovery for the month of March remains over the 50%.<br>➢ The total number of bed days used by Children and Younger People in Adult wards increased to 30 during the month and relates to 3 service users, 1 admitted to the Horizon centre in November 2017 who remains an inpatient and 2 admitted during the month. All 3 have now been discharged.<br><br>**Locality**<br>➢ Progress in Barnsley underway following the agreed disaggregation of social care staff from mental health teams given the dissolution of the section 75 agreement between the Trust and local authority scheduled for August.<br>➢ Delivery of the new Musculoskeletal contract has now commenced in Barnsley.<br>➢ Pressure in adult acute wards in Kirklees and Calderdale remains high.<br>➢ On call remains a key concern for CAMHs staff.<br>➢ The bid to host the operational delivery network for Learning Disability services was successful. |

| | |
|---|---|
| | **Priority Programmes**<br>➢ Out of area bed placements has reached unprecedented high levels. Work to safely reduce is an ongoing priority.<br>➢ Clinical Record System programme is now in the co-design phase.<br>➢ Proposals for new older peoples' services will be presented in May.<br><br>**Finance**<br>➢ Pre-STF deficit of £0.1m in March leading to a full year surplus of £1.1m. This is £0.1m higher than the control total.<br>➢ Sustainability & Transformation Funding (STF) of £1.6m achieved with potential further "bonus" income to be agreed in April.<br>➢ Achievement of the year-end position was only made possible by non-recurrent means.<br>➢ In-month out of area bed costs were at the highest level for three years in excess of £0.7m, resulting in a significant overspend and concerning trend.<br>➢ Agency costs remained at a similar level to February with expenditure of £555k in the month. The full year position is spend of £5.8m on agency staffing which is £4m lower than last year, but 4% higher than our agency cap. Acuity on inpatient wards is a key factor.<br>➢ CIP delivery of £6.5m is £0.8m lower than plan.<br>➢ Cash is ahead of plan at £25.6m due to the timing of capital expenditure and asset disposal receipts as well as earlier than normal receipt of some income in March.<br>➢ The current run rate, particularly in relation to out of area bed usage, is likely to lead to a sizeable deficit being incurred in April.<br><br>**Workforce**<br>➢ Sickness absence reduced slightly to 4.9% in March although the cumulative level of absence remains at 5.3%.<br>➢ Inpatient areas of sickness are an area of focus with a Health & Wellbeing trainer appointed to support staff in these areas. |
| | **Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.** |
| **Private session:** | Not applicable |

NHS
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# Integrated Performance Report

## Strategic Overview

**March 2018**

With **all of us** in mind.

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# Table of Contents

# Introduction

Please find the Trust's Integrated Performance Report (IPR) for March 2018. An owner is identified for each key metric and the report aligns metrics with Trust objectives and CQC domains. This ensures there is appropriate accountability for the delivery of all our performance metrics and helps identify how achievement of our objectives is being measured. This single report plots a clear line between our objectives, priorities and activities. The intention is to continue to develop the report such that it can showcase the breadth of the organisation and its achievements, meet the requirements of our regulators and provide an early indication of any potential hotspots and how these can be mitigated. An executive summary of performance against key measures is included in the report which identifies how well the Trust is performing in achieving its objectives. As outlined in last month's report, the transformation and priority programme sections are now being reported as a combined section. This report includes matching each metric against the updated Trust objectives. NHS Improvement has issued an updated Single Oversight Framework (SOF) following a period of consultation. A separate paper on these changes was taken to the December Board, with the most significant impact on the Trust likely to be the introduction of a metric relating to out of area beds. It is recognised that for future development, stronger focus on outcomes would be beneficial.

Given the timing of the Trust Board in April not all information is available yet in the IPR. A final and complete version will be provided by the end of the month.

The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions and will contribute towards streamlining the number of different reports that the board receives.

The Trust's three strategic objectives are:
- Improving health
- Improving care
- Improving resources

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:
- Strategic Summary
- Quality
- National metrics (NHS Improvement, Mental Health Five Year Forward View, NHS Standard Contract National Quality Standards)
- Locality
- Priority Programmes
- Finance
- Contracts
- Workforce

Performance reports are available as electronic documents on the Trust's intranet and allow the reader to look at performance from different perspectives and at different levels within the organisation. Our integrated performance strategic overview report is publicly available on the internet.

This dashboard is a summary of key metrics identified and agreed by the Trust Board to measure performance against Trust objectives. They are deliberately focussed on those metrics viewed as key priorities.

| Section | KPI | Target | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Single Oversight Framework metric | | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| CQC Quality Regulations (compliance breach) | | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green |
| **Improve people's health and reduce inequalities** | | **Target** | **Apr-17** | **May-17** | **Jun-17** | **Jul-17** | **Aug-17** | **Sep-17** | **Oct-17** | **Nov-17** | **Dec-17** | **Jan-18** | **Feb-18** | **Mar-18** | **Year End Forecast** |
| Total number of children & young people in adult inpatient wards [5] | | 0 | 0 | 1 | 1 | 2 | 3 | 2 | 3 | 1 | 2 | 2 | 1 | 3 | 1 |
| % service users followed up within 7 days of discharge | | 95% | 98.3% | 97.5% | 97.3% | 93.3% | 97.2% | 96.1% | 94.7% | 98.2% | 98.2% | 97.2% | 98.0% | *95.8%* | 4 |
| % clients in settled accommodation | | *60%* | 82.2% | 82.5% | 82.2% | 81.8% | 81.8% | 80.8% | 80.7% | 80.4% | 80.4% | 80.1% | 79.7% | *78.8%* | 4 |
| % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1] | | *TBA* | 80.3% | | | 87.5% | | | 86.8% | | | Due April 18 | | | |
| Out of area beds [2] | | <=100 Green, 101 -199 Amber, >=200 Red | 286 | 357 | 242 | 341 | 362 | 424 | 467 | 412 | 407 | 268 | 613 | 727 | 1 |
| IAPT – proportion of people completing treatment and moving to recovery | | 50% | 45.6% | 49.4% | 56.4% | 52.4% | 49.1% | 51.3% | 53.3% | 54.1% | 54.5% | 50.7% | 54.3% | *56.5%* | 4 |
| **Improve the quality and experience of care** | | **Target** | **Apr-17** | **May-17** | **Jun-17** | **Jul-17** | **Aug-17** | **Sep-17** | **Oct-17** | **Nov-17** | **Dec-17** | **Jan-18** | **Feb-18** | **Mar-18** | **Year End Forecast** |
| Friends and Family Test - Mental Health | | 85% | 85% | 82% | 86% | 89% | 79% | 85% | 86% | 86% | 85% | 85% | 85% | 87% | 85% |
| Friends and Family Test - Community | | 98% | 97% | 99% | 98% | 95% | 99% | 99% | 97% | 98% | 100% | 97% | 97% | 99% | 98% |
| Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) [6] | | N/A | 18 | 22 | 32 | 29 | 28 | 25 | 27 | 34 | 27 | 34 | 39 | 31 | N/A |
| Safer staff fill rates | | 90% | 110% | 111% | 103% | 112.6% | 109% | 111.8% | 112.9% | 115.7% | 113.4% | 117.1% | 117.5% | 115.7% | 100% |
| Number of records with up-to-date risk assessment (MH) [3] | | | KPI under development | | | | | | | | | | | | |
| IG confidentiality breaches | | <=8 Green, 9 -10 Amber, | 9 | 12 | 12 | 6 | 10 | 6 | 5 | 12 | 7 | 7 | 10 | 4 | |
| % people dying in a place of their choosing [4] | | | Reporting established from Sept 17 | | | | | 82.6% | 90.9% | 88.6% | 87.5% | 94.3% | 84.4% | | |
| **Improve the use of resources** | | **Target** | **Apr-17** | **May-17** | **Jun-17** | **Jul-17** | **Aug-17** | **Sep-17** | **Oct-17** | **Nov-17** | **Dec-17** | **Jan-18** | **Feb-18** | **Mar-18** | **Year End Forecast** |
| Projected CQUIN Shortfall | | £4.2m | £346k | £664k | £842k | £869k | £856k | £856k | £856k | £856k | £136k | £136k | £136k | £203k | £203k |
| Surplus | | In line with Plan | £26k | £53k | £95k | £204k | £226k | £6k | £158k | £235k | £551k | £635k | £1186K | £1139K | £1139K |
| Agency spend | | In line with Plan | £501k | £426k | £500k | £457k | £446k | £435k | £515k | £531k | £430k | £465k | £563K | £555K | £5.8m |
| CIP delivery | | £1074k | £472k | £1024k | £1643k | £2306k | £2950k | £3452k | £4117k | £4815k | £5442k | £6157k | £6816k | £7475k | £7.5m |
| Sickness absence | | 4.5% | 4.8% | 4.7% | 4.7% | 4.8% | 4.9% | 4.9% | 4.9% | 5.0% | 5.1% | 5.2% | 5.3% | 5.3% | 5.2% |
| Mental Health Act training | | >=80% | 51.2% | 56.9% | 70.5% | 75.0% | 80.3% | 81.6% | 83.4% | 84.7% | 86.6% | 86.4% | 86.0% | 84.7% | 85% |
| Mental Capacity Act Training | | >=80% | 64.9% | 69.6% | 78.0% | 82.5% | 86.1% | 87.6% | 88.9% | 90.3% | 91.1% | 91.0% | 91.1% | 90.7% | 90% |

*NHSI Ratings Key:*
*1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures*

***Notes:***
*1 - Please note: this is a proxy definition as a measure of clients receiving timely assessment / service delivery by having one face-to-face contact. It is per referral. This is a new KPI and is still under discussion with commissioner so may see further developments to this in future months. Recent development of this indicator has taken place in conjunction with commissioners. When first reported in Q1, reporting was against second contact, following review, it is felt that service delivery starts at the first contact and as a result the Q1 figure has been amended to reflect this.*
*2 - Out of area beds - this identifies the number of out of area bed days during the reporting month - the national definition for out of area bed is: is a patient that is admitted to a unit that does not form part of the usual local network of services. This is for Adult Acute and PICU Mental Health Services only. Whilst there has been improvements the number of days used remains above plan.*
*3 - data for this indicator is currently being identified and will be reviewed internally before being included in this report. It is anticipated we will be able to flow this data from October data which will be included in the November report.*
*4 - Data is now available for this indicator.*
*5 - further detail regarding this indicator can be seen in the National Metrics section of this report.*
*6- Further information is provided under Quality Headlines. Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm, and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed.*

**Lead Director:**

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

The performance information above shows the performance rating metrics for the new Single Oversight Framework which captures Trust performance against quality, finance, operational metrics, strategy and leadership under one single overall rating. The most significant reasons for the Trust to be rated as 2 were relates to our 16/17 agency expenditure performance and our financial risk.

Areas to Note:

**Quality**
• The CQC have now completed their well-led review and we await draft reports during late May
• Safer staffing levels remain positive overall, however some significant local pressures remain
• Restraint incident reporting has increased and is subject to further analysis
• Internal audit of our mortality review policy implementation receives significant assurance
• Under 18 admissions to acute wards remains a concern
• Quality improvement plan to support quality strategy finalised

**NHSI Indicators**
• The Trust continues to perform well against the vast majority of nationally reported measures
• Improving Access to Psychological Therapies – provisionally the proportion of people moving to recovery for the month of March remains over the 50% threshold but is yet to be finalised. It is anticipated that the threshold of 50% will be maintained
• The total number of bed days used by Children and Younger People in Adult wards has increased to 30 during the month and relates to 3 service users, 1 admitted to the Horizon centre in November 2017 who remains an inpatient and 2 who were admitted during the month - all 3 of these service users have now been discharged.

**Locality**
• Progress in Barnsley underway following the agreed disaggregation of social care staff from mental health teams given the dissolution of the section 75 agreement between the Trust and local authority scheduled for August
• Delivery of the new Musculoskeletal contract has now commenced in Barnsley
• Pressure in adult acute wards in Kirklees and Calderdale remains high
• On call remains a key concern for CAMHs staff
• The bid to host the operational delivery network for Learning Disability services was successful

**Priority Programmes**
• Out of area bed placements has reached unprecedented high levels. Work to safely reduce is an ongoing priority
• Clinical Record System programme is now in the co-design phase
• Proposals for new older peoples' will be presented in May

**Finance**
• Pre-STF deficit of £0.1m in March leading to a full year surplus of £1.1m. This is £0.1m higher than the control total.
• Sustainability & Transformation Funding(STF) of £1.6m achieved with potential further "bonus" income to be agreed in April
• Achievement of the year-end position was only made possible by non-recurrent means
• In-month out of area bed costs were at the highest level for three years in excess of £0.7m, resulting in a significant overspend and concerning trend.
• Agency costs remained at a similar level to February with expenditure of £555k in the month. The full year position is spend of £5.8m on agency staffing which is £4m lower than last year, but 4% higher than our agency cap. Acuity on inpatient wards is a key factor
• CIP delivery of £6.5m is £0.8m lower than plan
• Cash is ahead of plan at £25.6m due to the timing of capital expenditure and asset disposal receipts as well as earlier than normal receipt of some income in March.
• The current run rate, particularly in relation to out of area bed usage, is likely to lead to a sizeable deficit being incurred in April.

**Workforce**
• Sickness absence has reduced slightly to 4.9% in March, however, the cumulative level of absence remains at 5.3%, which remains higher than the target of 4.5%
• Inpatient areas of sickness are an area of focus with a Health & Wellbeing trainer appointed to support staff in these areas

## Quality Headlines

Work has been undertaken to identify additional quality metrics, some of these are under development and are likely to be in place by the end of quarter 1. For the new indicators where historic data is available, this has been included. These indicators can be used to measure progress against some of the Trusts quality priorities for 2017-18.

| Section | KPI | Objective | CQC Domain | Owner | Target | Q1 16/17 | Q2 16/17 | Q3 16/17 | Q4 16/17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Q1 17/18 | Q2 17/18 | Q3 17/18 | Q4 17/18 | Year End Forecast Position * |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Infection Prevention | Infection Prevention (MRSA & C.Diff) All Cases | Improving Care | Safe | TB | 6 | 0 | 0 | 1 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 4 |
| C-Diff | C Diff avoidable cases | Improving Care | Safe | TB | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| Complaints | % of feedback with staff attitude as an issue | Improving Health | Caring | AD | < 20% | 14% 23/168 | 7% 12/162 | 18% 28/158 | 12% 23/195 | 20% 13/63 | 14% 11/77 | 24% 19/77 | 24% 18/73 | 16% 9/58 | 22% 11/50 | 3% 2/69 | 13% 7/56 | 9% 4/43 | 17% 13/76 | 18% 13/72 | | 19.8% 43/217 | 18.2% 38/208 | 7.7% 13/168 | | 4 |
| Service User Experience | Friends and Family Test - Mental Health | Improving Health | Caring | TB | 85% | 72% | 71% | 71% | | 85% | 82% | 86% | 89% | 79% | 85% | 86% | 86% | 85% | 85% | 85% | 87% | 84% | 84% | 86% | 86% | 2 |
| | Friends and Family Test - Community | Improving Health | Caring | TB | 98% | 98% | 98% | 98% | 99% | 97% | 99% | 98% | 95% | 99% | 99% | 97% | 98% | 100% | 97% | 97% | 99% | 98% | 98% | 98% | 98% | 4 |
| Quality | Total number of reported incidents | Improving Care | Safety Domain | TB | N/A | 3509 | 3405 | 3293 | 2946 | 848 | 1023 | 978 | 1083 | 1084 | 897 | 996 | 993 | 971 | 1118 | 1143 | 1166 | 2849 | 3064 | 2960 | 3427 | N/A |
| | 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 | | | | | | 15 | 16 | 26 | 20 | 24 | 14 | 20 | 20 | 16 | 26 | 31 | 23 | 57 | 58 | 56 | 80 | |
| | 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 | N/A | 10 | 19 | 19 | 20 | 1 | 0 | 2 | 3 | 1 | 4 | 1 | 5 | 3 | 2 | 3 | 3 | 3 | 8 | 9 | 8 | N/A |
| | Total number of patient safety incidents resulting in death harm. (Degree of harm subject to change as more information becomes available) | Improving Care | Safety Domain | TB | N/A | 73 | 79 | 73 | 84 | 2 | 6 | 4 | 6 | 3 | 7 | 6 | 9 | 8 | 6 | 5 | 5 | 12 | 16 | 23 | 16 | N/A |
| | MH Safety thermometer - Medicine Omissions | Improving Care | Safety Domain | TB | 17.7% | 16.8% | 17.7% | Data not avail | 18.70% | 15.8% | 13.0% | 25.7% | 24.2% | 23.3% | 25.3% | 17.5% | 15.3% | 16.7% | 20.8% | 20.6% | 20.4% | 18.2% | 24.3% | 16.5% | 20.5% | 3 |
| | Safer staff fill rates | Improving Care | Safety Domain | TB | 90% | | | | | 110% | 111% | 103% | 112.6% | 109% | 111.8% | 112.9% | 115.7% | 113.4% | 117.1% | 117.5% | 115.7% | 109% | 111.1% | 114% | 116.8% | 4 |
| | Safer Staffing % Fill Rate Registered Nurses | Improving Care | Safety Domain | TB | 80% | | | | | 109.7% | 109.7% | 100% | 96.5% | 91.2% | 94.5% | 99.5% | 101% | 96.6% | 99.9% | 97.6% | 97.6% | 107% | 94.1% | 99% | 98.4% | 4 |
| | Number of pressure ulcers (attributable) [1] | Improving Care | Safety Domain | TB | N/A | 98 | 95 | 78 | 86 | 27 | 25 | 30 | 32 | 31 | 29 | 16 | 26 | 29 | 45 | 29 | 24 | 82 | 92 | 71 | 98 | N/A |
| | Number of pressure ulcers (avoidable) [2] | Improving Care | Safety Domain | TB | 0 | 1 | 4 | 3 | 2 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 2 | 1 | 2 | 2 | 3 |
| | Complaints closed within 40 days | Improving Health | Responsive | TB | 80% | | | | 28% 11/39 | 10% 2/20 | 24% 6/25 | 0% 0/18 | 10% 2/20 | 11% 2/18 | 17% 2/12 | 0% 0/18 | 19% 4/20 | 0% 0/5 | 28% | 8% 2/26 | | 12.7% 8/63 | 12% 6/50 | 9.3% 4/43 | | 1 |
| | Referral to treatment times | Improving Health | Responsive | KT/SR/CH | TBC | KPI under development | | | | | | | | | | | | | | | | | | | | |
| | Un-outcomed appointments [6] | Improving Health | Effective | KT/SR/CH | TBC | | 2.2% | 2.9% | 2.6% | 5.0% | 4.6% | 4.3% | 3.8% | 3.5% | 3.3% | 2.7% | 2.7% | 2.5% | 2.5% | 2.4% | 2.5% | 4.3% | 3.3% | 2.5% | 2.5% | N/A |
| | Number of Information Governance breaches [3] | Improving Health | Effective | MB | <=8 | 36 | 25 | 29 | 36 | 9 | 12 | 12 | 6 | 10 | 6 | 5 | 12 | 7 | 7 | 10 | 4 | 33 | 22 | 24 | 21 | |
| | Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment | Improving Health | Caring | AD | 80% | N/A | 79.26% | N/A | 80% | N/A | | | | | | | | | | | | 74% | 75% | N/A | 76% | N/A |
| | Staff FFT survey - % staff recommending the Trust as a place to work | Improving Health | Caring | AD | N/A | N/A | 65.19% | N/A | 66% | N/A | | | | | | | | | | | | 60% | 64% | N/A | 67% | N/A |
| | Number of compliments received | Improving Health | Caring | TB | N/A | Data not avail until Oct 16. | | 141 | 81 | 19 | 44 | 18 | 33 | 45 | 35 | 56 | 33 | 59 | 20 | 23 | | 81 | 113 | 148 | | N/A |
| | Eliminating Mixed Sex Accommodation Breaches | Improving Care | Safety Domain | TB | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 4 |
| | Number of Duty of Candour applicable incidents [4] | Improving Health | Caring | TB | N/A | 73 | 86 | 83 | 86 | 315 | | | | | | | | | | | Data due May 18 | 154 | | | | N/A |
| | Duty of Candour - Number of Stage One exceptions [4] | Improving Health | Caring | TB | N/A | Reporting established from Oct 16 | | 0 | 2 | 2 | 0 | 2 | 3 | 1 | 4 | 3 | 3 | 3 | 5 | | | 4 | 8 | 9 | | N/A |
| | Duty of Candour - Number of Stage One breaches [4] | Improving Health | Caring | TB | 0 | Reporting established from Oct 16 | | 0 | 1 | 4 | | | | | | | | | | | | 1 | | 2 | | |
| | % Service users on CPA given or offered a copy of their care plan | Improving Care | Caring | KT/SR/CH | 80% | 85.6% | 85.0% | 83.0% | 85.2% | 85.2% | 85.0% | 85.5% | 85.0% | 85.3% | 85.6% | 81.4% | 85.4% | 85.0% | 85.2% | 85.1% | 84.9% | 85.2% | 85.6% | 85.0% | | 4 |
| | % of prone restraint with duration of 3 minutes or less [8] | Improving Care | Safety Domain | KT/SR/CH | 80% | Reporting Established from July 16 | 79.7% | 75.6% | 66.3% | 68.40% | 75.70% | 75% | 77% | 80% | 80% | 79% | 69% | 82% | 70% | 80.6% | 79.4% | 75% | 80% | 77% | 76% | 4 |
| | Delayed Transfers of Care [10] | Improving Care | Effective | KT/SR/CH | 7.5% 3.5% from Sept 17 | 2.2% | 2.6% | 3.1% | 2.7% | 1.9% | 1.7% | 1.1% | 1.7% | 2.8% | 2.8% | 2.7% | 2.4% | 2.9% | 3.9% | 3.4% | 3.7% | 1.6% | 2.3% | 2.7% | 3.7% | 4 |
| | Number of records with up to date risk assessment | Improving Care | Effective | KT/SR/CH | TBC | KPI under development | | | | | | | | | | | | | | | | | | | | |
| | No of staff receiving supervision within policy guidance [7] | Improving Care | Well Led | KT/SR/CH | 80% | 39.5% (March 17) | | | | 59.3% | | | 61.0% | | | 64.7% | | | 86.5% | | | 59.3% | 61.0% | 64.7% | 86.5% | 4 |
| | Number of Falls (inpatients) | Improving Care | Safety Domain | TB | TBC | 162 | 158 | 136 | 95 | 38 | 52 | 49 | 39 | 54 | 46 | 41 | 43 | 66 | 40 | 80 | 61 | 139 | 139 | 150 | 181 | |
| | Number of restraint incidents | Improving Care | Safety Domain | TB | N/A | Data not avail | | | | 104 | 140 | 101 | 144 | 159 | 121 | 134 | 132 | 176 | 204 | 186 | 199 | 345 | 424 | 442 | 589 | N/A |

** See key included in glossary*

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

2 - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT 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 breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches.

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

6 - This is the year to date position for mental health direct unoutcomed appointments which is a snap shot position at a given point in time. The increase in unoutcomed appointments in April 17 is due to the report only including at 1 months worth of data.

7- This shows the clinical staff on bands 5 and above (excluding medics) who were employed during the reporting period and of these, how many have received supervision in the last 12 months. Please note that services only been fully using the system since December 2016.

8 - The threshold has been locally identified and it is recognised that this is a challenge. From June 17, the monthly data reported is a rolling 3 month position.

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

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

# Quality Headlines

During 2017/18 the Trust undertook some work to develop the key quality measures. There are a small number that require additional development, particularly relating to CAMHS Referral to Treatment waiting times. For which some national guidance is awaited.

As part of the Trust's ongoing review of quality, additional metrics have been identified for reporting in 2017/18 relating to:

• Number of records with up to date risk assessment - the data for this is being identified using Sainsbury's level 1 risk assessment. This metric will also allow the Trust to track improvement required within data quality plan. It is anticipated reporting will commence from April 18 - data is currently being reviewed and validated.

• Complaints closed within 40 days - The Trust takes complaints about services very seriously and wants to ensure a response that resolves the issues raised. The Trust is committed to learning lessons from feedback recognising the valuable opportunity to reflect on the care offered and use this as a means of improving.

The Trust adopts an approach to complaints and feedback that promotes resolving issues at service line wherever and whenever this is possible. The customer service team maintain central oversight and management of the complaints process with support offered to service colleagues.

The quality of the Trust's resolution of complaints is under review. The current process involves investigators, general managers, service directors, nursing and medical directors as appropriate and the Chief Executive. Given the number of people involved, this can result in delay in offering a response, often exceeding the internal 40 day target. The 40 day target was set by the Trust and is much more ambitious than the national six month target set under NHS complaint regulations.

The purpose of the review is to increase ownership of issues at service line and promote a more timely response to the complainant. The Director of Nursing and Quality is leading on this work which is being taken forward through the Operational Management Group. The intention is to introduce steps to ensure service involvement as soon as possible when issues are raised and scrutiny of completed investigation toolkits by Trios before they are returned to Customer Services. Draft responses will then be prepared in Customer Services. Drafts will be reviewed by Trios to ensure all clinical issues are identified and addressed and that the investigation has provided sufficient information to enable a full response. Deputy district directors will then review and sign off the draft response, with a final (edited if required) version shared with the Chief Executive for review and signature. In light of the service developments the 40 day target has been suspended until 1st April 2018, when additional targets will also be included to demonstrate performance of the complaints management process.

• % of prone restraint with duration of 3 minutes or less - The number of restraint incidents occurring over 3 minutes during March 18 has decreased slightly compared to last month and is now reporting just under the 80% threshold at 79.4% This relates to 7 incidents out of 34 being for 3 minutes or more. All had cogent reasons for restraint. Training is provided giving alternatives to the use of prone restraint and why they are preferable. If prone restraint is used, staff must clearly identify why alternatives could not be used. This allows for staff reflection on the potential use of alternatives. Length of time in prone restraint can be accurately measured in Datix against the target of less than 3 minutes duration.

The total number of all restraints stands at 200 which is well above the mean number of restraints over the past 24 months which is 142.67.

• The total number of all restraints incidents reported has increased during the month and is above the mean number of restraints over the past 24 months which is 142.67. Further analysis of this data is being undertaken but it is anticipated this may be linked to the acuity. The incidents are spread across BDUs and a small number of individuals have multiple incidents reported.

• NHS Safety Thermometer - Medicines Omissions – This only relates to Inpatient areas in Calderdale, Kirklees and Wakefield. SWYPFT has been focusing on reducing medication omissions on in-patient areas for the past 3.5 years. The Mental Health Safety Thermometer's national data has shown that the trust has been an outlier when benchmarked to other mental health/combined trusts. The national average for medication omissions on in-patient units is currently at 16%, SWYPFT has been around the 24% mark. At quarter 4 the average for SWYPFT was 20.5%. Analysis of the data has been undertaken and it has been identified that the monthly figures presented on the national system are not always that months data figures but can include the previous months data if it has been input the following month. In order to assist with this the Trust will be tightening up the data entry process. Previous analysis of patient level data related to medicine omissions acuity levels on older peoples wards and the response to winter pressures. The biggest reason for medicine omissions was refusal by the service user.

• Duty of Candour - Number of Stage One breaches - 4 breaches reported to end February 2018. This relates to 2 in Kirklees BDU - 1 where a verbal apology was given on day 14 and the service user declined a letter of apology from the Trust; 1 who was admitted to an out of area placement following assessment. Duty of candour reviewed by manager and action taken when need identified. 2 in the Wakefield BDU - 1 related to a patient who fell on Stanley ward and 1 related to Older People CMHT where the apology took place outside the required timeframe. The guidance for duty of candour stipulates that apology should be made within 10 days.

• Number of Falls (inpatients) - February saw a spike in the number of reported falls and the detail around this was reported in last months report. March 18 has seen a decrease, however, the number of falls remains slightly over the monthly average with 61 falls being reported, monthly average for April 17 - Jan 18 is 47.

• Friends and Family Test - Community - the Trust have set a local stretch target of 98% for this indicator. This has been set based on historic performance. The Trust regularly reports above this level and benchmarks well with comparable organisations.

• Delayed transfers of care - the trust are reporting a figure of 3.7% for the month of March. This is above the NHS mandate threshold of 3.5%. This is attributed to delays in Calderdale, Kirklees and a small number in Barnsley. Discussions regarding the social care attributable delays takes place with our local authority partners through existing joint forums.

## Safety First

### Summary of Incidents during 2017/18

| | Q1 17/18 | Q2 17/18 | Q3 17/18 | Q4 17/18 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Green no harm | 1765 | 1893 | 1776 | 1984 | 537 | 625 | 603 | 662 | 669 | 562 | 608 | 587 | 581 | 662 | 653 | 669 | **7418** |
| Green | 782 | 856 | 826 | 1051 | 228 | 286 | 268 | 317 | 297 | 242 | 272 | 264 | 290 | 338 | 355 | 358 | **3515** |
| Yellow | 227 | 227 | 261 | 297 | 66 | 87 | 74 | 77 | 87 | 63 | 84 | 102 | 75 | 86 | 98 | 113 | **1012** |
| Amber | 56 | 59 | 63 | 70 | 14 | 17 | 25 | 18 | 25 | 16 | 21 | 28 | 14 | 23 | 30 | 17 | **248** |
| Red (should not be compared with SIs) | 19 | 29 | 34 | 25 | 3 | 8 | 8 | 9 | 6 | 14 | 11 | 12 | 11 | 9 | 7 | 9 | **107** |
| **Total** | **2849** | **3064** | **2960** | **3427** | **848** | **1023** | **978** | **1083** | **1084** | **897** | **996** | **993** | **971** | **1118** | **1143** | **1166** | **12300** |

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

### Summary of Serious Incidents (SI) by category 2017/18

| | Q1 | Q2 | Q3 | Q4 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Suicide (incl apparent) - community team care - current episode** | **4** | **10** | **13** | **6** | 1 | 1 | 2 | 5 | 2 | 3 | 4 | 4 | 5 | 2 | 3 | 1 | **33** |
| **Pressure Ulcer - grade 3** | **1** | **1** | **3** | **1** | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | **6** |
| **Information disclosed in error** | **1** | **1** | **2** | **0** | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | **4** |
| **Suicide (incl apparent) - community team care - discharged** | **0** | **2** | **2** | **0** | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | **4** |
| **Physical violence (contact made) against other by patient** | **1** | **1** | **1** | **1** | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | **4** |
| **Suicide (incl apparent) - inpatient care - current episode** | **0** | **0** | **1** | **2** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | **3** |
| **Administration/supply of medication from a clinical area** | **0** | **1** | **1** | **0** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | **2** |
| **Death - confirmed related to substance misuse (drug and/or alcohol)** | **1** | **0** | **1** | **0** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | **2** |
| **Fire / Fire alarm related incidents** | **1** | **1** | **0** | **0** | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** |
| **Self harm (actual harm)** | **2** | **0** | **0** | **0** | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** |
| **Death - cause of death unknown/ unexplained/ awaiting confirmation** | **0** | **1** | **0** | **0** | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Formal patient absent without leave** | **0** | **0** | **1** | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | **1** |
| **Illegal Acts** | **1** | **0** | **0** | **0** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Informal patient absent without leave** | **0** | **0** | **1** | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **1** |
| **Self harm (actual harm) with suicidal intent** | **0** | **0** | **0** | **1** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| **Vehicle Incident** | **1** | **0** | **0** | **0** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Allegation of violence or aggression** | **0** | **0** | **0** | **1** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** |
| **Homicide by patient** | **1** | **0** | **0** | **0** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Physical/sexual violence by other** | **1** | **0** | **0** | **0** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Total** | **15** | **18** | **26** | **12** | **3** | **3** | **9** | **9** | **2** | **7** | **7** | **11** | **8** | **4** | **4** | **4** | **71** |

**Mortality**

**Assurance**: 360 Assurance Internal audit report on Learning from Healthcare Deaths has been received giving Significant Assurance. Mortality review group workshop being arranged to implement audit findings.

**Reporting**: The Trust's Learning from Healthcare Deaths information is now reported through the quarterly incident reporting process. Reports are available on the Trust website when approved by Trust Board. These include learning to date.

See http://www.southwestyorkshire.nhs.uk/about-us/performance/learning-from-deaths/

Quarter 3 and 4 data is currently being drafted.

**Learning:** Mortality is being reviewed and learning identified through different processes:

-Serious incidents and service level investigations – learning will be shared in Our Learning Journey report for 2017/18

-Structured Judgement Record Reviews – 8 cases have been completed for Q1 and Q2 cases. Due to small numbers to date, it is difficult to identify any themes. Of note, in 5 of the 8 cases, the overall care was rated as good (4) or excellent (1). The learning from healthcare deaths report includes examples of areas for improving practice identified by the reviewers, and also good practice examples. These will be developed into themes as more reviews are completed.

**Policy**: A review of the Learning from Healthcare Deaths policy will take place to include feedback from the audit findings and learning from the first six months of policy implementation in consultation with Northern Alliance colleagues. Any comments on the policy are welcomed to feed into the review process via risk@swyt.nhs.uk

• The Trust's Learning from Healthcare Deaths information is now reported through the quarterly incident reporting process. Reports are available on the Trust website when approved by Trust Board. These include learning to date.

Mortality is being reviewed and learning identified through different processes:

Serious incidents and service level investigations – learning will be shared in Our Learning Journey report for 2017/18

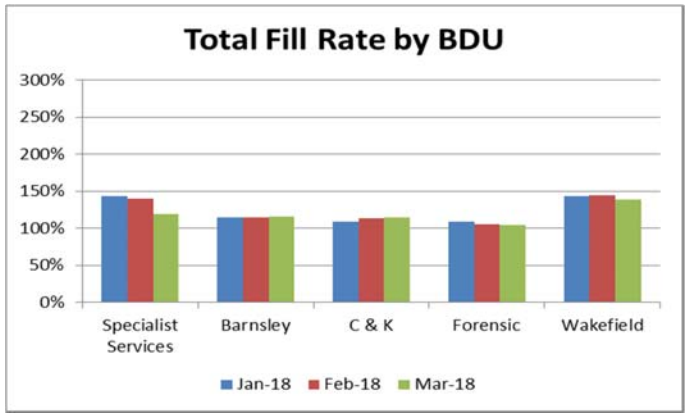
Structured Judgement Record Reviews – 8 cases have been completed for Q1 and Q2 cases. Due to small numbers to date, it is difficult to identify any themes. Of note, in 5 of the 8 cases, the overall care was rated as good (4) or excellent (1). The learning from healthcare deaths report includes examples of areas for improving practice identified by the reviewers, and also good practice examples. These will be developed into themes as more reviews are completed. See the following link for further information http://www.southwestyorkshire.nhs.uk/about-us/performance/learning-from-deaths/

## Safer Staffing

**Overall Fill Rates: 117.5%**
**Registered fill rate: (day + night) 97.6%**
**Non Registered fill rate: (day + night) 137.8%**

**Overall fill rates for staff for the all inpatient areas remain above 90%.**

**BDU Fill rates - Nov 17 - Feb 18**




| Fill Rate | Month | | |
|---|---|---|---|
| BDU | Jan-18 | Feb-18 | Mar-18 |
| Specialist Services | 143% | 140% | 119% |
| Barnsley | 115% | 115% | 116% |
| C & K | 108% | 114% | 114% |
| Forensic | 109% | 106% | 105% |
| Wakefield | 143% | 145% | 138% |
| **Grand Total** | **117%** | **118%** | **116%** |

**The figures (%) for March 2018:**

**Registered Staff:**
Days - 90.0 (decrease of 0.8 on February)
Nights -105.2 (increase of 0.8 on February)

**Registered average fill rate:**
Days and nights - 97.6 (remained consistent with February)

**Non Registered Staff:**
Days - 127.3 (decrease of 5.7 on February)
Nights - 142.8 (increase of 0.2 on February)

**Non Registered average fill rate:**
Days and nights - 135.0 (decrease of 2.8 on February)

**Overall average fill rate all staff:**
115.7 (decrease of 1.8 on February)

**Summary**
For the seventh consecutive month, no ward fell below a 90% overall fill rate in March. Of the 30 inpatient areas listed 20 (66%) again achieved greater than 100%. Indeed of these 20 areas, 9 again achieved greater than 120%.
Registered On Days (Trust Total 90.8%)
There has been an increase in the number of wards that have failed to achieve 80%, six wards in all (19.8%) compared to 4 (13.2%) in February. Within the Forensic BDU Chippendale remained at 74%, Appleton decreased to 72% (-18%) and Johnson decreased to 78% (- 5%). In Barnsley BDU Willow decreased to 78% (-4%) . Within the Wakefield BDU Chantry Unit has decreased to 76% (-2%) and Poplars has decreased to 73% (-9%)
Registered On Nights (Trust Total 104.8%)
No ward has fallen below the 80% threshold. The number of wards who are achieving 100% and above fill rate on nights remained at 70% (21 wards) for the third consecutive month.
Average Fill Rates for Barnsley BDU increased by 1% to 116%. Calderdale and Kirklees BDU remained at 114%. Forensic BDU were 105% with a decrease of 1%. Wakefield BDU were 38% with a decrease of 5%. Specialist services were 119% with a decrease of 21%.
Despite the achievement and above of expected fill rates, significant pressures remain on inpatient wards due to demands arising from acuity of service user population. This is particularly apparent in PICU and Priory in Wakefield, Ward 18 and Beechdale within the C&K BDU where additional duties such as special observations and 2 staff to 1 service user observations are being used. Measures have been taken to support the ward teams with bank, agency and off ward staff during this period.

## Information Governance

There were 4 confidentially breaches reported during March 18. Each incident is being investigated and corrective actions will be taken where required. A breakdown of the incidents can be seen below:
• 2 incidents of data being disclosed in error, due to incorrect patient address information and incorrect enclosures with patient letters.
• 2 incidents of staff information being disclosed in error as occupational health reports were sent to the wrong managers.
The Trust made its IG toolkit submission with a level 2 achieved following significant assurance for internal audit.

## Commissioning for Quality and Innovation (CQUIN)

For 2017/18, the CQUIN schemes are part of a national two year scheme. A number of the indicators work across partner organisations and collaboration has been required. The national CQUIN indicators on improving the health of our staff, and Physical Health for people with Severe Mental Illness are retained from the 2016/17 scheme and new indicators for the Trust are:
• Preventing ill health by risky behaviours – alcohol and tobacco
• Child and Young Person MH Transition
• Improving services for people with mental health needs who present to A&E

Planned CQUIN income for 2017/18 totals £4.2m, the forecast shortfall is £204k. Of the shortfall £18k relates to Q2 performance with the remainder relating to Q4 forecast performance. A shortfall is forecast in Q4 for the CQUIN relating to improvement of health & wellbeing of staff, cardio metabolic assessment and treatment for patients with psychoses and collaboration with primary care clinicians.
Quarter 4 CQUIN information is submitted for commissioner review at the end of April and is usually agreed by the end of Quarter 1.

Forensic services continued with the national forensic scheme, this included 2 indicators, both of which the indicators were a continuation of the 2016/17 scheme:
• Recovery colleges for medium and low secure patients
• Reducing restrictive practices within adult low and medium secure services.

CQUIN leads have been agreed for 2018/19. Services are reviewing and working towards the requirements for next year.

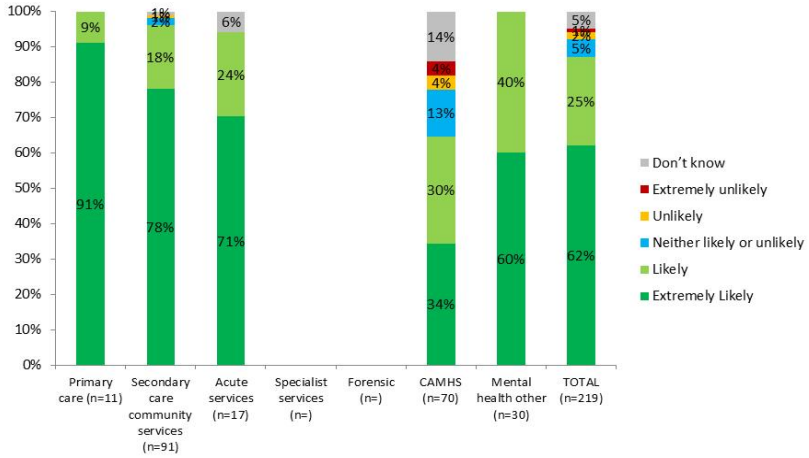
A new set of indicators for the Barnsley alliance contract for 2018/19 are currently being negotiated.

## Patient Experience

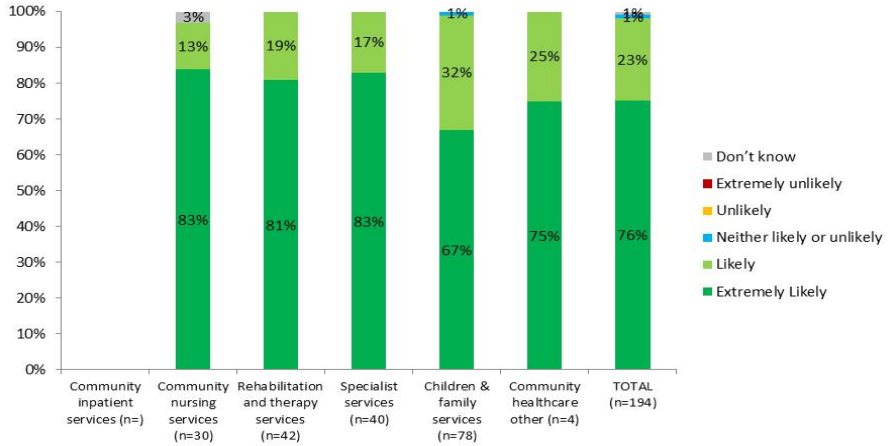
**Friends and family test shows**

- Community Services – 99% would recommend community services.
- Mental Health Services – 87% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 34% (CAMHs) and 91% (primary care services)
- Small numbers stating they were extremely unlikely to recommend.

**Mental Health Services**




**Community Services**



## Care Quality Commission (CQC)

**CQC action plan – CQC – rating Green**
Six of our core services have now been re-visited and as a result will be developing a new action plan to meet any 'must' and 'should' do's identified from these visits.

**CQC Inspection 2018 visits**
CQC have completed all of their planned re-visits to our core services. We are in the process of our well-led review. During this time CQC also undertook a further visit to our Wakefield inpatient mental health services for working age adults to discuss and look at the issue around nurse call bells in bedrooms.

**CQC reporting arrangements**
CQC have sent preliminary findings letters to all those teams and services who received a care service inspection re-visit. These letters were very brief and provided feedback on good practices and areas for improvement. There has been a mixed reaction to some of this feedback in terms of the lack of detail and accuracy of the findings. We are advising that teams keep a record of any comments from this feedback for future reference as we will be given the opportunity to challenge any factual accuracy comments when we receive our core service and well-led inspection reports. These reports are expected within 12 weeks from the date of our well-led review.

**Additional data requests**
During our core service re-visits we received 203 data information requests. In total we submitted around 580 documents during this period. We are now receiving a small number of additional data requests from the well-led review.

**Well-led review**
Our well-led review began on 9 April 2018 and is due to be completed on 11 April 2018. This review has included interviews with key individuals, a number of focus groups and looking at information files of live cases in relation to such things as ongoing complaints and serious incidents.

**Registration activity**
We continue to keep CQC notified about any planned changes to our services that may impact on our registration.

**CQC fees**
CQC have announced their new annual fees for 2018/2019.

## Legal update - Mental Health act

- WiFi is now accessible for patients across the Trust. The associated policy is being reviewed and a communications plan is in place
- The Government response to the Law Commissions proposals for the amendment to the MCA and DoLS has been published and a briefing has been prepared for MHAC
- The Independent Review of the MHA continues and the Trust has a seat on the Advisory Panel and several working groups
- The CQC published their annual report for MHA activity. The document has been distributed in the organisation and a briefing has been prepared for MHAC
- It has been noticed that local MHA ward visits are highlighting issues relating to discharge planning

## Safeguarding

**Assurance:**

• Ensured that the safeguarding adult's level 1, 2 training remains above the Trust mandatory 80% requirement. Additionally the team has delivered bespoke team training and continues to support the delivery of the Care Certificate Training, and the Prevent sessions

• The Kirklees serious incident (in relation to fire death) has progressed and the lead investigator has met with the family. The Specialist Adviser and the Lead Investigator have met and interview staff in relation to the incident and actions regarding training for hoarding and self-neglect have been identified

• Undergone a 'challenge event' for Kirklees Safeguarding Adults Board to provide assurance that we have safeguarding embedded within the organisation

• Provided adult's safeguarding supervision to a Team in Kirklees and a Team in Barnsley which evaluated well

• Completed and submitted an Individual Management Review for Calderdale

**Improvement:**

• The Safeguarding Adults Specialist Adviser has worked collaboratively with the Comms team to develop the safeguarding adult's leaflets that is aimed at the service user / carer audience. The development of the leaflets included the voices and engagement volunteers / befriender service.

• The Safeguarding Team attended a partner agency event listening to women where Female Genital Mutilation (FGM) is prevalent within their communities. This event was part of a project to engage with local communities. The Safeguarding Team was involved in the development of the Wakefield protocol for FGM.

• The Safeguarding Team and the Reducing Restrictive Physical Interventions (RRPI) Team conducted a de-brief for staff on a Wakefield inpatient unit.

• The RRPI Team and the Safeguarding Team were involved in a webinar session to consider its possible application for future use.

• The Safeguarding team and the RRPI team attended the low secure safeguarding forum.

• The RRPI Team are now aligned to Safeguarding in order to strengthen our working together to keep service users and staff safe.

**Leadership:**

• The Safeguarding Team have met with the Safeguarding Adviser in Kirklees Local Authority and have planned sessions to disseminate the information relating to the new multi-agency policy and procedures across West and North Yorkshire and Harrogate.

• Accountability lies with the Executive Director of Nursing and Quality and there is delegated responsibility to Assistant Director of Nursing supported by a Named Nurse. The 4 LSABs are supported by the Director Deputy or Assistant and subgroups are attended by the Specialist Adviser with support from the safeguarding adult nurse advisor.

• The Safeguarding Strategic and Operational meetings have merged and the initial response from the first meeting has been positive.

## Infection Prevention Control (IPC)

Infection Prevention and Control Annual programme 2017-18 has been completed. All except one objective has been completed.

Objective 2.h the Audit of Antibiotic Policy has not been achieved, this is rated at red.

The annual antibiotic audit has been cancelled for this year (2017/18), this decision was agreed by the Drugs & Therapeutics Committee on 6 February 2018. The committee assessed the risk in terms of doing the audit verses additional pressure on the pharmacy team and decided to defer the audit until November 2018.

March 2018 – confirmed outbreak of Influenza A, at Poplars CUE. All infection prevention and control outbreak measures were put in place.
As a result the ward was closed for a period of 7 days. 4 patients and 2 staff were affected by the outbreak.
Two patients were admitted to acute hospital for assessment and treatment. One of these patient died 7 days after admission (the person had very complex co morbidities). Death certificate is still pending. The service are completing a service line investigation, this will be supported by the infection prevention and control team and a patient death mortality review.
Staff were very responsive and worked well with outbreak control and respiratory precautions are in place. The trust also utilised business continuity plans.

Barnsley BDU has a locally agreed C difficile toxin positive target of 6. The BDU achieved this trajectory with a year-end total of 3 cases, all have been scrutinised at the post infection review meeting and deemed unavoidable.

Achieved Mandatory training targets:

Hand Hygiene-Trust wide Total – 89%
Infection Prevention and Control- Trust wide Total – 86%

This section of the report outlines the Trusts performance against a number of national metrics. These have been categorised into metrics relating to:
• NHS Improvement Single Oversight Framework - NHS providers must strive to meet key national access standards, including those in the NHS Constitution. During 16/17, NHS Improvement introduced a new framework for monitoring provider's performance. One element of the framework relates to operational performance and this will be measured using a range of existing nationally collected and evaluated datasets, where possible. The below table lists the metrics that will be monitored and identifies baseline data where available and identifies performance against threshold. This table has been revised to reflect the changes to the framework introduced during 2017/18.
• Mental Health Five Year Forward View programme – a number of metrics were identified by the Mental Health Taskforce to assist in the monitoring of the achievement of the recommendations of the national strategy. The following table outlines the Trust's performance against these metrics that are not already included elsewhere in the report.
• NHS Standard Contract against which the Trust is monitored by its commissioners. Metrics from these categories may already exist in other sections of the report.
The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

**NHS Improvement - Single Oversight Metrics - Operational Performance**

| KPI | Objective | CQC Domain | Owner | Target | Q1 16/17 | Q2 16/17 | Q3 16/17 | Q4 16/17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Q1 17/18 | Q2 17/18 | Q3 17/18 | Q4 17/18 | Year End Forecast Position * | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Max time of 18 weeks from point of referral to treatment - incomplete pathway | Improving Care | Responsive | SR | 92% | 98.2% | 97.0% | 97.5% | 98.7% | 98.9% | 97.8% | 98.20% | 98.8% | 96.0% | 95.7% | 96.0% | 94.6% | *94.5%* | 98.1% | 99.1% | 97.4% | 98.3% | 96.8% | 95.0% | 97.4% | 4 | |
| Maximum 6-week wait for diagnostic procedures | Improving Care | Responsive | SR | 99% | 99.6% | 100% | 100% | 100% | 99% | 100% | 100.0% | 100.0% | 100.0% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99.7% | 100% | 100% | 100% | 4 | |
| % Admissions Gate kept by CRS Teams | Improving Care | Responsive | SR/CH | 95% | 96.9% | 99.3% | 99.2% | | 95.6% | 98.3% | 100.0% | 97.8% | 96.9% | 95.2% | 97.2% | 95.3% | 97.9% | 100% | 100% | 98.8% | 98.5% | 96.6% | 96.9% | 99.6% | 4 | |
| % SU on CPA Followed up Within 7 Days of Discharge | Improving Care | Safe | SR/CH | 95% | 96.7% | 97.8% | 97.3% | 97.5% | 98.3% | 97.5% | 97.3% | 93.3% | 97.2% | 96.1% | 94.7% | 98.2% | 98.2% | 97.1% | 98.0% | *95.8%* | 97.6% | 95.5% | 96.9% | *96.7%* | 4 | |
| Data Quality Maturity Index [4] | Improving Health | Responsive | SR/CH | 95% | Reporting from Nov 17 | | | | | | | | 98.0% | | Due end April 18 | | | Due end July 18 | | | | 98% | | | 4 | |
| Out of area bed days [5] | | | | | Reporting from April 17. | | | | 286 | 357 | 242 | 341 | 362 | 424 | 467 | 412 | 407 | 268 | 613 | 727 | 885 | 1127 | 1286 | 1608 | 1 | |
| IAPT - proportion of people completing treatment who move to recovery [1] | Improving Health | Responsive | SR/CH | 50% | 50.1% | 52.5% | 48.0% | 50.5% | 45.6% | 49.4% | 56.4% | 52.4% | 49.1% | 51.3% | 53.3% | 54.1% | 54.5% | 50.7% | 54.3% | *56.5%* | 50.1% | 49.2% | 53.8% | *54.0%* | 3 | |
| IAPT - Treatment within 6 Weeks of referral [1] | Improving Health | Responsive | SR/CH | 75% | 76.1% | 83.6% | 88.9% | 86.0% | 80.3% | 84.2% | 81.2% | 79.4% | 80.90% | 82.78% | 87.68% | 91.57% | 91.9% | *90.7%* | 88.5% | *92.5%* | 81.9% | 81.1% | 89.8% | *90.6%* | 4 | |
| IAPT - Treatment within 18 weeks of referral [1] | Improving Health | Responsive | SR/CH | 95% | 98.9% | 99.3% | 97.9% | 99.9% | 99.6% | 99.4% | 99.6% | 99.6% | 99.31% | 99.01% | 99.51% | 99.44% | 100% | *99.7%* | 100% | *99.7%* | 99.5% | 99.4% | 99.6% | *100%* | 4 | |
| Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops | Improving Care | Responsive | SR/CH | 50% | 77.5% | 82.0% | 82.2% | 73.6% | 86.1% | 88.9% | 89.2% | 76.3% | 96.1% | 80.9% | 92.3% | 81.2% | 94.1% | 89.5% | 92.3% | 86.7% | 89.2% | 84.4% | 89.5% | 89.8% | 4 | |
| % clients in settled accommodation | Improving Health | Responsive | SR/CH | *60%* | Reporting developed from Sept 16 | | 82.7% | 82.9% | 82.2% | 82.5% | 82.2% | 81.8% | 81.8% | 80.8% | 80.7% | 80.4% | 80.4% | 80.1% | 79.7% | *78.8%* | 82.2% | 80.8% | 80.2% | *78.8%* | 4 | |
| % clients in employment | Improving Health | Responsive | SR/CH | *10%* | Reporting developed from Sept 16 | | 8.3% | 8.8% | 9.3% | 8.8% | 9.0% | 9.3% | 9.3% | 8.7% | 8.4% | 8.4% | 8.4% | 9.0% | 8.8% | *9.0%* | 9.0% | 8.7% | 8.6% | 9.0% | 1 | |
| Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach) | Improving Care | Responsive | SR/CH | | | | | | Due Q4 (reporting available June 18) | | | | | | | | | | | | Due Q4 | | | | 2 | |

| Mental Health Five Year Forward View | Objective | CQC Domain | Owner | Target | Q1 16/17 | Q2 16/17 | Q3 16/17 | Q4 16/17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Q1 17/18 | Q2 17/18 | Q3 17/18 | Q4 17/18 | Year End Forecast Position * | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total bed days of Children and Younger People under 18 in adult inpatient wards | Improving Care | Safe | SR/CH | *TBC* | 14 | 2 | 60 | 86 | 0 | 1 | 3 | 42 | 45 | 21 | 22 | 2 | 38 | 38 | 28 | 30 | 4 | 108 | 62 | 96 | N/A | |
| Total number of Children and Younger People under 18 in adult inpatient wards | Improving Care | Safe | SR/CH | *TBC* | 4 | 1 | 4 | 3 | 0 | 1 | 1 | 2 | 3 | 2 | 3 | 1 | 2 | 2 | 1 | 3 | 2 | 4 | 5 | 4 | N/A | |
| Number of detentions under the Mental Health Act | Improving Care | Safe | SR/CH | *TBC* | 167 | 174 | 156 | 168 | 212 | | | 221 | | | 186 | | | 180 | | | 212 | 221 | 186 | | N/A | |
| Proportion of people detained under the MHA who are BME [2] | Improving Care | Safe | SR/CH | *TBC* | 15.0% | 10.3% | 10.9% | 19.6% | 10.8% | | | 13.6% | | | 15.1% | | | 9.4% | | | 10.8% | 13.6% | 15.1% | | N/A | |

| NHS Standard Contract | Objective | CQC Domain | Owner | Target | Q1 16/17 | Q2 16/17 | Q3 16/17 | Q4 16/17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Q1 17/18 | Q2 17/18 | Q3 17/18 | Q4 17/18 | Year End Forecast Position * | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance [1] | Improving Health | Responsive | SR/CH | 90% | 97.8% | 97.9% | 97.8% | 98.0% | 95.9% | 97.0% | 98.7% | 98.0% | 97.9% | 97.1% | 96.5% | 97.9% | 98.1% | 97.5% | 99.2% | *Due end April* | 98.7% | 97.1% | 98.4% | | 4 | |
| 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 | SR/CH | 99% | 99.5% | 99.6% | 99.7% | 99.7% | Data Not avail [3] | 99.7% | 99.7% | 99.7% | 99.7% | 99.7% | 99.9% | 99.8% | 99.8% | *99.8%* | 99.8% | *99.8%* | 99.7% | 99.8% | *99.8%* | *99.8%* | 4 | |
| Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance | Improving Health | Responsive | SR/CH | 90% | 89.6% | 91.1% | 94.0% | 90.2% | Data Not avail [3] | 89.8% | 89.3% | 89.4% | 90.2% | 90.9% | 91.0% | 90.9% | 90.9% | 90.9% | 90.8% | *90.4%* | 89.3% | 90.3% | *90.8%* | | 4 | |

** See key included in glossary.*
*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 - BME includes mixed, Asian/Asian British, black, black British, other*
*3 - There was no April Primary submission due to the transition to MHSDS v2. Data flow monthly from May 17 onwards.*
*4 - This indicator was introduced from November 2017 as part of the revised NHSI Single Oversight Framework operational metrics. It measure the proportion of valid and complete data items from the MHSDS:*
- *ethnic category*
- *general medical practice code (patient registration)*
- *NHS number*
- *organisation code (code of commissioner)*
- *person stated gender code*
- *postcode of usual address*

*As this is a revised indicator, the initial focus (until April 2018) will be ensuring providers understand their current score and, where the standard is not being reached, have a clear plan for improving data quality. During 2018/19, failure to meet the standard (95%) will trigger consideration of a provider's support needs in this area.*
*5 - Out of area bed days - progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021. The process for agreeing trajectories toward eliminating acute mental health out-of-area placements (OAPs) is being jointly led by the NHS England and NHS Improvement regional teams during October to December 2017 - this has now been extended to April 2018. 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. The January 2018 submission will be taken as an agreed baseline position.*

**Areas of concern/to note:**
• The Trust continues to perform well against the vast majority of NHS Improvement metrics
• Within the Improving Access to Psychological Therapies people moving to recovery indicator shows that the threshold has been met though only by a close margin. This is a provisional figure, the final figure will be available at the end of the month and it is anticipated that this will show further improvement on the 50% threshold.
• Out of area beds days has seen a further increase in March 2018. This is attributed to acuity levels and increased demand in both acute and PICU services. Current data (18th April) shows that there has been a slight reduction in psychiatric intensive care unit (PICU) and Acute bed days for the month of April to date.
• Total beds days of Children and Younger People aged under 18 increased to 30 days in March and relates to the new admission of two 17 year olds - whose lengths of stay were 3 and 5 days; and the continued stay of one 17 year old who was admitted at the end of November to the Horizon centre has since been discharged. The Trust has robust governance arrangements in place to safeguard young people when they are admitted to our adult wards; 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. Work is taking place as part of the new models of care programme to address this issue. The Trust have 2 beds that can be made available (1 male, 1 female) in the event of national unavailability. 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 Trusts 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.

This section of the report is to be developed during 2017/18 and populated with key performance issues or highlights as reported by each business delivery unit (BDU).

**Barnsley BDU:**

• Sickness – the BDU position for sickness during the month of March 18 reduced significantly down to 4.8%.
• Under performance against the local threshold for mandatory training on Food Hygiene continues to report below the expected thresholds. The BDU are undertaking a review to ensure that the relevant staff in the workforce requiring this training are identified.

**Mental Health**
• Improving Access to Psychological Therapies (IAPT) has sustained its improved performance meeting required KPIs in March. The IAPT tender process is underway.
• Work continues to implement the transformation action plan in community mental health services – this is monitored by the BDU management meeting to ensure that progress is being made and that the District Director is fully sighted on progress. In addition, the service is informing its action plan with the findings of the interim review of acute and community transformation in Barnsley, presented to the Transformation Steering Group on the 4th April 2018.
• Progress is underway around changes to mental health community services required following the agreed disaggregation of the social care resources from the teams following the dissolution of the S75 agreement between SWYFT and Barnsley Metropolitan Borough Council (BMBC) planned for August 2018. This will involve all social care staff removing from the current integrated model to a BMBC team, and the requirement for new partnership working arrangements going forward.
• Performance around care programme approach (CPA) reviews remains below target, an action plan is in development in the service and at team level to address issues.
• The atypical variance in Delayed Transfers of Care (DTOC) notable in January and March has now reduced to within range with patient flow and reporting issues addressed by the service area.
• Negotiations continue with the CCG to address the waiting lists in Psychology in the community service line. Significant improvements have been made by the service through the implementation of a revised clinical pathway, skill mixing of the staff team and streamlining the service offer to maximise use of our resources.

**General Community**

• Musculoskeletal (MSK) – Delivery has commenced against the new contract from 1st April. Discussions are currently taking place around the provision of clinical injections as Barnsley Hospital have raised some concern regarding clinical thresholds.
• Stroke Rehabilitation Unit – February 18 saw some under performance against a couple of the Stroke rehabilitation KPIs with the number of 6 month reviews undertaken being impacted by the adverse weather conditions. A piece of work is being undertaken to review data relating to the modified rankin scale as there have been a number of months of under performance against the contracted threshold – nationally the team benchmark well in this area and so further local understanding of this data is required.
• Under performance against the local threshold for mandatory training on food hygiene continues to report below the expected thresholds. The BDU is undertaking a review to ensure that the relevant staff in the workforce requiring this training are identified.

This section of the report is to be developed during 2017/18 and populated with key performance issues or highlights as reported by each business delivery unit (BDU).

**Calderdale & Kirklees BDU:**

**Key Issues**

• Meeting held with Calderdale and Kirklees Local Authorities and CCGs in April to consider options for developing business cases for access to Better Care Funds (BCF). Focus on two projects which are within the Improved BCF (IBCF) offer.
• Additional 7 day support to all wards to focus on support for early discharge and delayed transfers of care (DTOC). To be a link to housing, benefits and at home rapid support on discharge. Both local authorities are supportive. A fully costed model has been shared with both councils and CCGs.
• Number of DTOC days in SWYPT/Calderdale CCG reduced slightly in March against the February performance, but was above KPI tolerances. Specialist placements are an area of commissioning review especially for Older Adults.
The DTOCs in Kirklees increased slightly. These performances indicate the slower discharge rates in adult and older adult services during February and March.
• NHSI Improvement's intensive support team diagnostic review draft document has been sent back by the Trust and CCG to NHSI now all the detail has been checked. Helpful conversations between the Trust and CCG continue on the level of investment and linking to realistic KPIs against current and future CCG funding plans.
• Adult Acute ward pressures remained high, with for example, 5 one to one levels on Ward 18 in February throughout March. This has led to an increase in bank and agency expenditure in order to keep wards safely staffed. It is worth noting that length of stay levels and occupancy levels all increased in last quarter in Adult and Older Adults.
Out of areas bed use has reduced but has not stopped.

**Strengths**

• Improved and sustained performance across all service lines for KPIs.
• Sickness Absence management is positive and absence reduced in March.
• Mandatory training figures are very positive.
• Supervision levels are green.
• Memory Services National Accreditation Programme (MSNAP) in Kirklees maintained for 18/19.

**Challenges**

• Occupancy levels (high above 95%) and continue to be monitored closely.
• Adult bed capacity/out of area.
• Improving access to psychological therapies (IAPT) Kirklees referral numbers dropped in March. Thought to be connected to snow events and Easter.

**Forensic BDU:**

**Medium and Low Secure**

• Low Secure – external review has commenced following a homicide (community service user). Internal review completed, action plan completed. Work is progressing re the actions.
• Noted increase in falls relating to one service user in medium secure. Investigations are ongoing.
• National service review continues. Recent management changes in NHSE have led to a ‘pause’ in proceedings to ensure the work is in line with the national initiatives.
• All mandatory training for the BDU is Green.
• Focus on reducing sickness continues.

**Forensic CAMHS**

• Sickness levels are currently very high in this team and contingency plans are in place for safe delivery of the service. Return to work plans now in place for some staff who have been on long term sick.
• Implementation of the region wide Forensic Service has operationalised and the Partnership Board established. There has been a steady flow of referrals so far which is predicted to increase once the communication strategy is implemented. Early indications are that the service has got off to a good start.
• Implementation of Secure Stairs (a more psychologically/Multi Disciplinary Team way of working with young people in custody) informed has commenced in Adel Beck and Wetherby.

This section of the report is to be developed during 2017/18 and populated with key performance issues or highlights as reported by each business delivery unit (BDU).

**Specialist BDU:**

**Child and Adolescent Mental Health Services (CAMHs)**

• Sickness rates continue to reduce in Wakefield and have reduced in Barnsley. Calderdale and Kirklees sickness absence remains low.
• Continued team development in Wakefield through recent away days have been positive and well received by staff.
• On call remains a key concern for staff. Developmental work continues with regard to an all-age psychiatric liaison team model with the intention of ensuring safer and more sustainable 24/7 crisis resolution delivery. In the short-term adjustment to on-call arrangements is being developed to reduce individual/service impact.
• Ongoing work continues in relation to the all age liaison proposals
• Work continues with commissioners in Wakefield in relation to the Forensic CAMHs/CAMHs service review
• Mandatory training compliance continues to improve and appraisals are booked for the forthcoming period
• The new care navigator as part of the CAMHS Tier 4 New Care Models work has started. The role is expected to support to teams to reduce CAMHS tier 4 admissions and, where admission is necessary, improve access and pathways.

**Learning Disability**

• The bid to host the Operational Delivery Network was successful. This will also tie well into to the Trust leading work across the local mental health partnership on autism and ADHD pathways.
• Capital programme work will commence on Horizon in the first quarter of 2018/19. This will remove any environmental limitations to full occupancy – allowing the more proactive marketing of the 2 spot purchasing beds. Discussions continue with Leeds and Bradford to work towards a shared assessment and treatment provision.
• The service have secured 2 spaces for nurses to attend the NHSE STOMP (stopping over-medication of people with a learning disability, autism or both with psychotropic medicines) This will support the rolling out of a consistent approach/ project for STOMP across our 4 localities.

**Wakefield BDU:**

• The acute service line continues to experience high demand and staffing pressures. Cross-unit flexibility is supporting capacity. Due to the acuity and particular presentation and risk of service users on the units at this time, extra staffing continues to be required to provide safe levels of observation. Capacity in the psychiatric intensive care unit (PICU) PICU should be improved by the transfer of one patient to medium secure services.
• Use of out of area beds (OOA) (Acute and PICU) for Wakefield service users has not sustained its previous month's reduction which had been down to zero in Acute beds, although intensive work is ongoing to explore all possible alternatives at the point of admission, and to reduce OOA episode duration once commenced.
• Intensive home based treatment team (IHBT) episodes remain below target. Work to develop and refocus the IHBT offer is ongoing and recruitment to additional posts underway, informed and focussed by the initial results of the core fidelity audit undertaken across Wakefield and Barnsley.
• Care programme approach (CPA) reviews for the BDU are at 100%.

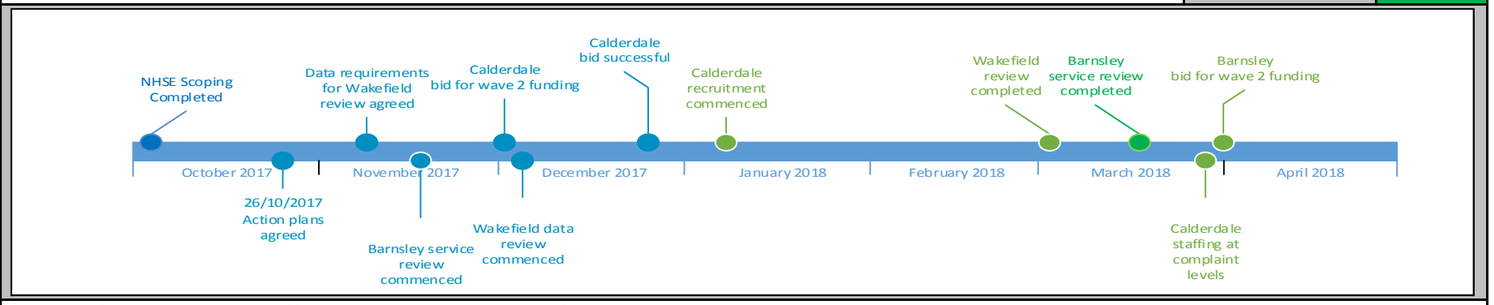
**Summary of progress highlights for the Trusts priority programmes for March 2018 include:**

**Flow and out of area beds:**
• Out of area placements reached unprecedented high levels through February 2018 and into March the overall situation is still severe. Work to safely reduce these pressures is an ongoing operational priority.
• Work is continuing to focus on establishing change plans that focus on highest priorities in each locality and each area is developing a sustainability plan to determine how their locality specific problems will be addressed.
• Our bed management protocol has been signed off.
• Planning for a patient flow event in Calderdale, sponsored by the Academic Health Science Network, is scheduled for May 2018.

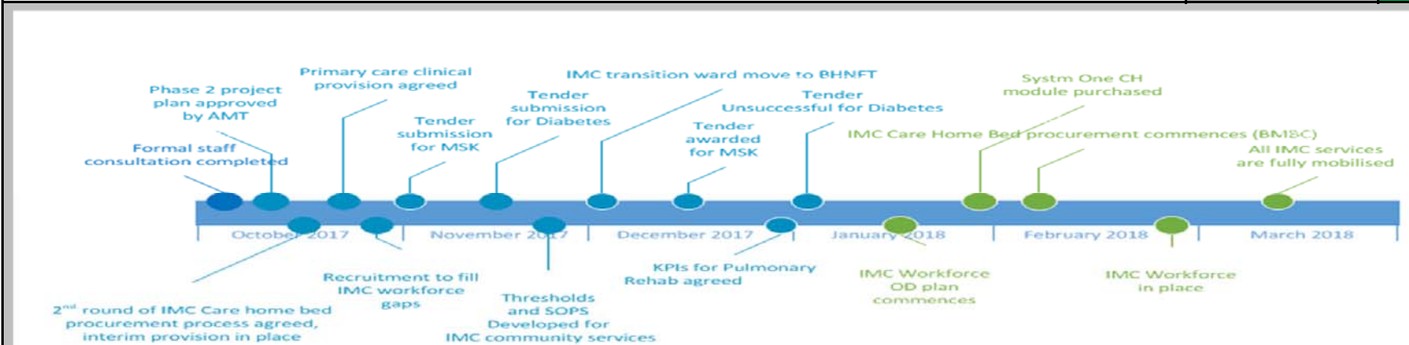
**Clinical Record System**
The clinical record system programme is now into the co-design project phase and is on track with key milestones.
• There is a good level of engagement and the co-production of quality maps of current and future ways of working being developed. The outputs from co-design workshops are to be reviewed by the mental health clinical safety design group to ensure that best practice is incorporated and unnecessary variation is minimised across services and business development units. The Board and EMT have been invited to be part of these co-design workshops.
• An issue emerged over the format and content of the initial data extraction which has caused an initial delay to progress. A resolution plan with a way forward has been agreed and due to contingency built into the overall plan the overall go live date is unaffected by this issue.

**Older Peoples Transformation**
• Business cases for the community and inpatient models will be presented to EMT in May and work is ongoing to define the community workforce model in more detail to ensure new roles are an integral part of the model design.
• Quality Impact assessment for community model is now in place and an overall Quality Impact Assessment for the workforce model will be conducted when completed.
• Equality Impact Assessment for inpatient model now drafted and awaiting agreement.
• Ongoing activity is taking place to highlight innovations in new ways of working.
• Outline engagement plan now in place for coming months and formal consultation readiness has been reviewed.

**Community Forensic CAMHS service**
• Referrals through the Single Point of Assessment, which commenced at end of February on track with the implementation plan, continue.
• Following sign-off of the implementation plan for this service the content of a contract variation to the NHSE secure estate contract has been agreed.
• Due diligence is ongoing for all partners
• Formal launch of the service will be conducted later in the year.

| Priority | Scope | Update | Area | RAG |
|---|---|---|---|---|
| **IMPROVING HEALTH** | | | | |
| **Strategic Priority One: People First** | | | | |
| Enhancing Liaison Services | Transition to a new framework for liaison services. Identification of where current gaps in provision are and support development of plans for appropriate liaison services to support commissioner intentions to work towards CORE 24 compliance by 2020.<br>Establishment of a benefits realisation framework to support the 3 year evaluation of the project. | Wakefield<br>• Recruitment - All staff in post<br>• Gathering data as requested for evaluation.<br>• Review meeting set up to look at progress against KPI's<br>Calderdale<br>• Bid for an early release of wave 2 part funding to support the recruitment of two posts has been successfully secured.<br>Barnsley<br>• The CCG are supportive of a Wave 2 bid for Core 24 monies and steps are being taken by the service to support this. | Progress Against Plan | |
| | | Risks are being managed and mitigated within the individual services | Management of Risk | |
| | |  | | |
| Improving People's Experience and Equalities | A structured approach to ensuring that we collect and act on patient experience feedback building upon our current strong foundations. We have identified five objectives for improvement during 2017/2018, including a programme to formally connect with other priority objectives. | This priority is updated in the Quality section of this integrated performance report | | |
| Recovery based approaches | Further develop a range of innovative initiatives which promote recovery focused approaches in order to meet the Trust mission, including:<br>Co-produce an integrated recovery development plan<br>Test new approaches to recovery, developing from what we learn in order to maximise effectiveness and impact<br>Continue to build, support and sustain recovery work which has already been undertaken or is already planned | • Work continues in line with the milestone plan as agreed by the Transformation Board.<br>• Progress includes work on the alignment of the work of Altogether Better, Creative Minds, the Mental Health Museum, Recovery Colleges and Spirit in Mind through a workshop and subsequent development plan.<br>• Evaluation methods for recovery based approaches are being further developed through a community of practice. This work is linked to the Trust approach to measuring impact on individuals and communities in line with the Trust mission<br>• Work continues to build, support and sustain recovery work which has already been undertaken. Work is being undertaken to co-produce the Recovery College business plan which focuses on sustaining and developing the five recovery colleges. Workshops are happening in all the districts and meetings are being held with senior leaders. | Overall Priority Performance | |
| Physical /Mental Health | Improve the physical health of people with mental health difficulties and the mental health of people with physical health difficulties | Activity on physical health continues to be delivered as part of CQUIN. See CQUIN section of IPR for more information. | Overall Priority Performance | N/A |

| **Strategic Priority Two: Joining up Care** | | | | |
|---|---|---|---|---|
| Supporting place-based plans | Develop place based plans for each district which are part of the Trust Strategy | Discussed quarterly at Strategic Board and monthly updates to Executive Management Team (EMT) so no direct update required in this section of the IPR | | |
| Accountable Care in Barnsley and Wakefield | Work with partners as part of the development of accountable care systems. Influence the SWYPFT role in each Accountable Care Organisation (ACO). | Discussed quarterly at Strategic Board and monthly updates to EMT so no direct update required in this section of the IPR | | |
| New models of care and vanguards<br><br>Barnsley Intermediate Care, Respiratory, Diabetes and MSK | Work with partners to introduce new models of Care across SWYPFT footprint<br><br>Barnsley Intermediate Care, Respiratory, Diabetes and Musculo-Skeletal service. | **MSK**<br>Mobilisation is on track.<br>**Pulmonary Rehabilitation - Respiratory Services**<br>• As part of the Alliance agreement all providers are working jointly on the development and implementation of a new model for the service, with BHNFT leading the process. Implementation is on target. KPIs, Quality Indicators and data flows have been amended without negotiation and will be raised at AMT.<br>**Diabetes**<br>Formal consultation with staff is ongoing with regards to TUPE of staff to BHNFT.<br>**Intermediate Care**<br>• Mobilisation of the new model continues with key workstreams linked to KPIs, IM&T and assessment processes progressing.<br>• Mobilisation within community continues, recruitment to the staffing model and skill mix commenced.<br>• Interim solution in place for the Independent Sector Care Home beds which is being mobilised, BMBC have commenced the procurement process. | Progress Against Plan | |
| | | The Partnership Intermediate Care Mobilisation Team meeting manages the risks and has produced a risk log on behalf of the Alliance which reports to Barnsley ACO NGOC implementation group (and AMT as appropriate) on a monthly basis. Other risks are being managed internally by services as part of business as usual. | Management of Risk | |



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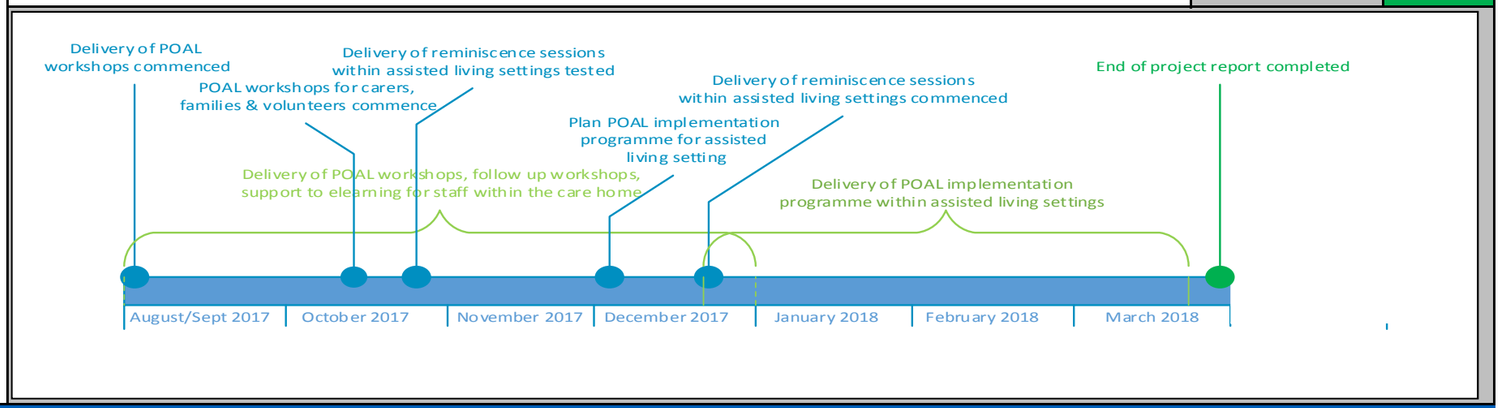
| New models of care and vanguards<br><br>Wakefield - Care Home Vanguard and Public Health as part of Connecting Care Vanguard<br>Calderdale - Prevention and Supporting Self Management Vanguard | Work with partners to introduce new models of Care across SWYPFT footprint<br><br>Wakefield - care home vanguard and public health<br>Calderdale - Prevention and Supporting Self Management Vanguard | **Wakefield**<br>• Portrait of a Life (POAL) as part of Wakefield Care Home Vanguard: training and support session on life story work and person centred care interventions provided to 12 of 13 care homes for Wave 2 2017/2018 and to one assisted living facility. Project is on track and meeting KPIs.<br>• Wakefield Connecting Care: Work is being undertaken to align SWYPFT involvement in new models of care. Steps are being taken to move to a single leadership model for Connecting Care, Mid Yorkshire NHS Hospitals Trust (MYHT) and Adult Social Care, Wakefield Metropolitan District Council (WMDC).<br>• Care Navigation: The role out across Wakefield GP's is on plan. Directory of Services redesigned and working well. Extracting data from the GP systems had been problematic, resulting in data not reflecting output correctly. CCG are investigating improvement to coding.<br>• Public Health – Live Well Wakefield service, led by Nova, is performing well and meeting all KPI's. Feedback from commissioners has been very positive and the partnership with Nova is working well.<br>A partnership bid for the provision of social prescribing in Wakefield for the next three years is under development.<br>**Calderdale.**<br>A single plan for Calderdale is under development. Work continues to develop an integrated community service offer through implementation of five localities. | Progress Against Plan | |
| | | Risks are managed by the Vanguard projects which report into the Vanguard PMO (Wakefield) and Vanguard Board (Calderdale) on a monthly basis - there are no significant risks to date. | Management of Risk | |

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| **IMPROVING CARE**<br>**Strategic Priority Three: Quality Counts, Safety First** | | | | |
| Patient Safety | Continue to implement the patient safety strategy including: Measuring and monitoring patient safety framework awareness and use in practice; establish a sustainable resource to support the roll out and continuing support for safety huddles; develop a process and resources for considering human factors within incident review | This priority is updated in the Quality section of this integrated performance report | | |
| | Co-produce, develop and agree a new model of care for Older people with mental health difficulties that improves outcomes, experience and efficiency. To effectively implement this model and demonstrate the impact. | • Business cases will be presented to EMT in May and work is ongoing to define the community workforce model in more detail to ensure new roles are an integral part of the model design.<br>• Quality Impact assessment for community model now in place - agreed to hold an overall quality assurance process for the workforce model when completed.<br>• Equality Impact Assessment for inpatient model now drafted and awaiting agreement.<br>• Ongoing activity taking place to highlight innovations in new ways of working, including potential alignment with recovery colleges.<br>• Outline engagement plan now in place for coming months and formal consultation readiness has been reviewed. | Progress Against Plan | |

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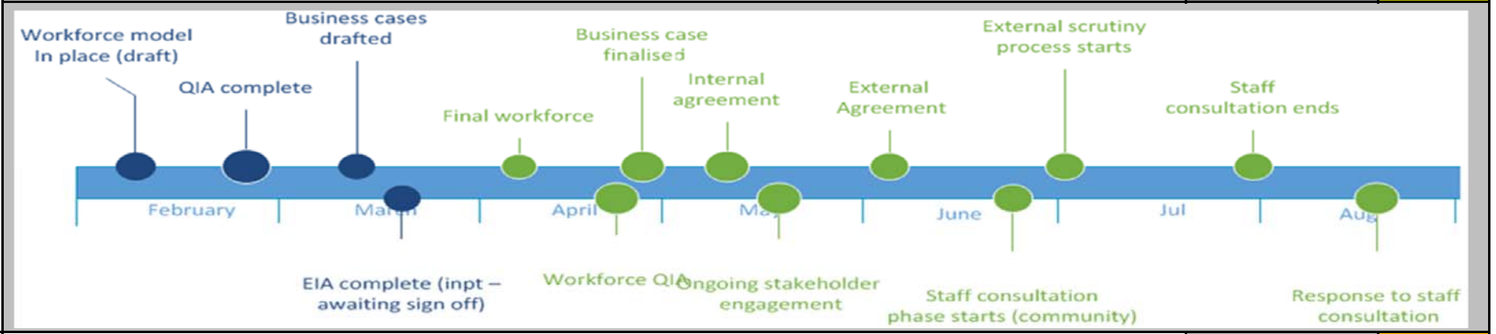
| Older Peoples Services Transformation | | The complexity of the differing workforce models already in place across the Trust remains a challenge though project team has undertaken extensive, comprehensive levels of rigour to unpick and understand this with a view to bringing a transformational model to this stage and activity is still ongoing to ensure that we get this right.<br>The ongoing risk of slippage in the project timescale due to limited capacity across the project and across the BDUs remains. | Management of Risk | |
| | |  | | |
| Improving autism and ADHD | Address issues in relation to access and equity across these services. Work is occurring operationally internal to the Trust that will reflect developments through the West Yorkshire (Sustainability and Transformation Plan ) STP- yet to be developed. | Work has yet to be finalised on the detail for this priority and development of an implementation plan. | Progress Against Plan | |
| | | No known risks identified at this time. | Management of Risk | |
| | | Implementation plan will be developed once the scope for this priority is clearer. | | |
| Perinatal mental health | To implement the new service within the Trust. To evaluate the impact in terms of outcomes, experience and use of resources | • This priority programme has now gone live and has been handed over to operational management.<br>• A project closure report has been presented to the Transformation board and to EMT.<br>• A post implementation review will then be conducted 12 months after hand over | Progress Against Plan | |
| | | Any residual risks will be reported here in March following the project closure report. | Management of Risk | |
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| West Yorkshire work - CAMHS Tier 4 | Work in this priority is focused on supporting Leeds Community Healthcare NHS Trust (LCH) as lead provider in the provision of Tier 4 CAMHS beds, led by Leeds Community Healthcare. Aim of the project is to improve access times.<br>SWYPFT is a Partner in this contract together with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust<br>Funding has been secured though STP NMoC work stream | • Work in this project is focused on the delivery of services differently for children's admissions to prevent them from being miles away from home, trying to keep them local and out of hospital whenever possible. This is through use of locally placed beds and home based treatment teams in local areas.<br>• Project is two year pilot<br>• Planned 'go live' of new care model for this workstream has been changed to April 2018 as per national advice so now rated as green on progress.<br>• SWYPFT contribution to the new care model continues. | Progress Against Plan | |
| | | Risk management has yet to commence for this priority as part of the planning phase for this new model of care. | Management of Risk | |
| | | Implementation planning will be an integral part of the planning phase of this priority | | |
| West Yorkshire work – Secure Adult MH | Forensics – Leading the work with other providers across Yorkshire and Humber | • A bid was submitted through the West Yorkshire STP for NMoC was unsuccessful, however the Trust is continuing in defining a review of forensics services through specialist community work. | Progress Against Plan | |
| | | A workshop of providers and commissioners has been held and identified actions will take the project to the next phase of this work | Management of Risk | |
| | | Discussions continue regarding links between this work and locked rehabilitation. | | |
| West Yorkshire work – Suicide prevention | Leading West Yorkshire STP wide work on zero suicides | This priority is updated in the Quality section of this integrated performance report | | |
| West Yorkshire work Eating Disorders | Eating Disorders- Provision of community treatment services for eating disorders across West Yorkshire lead by Leeds and York Partnership NHS Foundation | • Work in this priority is focused on supporting the Leeds and York Partnership NHS Foundation Trust as lead provider in the provision of a West Yorkshire wide new model for community treatment services for adults with eating disorders.<br>• The adult eating disorders service, called the Eating Disorders West Yorkshire and Harrogate Network (EDWYHN), has SWYPFT as a partner as part of the West Yorkshire STP.<br>• Funding has been secured though STP NMoC work stream<br>• SWYPFT are active on the new care models programme board and steering group<br>• The Leeds and York Partnership business case has been shared with EMT<br>• Quality Impact assessment undertaken<br>• Plans presented to Greater Huddersfield CCG<br>• Transition plans for existing service user is developed: All current patients who are not close to discharge to transfer to the new service by 1st May | Progress Against Plan | |
| | | Any implementation risks are with Leeds and do not transfer to SWYPFT | Management of Risk | |
| | | Implementation plan in development | | |
| Quality priorities | Delivery of the quality priorities as set out in the Quality account | This priority is updated in the Quality section of this integrated performance report | | |
| | SWYPFT, as lead provider, to provide forensic CAMHS services across Yorkshire and Humberside in partnership with: Sheffield Children's Hospital; Tees, Esk and Wear Valleys FT and; Humber FT. | • Following sign-off of the implementation plan for this service the content of a contract variation to the NHSE secure estate contract has been agreed, but still requires NHSE and SWYPFT signature.<br>• Sub-contract content for all partners has been agreed - these still need formalising and signing with partners<br>• Due diligence is ongoing<br>• One off set up costs have been paid to the partner Trusts<br>• Referrals through the Single Point of Assessment, which commenced at end of February, continue. | Progress Against Plan | |

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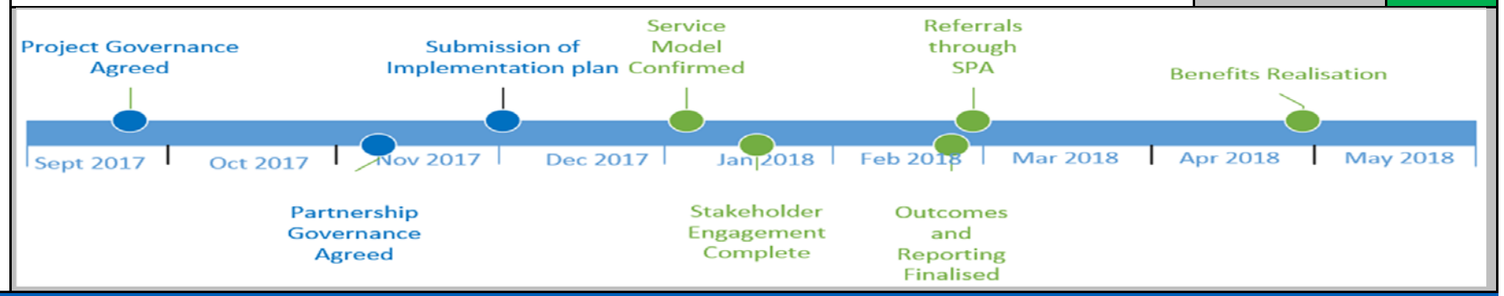
| Community Forensic CAMHS | | • There are currently no high level risks identified in this project.<br>• Risk sharing agreements are being developed for the partnership<br>  | Management of Risk | |
| **Strategic Priority Four: Compassionate Leadership** | | | | |
| Leadership development | Leadership and management strategy which includes development of an integrated change network | This priority programme is updated bi-monthly and the next update is due in March. Details of the last update include:<br>• Values into behaviours - shared and roll-out planned after launch in Q1 2018; incorporated into revised Appraisal<br>• Learning Needs Analysis - completed<br>• Leadership and management framework – leaders/managers expectations obtained and incorporated<br>• Corporate Leadership and management offer – developed further and costed<br>• SWYPFT Leadership and management programmes – shared via Workforce Planning workshops; implemented and collaborative programmes with Bradford DCT and Leeds and York Partnership Trusts agreed<br>• Moving Forward programme – launched<br><br>Revised implementation plan with extension to agreed timescales now in place:<br>• Middle Ground 5: first run (pilot) confirmed for February and March 2018 and first run of the programme agreed for 2018. Revisions agreed and redesign underway.<br>• TRIO development programme: Review of needs completed as part of Workforce Planning workshops within 2018/2019 Business Planning<br>• Maximising Potential: Funding via 'In Place Leadership Fund secured; development (workshops and pilot) is ahead of schedule. Launch of the programme is linked to the launch of the new streamlined appraisal process, which is due in Q1 2018.<br>All other work-streams/key deliverables are progressing as per agreed timescales. | Overall Priority Performance | |
| Change and quality improvement | Develop and agree Quality Strategy which includes the Integrated Change Framework | Further work has been undertaken on the quality strategy which is due to be presented into the Executive Management Team on 18th January 2018. This strategy includes how the Trust assures quality as well as how we improve quality. The Integrated Change Framework is aligned and integrated with this strategic approach. | Overall Priority Performance | |
| Membership | Develop an approach to membership which maximises the impact of members in key activities | • The 'Membership Priority' project group is ongoing and working to an agreed implementation plan<br>• A communication plan is in development.<br>• Implementation actions for this priority are across two years - 2017/2018 and 2018/2019<br>• No identified risks are of concern for this priority hence RAG rating of green. | Overall Priority Performance | |

**IMPROVING USE OF RESOURCES**

**Strategic Priority Five: Operational Excellence**

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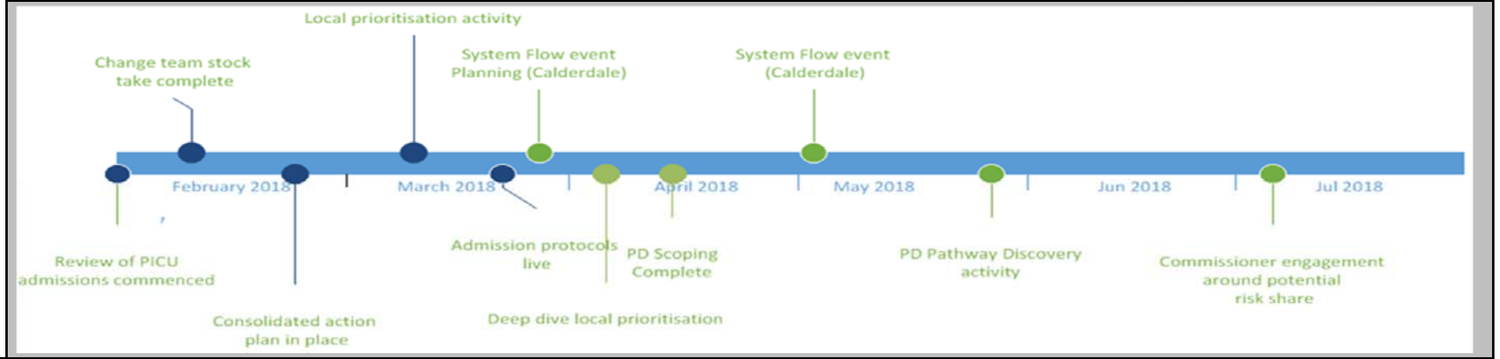
| Flow and out of area beds | Improve flow and reduce/eliminate use of out of area beds so that everyone is in the right bed including their own.<br>This is part of the West Yorkshire STP work stream for acute inpatient shared bed base and development of Psychiatric Intensive Care Units (PICU).<br>By March 2018 the Trust will have a shared bed base across West Yorkshire. | • Out of area placements reached unprecedented high levels through February 2018 and whilst there has been slight reductions in March the overall situation is still severe.<br>• Work is continuing to focus on establishing change plans that focus on highest priorities in each locality.<br>•Each area is developing a sustainability plan to say how their locality specific problems will be addressed. These will cover pathway issues and will strengthen the community offer, support in a crisis, gate keeping, patient flow and risk taking on discharge.<br>• Our bed management protocol has now been signed off. It aims to promote and support a challenging and problem solving approach before admissions and an out of area placement. This includes assertive use of Intensive Home Based Treatment, enhanced coordination of patient flow across our estates and senior level clinical input in risk taking.<br>• Planning for the patient flow event in Calderdale, sponsored by the Academic Health Science Network is scheduled for 1 May 2018. It will include a range of stakeholders and focus on the issues that lead to hospital bed use in that locality. | Progress Against Plan | |
| | | Current risk is that we continue to overspend on Out of Area Beds and people have to travel far for their care unless pressures on the system has increased. This risk has moved off trajectory with recent pressures on the system. | Management of Risk | |
| | |  | | |
| Workforce – sickness, rostering, skill mix and agency | Effective management of workforce to increase effectiveness and efficiency.<br>These are operational excellence projects to develop standards ways of working and increase efficiencies in areas of sickness, rostering and agency spend | This priority is updated in the Workforce section of this integrated performance report.<br>Sickness absence performance is in the Summary section of the IPR under the heading 'Improve the use of Resources' and within the workforce section of the report performance is summarised for sickness absence; turnover and stability; and on the workforce performance wall. | | |
| Effective use of supplies and resources | Effective use of non-pay money to support high quality care through effective use of resources | Progress on this priority is reported bi-monthly on the IPR. | Overall Priority Performance | |
| CQUIN | Deliver Trust CQUINS | This priority is updated in the Finance and Contracts section of this integrated performance report | | |
| Financial sustainability and CIP | Develop and deliver Cost Improvement Programme (CIP). | This priority is updated in the Finance and Contracts section of this integrated performance report | | |

**Strategic Priority Six: Digital by Default**

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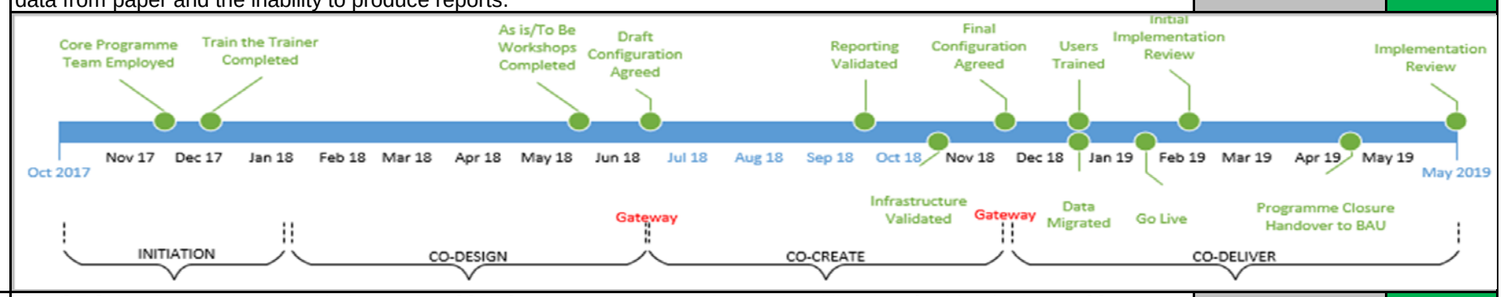
| Clinical record system | Plan and deliver a new clinical record system which supports high quality care | An issue emerged over the format and content of the initial data extraction which has caused an initial delay. Discussions were escalated to director level and a resolution plan is being drafted after agreeing a way forward in principle. There is contingency built into the overall plan and it is likely that work will be underway in the first 2 weeks of April and therefore the overall go live date is unaffected.<br><br>Other aspects of the co-design work are going well, with good level of engagement and the co-production of quality maps of current and future ways of working being developed. The outputs from the co-design workshops, namely the 'to-be' process maps will be reviewed by the CRS for MH clinical safety design group to ensure that best practice is incorporated and unnecessary variation is minimised across services and business development units.<br><br>The Board and EMT have been invited to attend the co-design workshops. | Progress Against Plan | |
| | | Robust plans are being developed around the following critical risks:<br>Datix Risk ID 1222: In the event of not knowing the full list of services, sites and users, there will a risk of missing a service, site, and user, which will result in reverting back to paper for SystmOne<br>Datix Risk ID 1224: In the event of staff not being trained there will be a risk of staff unable to access the Clinical Records System Programme which will result in lack of visibility of the shared record<br>Datix Risk ID 1225: In the event of not having enough server resources for report production there will be a risk of a financial impact to provide such resources<br>Datix Risk ID 1230 In the event of the number of Rio users being in the excess of the assumed 3500 licenses there is a risk of a financial impact to provide access to all the users of the system<br>Datix Risk ID 1251: In the event of during the transition (cut over) there is no clinical record system to use, there will be a risk of services have to revert to services business continuity plans and there will be no access to an electronic patient record which will result in delay and inconvenience to patients, services and staff followed up later by the need to re-enter data from paper and the inability to produce reports. | Management of Risk | |
| | |  | | |
| Digital health | Improve access to digital health opportunities.<br>Identify our approach to supporting digital health developments.<br>Increase digital clinical practice. | The ORCHA pilot was launched in December 2017 for three months and is ongoing. The data for March shows 68 clinicians have been issued with a license to prescribe/recommend apps to the people they are working with. Data shows that 22 people have activated their license, and 0 apps have been recommended to individuals. There has also been 222 visits to the website, whereby people will have downloaded apps independently themselves. There is ongoing engagement and communication with clinicians to support them to use the app library. | Progress Against Plan | |
| | | The project has now been extended to all teams in each of the BDUs. Many of the clinicians do not have a smart phone (and there is no available budget) which would enable people to be more agile with the use of the platform. Staff are using laptops, and/or providing a leaflet with new appointment letters to enable young people to look for themselves from their own mobile phones or devices. This could mean there are more downloads than prescriptions (no issue therefore risk is still rated as green), however this may affect staff usage of the platform. In other organisations staff are using personal smartphones to use the platform- there is no personal usage cost as all prescription texts are paid for by the platform, and no personal data is stored on the handset. The project team will explore this option with the management team/IG/policy with the review for scale up following the three month pilot. | Management of Risk | |

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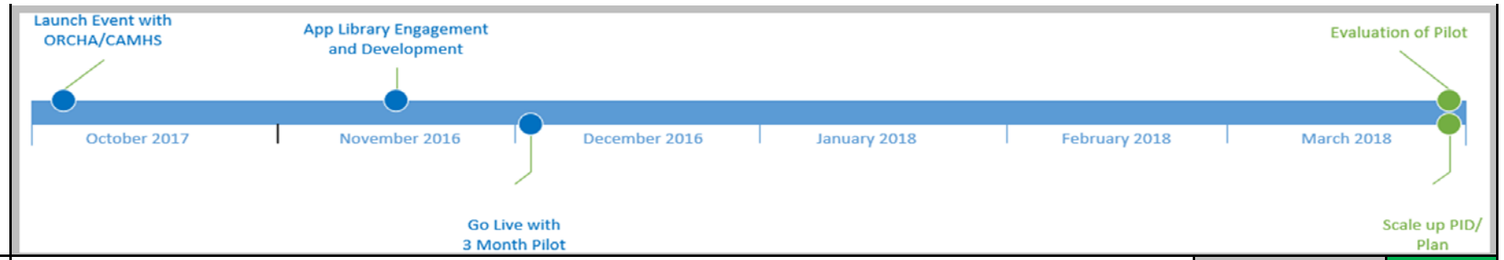
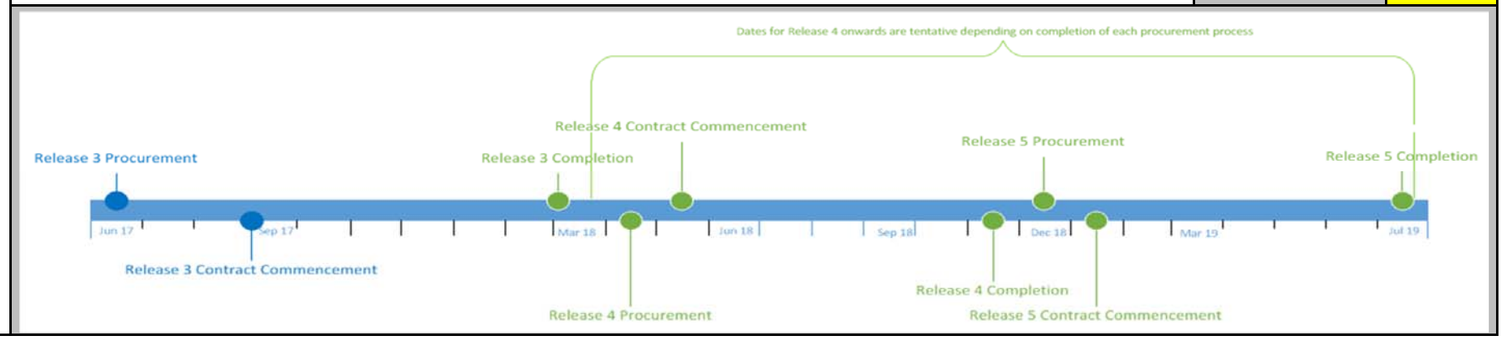
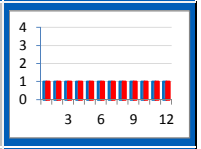
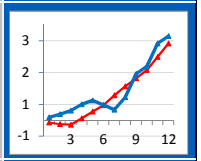
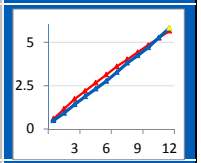
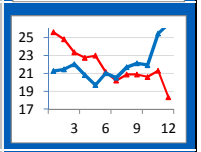
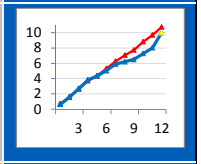
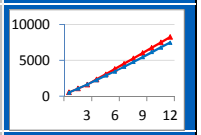
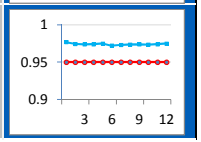
| | |  | | |
| Data driven improvements and innovation | Increase the accessibility of good quality, easy to use data which informs improvement. | • A suite of analytical reports are now available for the Working Age Adult Acute pathway. This includes trend and benchmarking reporting and will continue to be developed on an ongoing basis<br>• A number of engagement activities have taken place to try and increase uptake and usage of reports - this includes messages being circulated via established Trust communication routes, demos of products at Trust Operational Management Group, one to one sessions with key stakeholders<br>• Release 3 of the Business Intelligence Programme is underway with support from an external supplier - this is a six month release focussed on supporting Neighbourhood Nursing Services in Barnsley - expected delivery is late March 2018<br>• Preparation is taking place for the procurement for the next release<br>• Delivery could be impacted due to involvement of staff in clinical record system implementation (reference as a risk below) | Progress Against Plan | |
| | | Key risks identified are:<br>• Engagement with Business Intelligence across the Trust - more work needs to be done on engagement if the value of the work is to be realised; work is taking place with Trust Communications team to improve this<br>• Implementation of SystmOne for Mental Health - may have a resource impact on Business Intelligence Programme due to involvement of staff in workstreams; work will be required to integrate SystmOne Mental Health data into Data Warehouse | Management of Risk | |
| | |  | | |

| Implementation deliverables | | RAG Ratings | |
|---|---|---|---|
| ● | On Target to deliver within agreed timescales | | On Target to deliver within agreed timescales/project tolerances |
| ● | On Trajectory but concerns on ability/confident to deliver within agreed timescales | | On Trajectory but concerns on ability/confident to deliver actions within agreed timescales/project tolerances |
| ● | Off Trajectory and concerns on ability/capacity to deliver within agreed timescales | | Off Trajectory and concerns on ability/capacity to deliver actions within agreed timescales/project tolerances |
| ● | Action will not be delivered within agreed timescales | | Actions will not be delivered within agreed timescales/project tolerances |
| ● | Action Complete | | Action Complete |

# Overall Financial Performance 2017 / 2018

## Executive Summary / Key Performance Indicators

| | Performance Indicator | Year End Position | Narrative | Trend |
|---|---|---|---|---|
| 1 | NHS Improvement Finance Rating | 1 | The NHS Improvement financial and use of resources risk rating is maintained at 1 for the 12 months to the end of March 2018. |  |
| 2 | Normalised Surplus (inc STF) | £2.6m | March 2018 finance performance excluding STF is broadly in line with plan at a deficit of £0.05m. Including STF this is a surplus of £0.2m. The year end surplus excluding STF is £1.1m, including STF the surplus is £2.6m. Delivery of the year-end surplus was only possible with significant non-recurrent measures. |  |
| 3 | Agency Cap | £5.8m | Agency expenditure in March 2018 was above average for the year and NHS Improvement cap at £0.6m. The year end total of £5.8m exceeds the NHSI Agency cap by £161k (3%), but it is £4.0m lower (41%) than prior year. |  |
| 4 | Cash | £26.6m | The Trust cash position is £8.2m above plan in March with continued focus on working capital management and lower than plan, and timing of capital expenditure, combined with disposal proceeds. |  |
| 5 | Capital | £10m | Capital Expenditure is £0.7m lower than plan. Spend in year has continued to focus on the Fieldhead development along with other Estate requirements and IT infrastructure. |  |
| 6 | Delivery of CIP | £7.5m | At year end the delivery of CIPs is £0.8m behind plan. This is in line with the forecast. |  |
| 7 | Better Payment | 97% | This performance is based upon a combined NHS / Non NHS value. |  |

| | | |
|---|---|---|
| Red | Variance from plan greater than 15% | Plan |
| Amber | Variance from plan ranging from 5% to 15% | Actual |
| Green | In line, or greater than plan | Forecast |

# Contracting - Trust Board

## Contracting Issues - General

Mobilisation plans for new contracts were completed in March for a 1 April 2018 commencement: Barnsley MSK, Doncaster Smoke Free, Wakefield TB, Regional Community Forensic CAMHs Services and Secure Stairs within the Forensics Secure Estate. Final actions in exit plans from Smoke Free services in Rotherham and Community Diabetes Services in Barnsley were undertaken. In line with the 2018/19 annual planning guidance, commissioning intentions and contract offers have been agreed with main CCG commissioners. The contract variation with NHSE for Forensic Services remains to be agreed.

## Commissioning for Quality and Innovation (CQUIN)

Final confirmation from NHSE regarding Forensic services CQUIN for Q3 remains outstanding.

## Contracting Issues - Barnsley

Key strategic work areas in Barnsley continue across Intermediate care, Respiratory, MSK, Diabetes and Stroke services. Key priorities include mobilisation of the new MSK service and implementation of the exit from Diabetes services which transfer to BHNFT on 1 April 2018. The Alliance Agreement and underlying Service Contracts have been agreed.

## Contracting Issues - Calderdale

Key priorities relate to a sustainable 24/7 crisis resolution service and pressures within Psychology services. A specialist ASD Service for Adults will be enhanced in 2018/19. Key ongoing work streams include the mobilisation and implementation of the expansion of IAPT services to Long Term Conditions and full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Development of the THRIVE model of delivery for CAMHs services in Calderdale continues between commissioners and providers.

## Contracting Issues - Kirklees

The current priority areas of work include IAPT services and expansion to Long Term Conditions, and the reconfiguration of adult mental health rehabilitation services. A specialist ASD Service for Adults will be enhanced in 2018/19.

## Contracting Issues - Wakefield

A key ongoing work stream includes the full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Transformation of CAMHs services remains a key priority and work stream with commissioners. Mobilisation was on track for the provision of TB services commencing 1 April 2018.

## Contracting Issues - Forensics

Following successful award of the Lead Provider role for the Yorkshire & Humber delivery of Community Forensic CAMHs services work continues on mobilisation. A bid to NHSE to support the implementation of Secure Stairs within the Forensics Secure Estate at Adel Beck was confirmed successful and work is ongoing with NHSE regarding mobilisation and contracting arrangements.

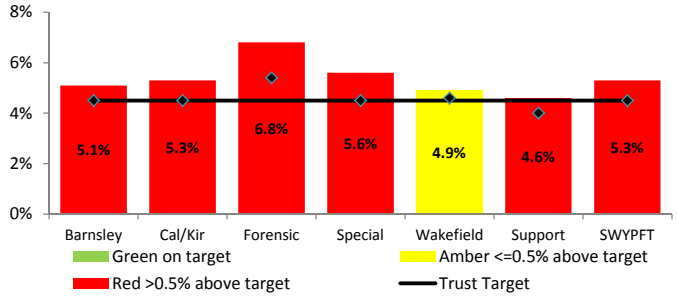
## Contracting Issues - Other

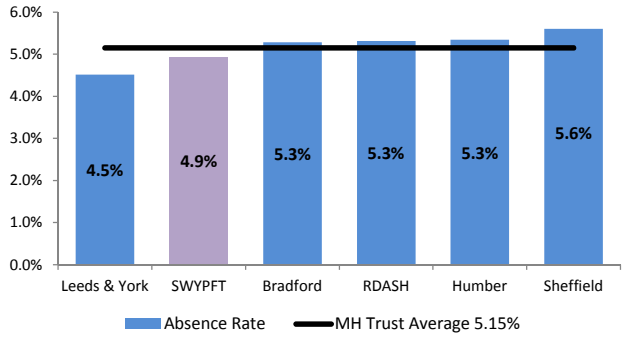
Meetings with Doncaster Commissioners continues regarding the mobilisation plan for the new Smoke Free Services model to commence 1 April 2018. Work continues on implementation of the exit from Smoke Free services in Rotherham. A contract extension for three years for the continued provision of Smoke Free Services in Wakefield has been agreed.

# Workforce

## Human Resources Performance Dashboard - March 2018

### Sickness Absence



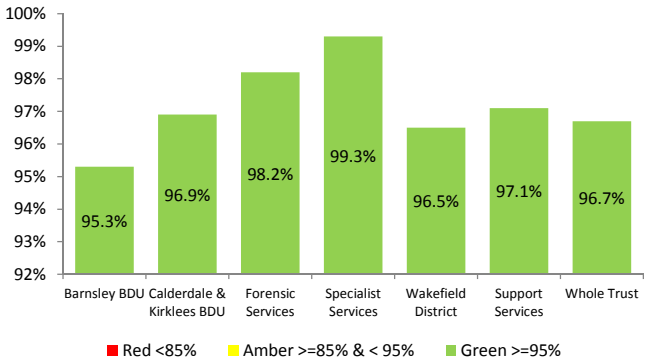

**Current Absence Position and Change from Previous Month - March 2018**

| | Barn | Cal/Kir | Fore | Spec | Wake | Supp | SWYPFT |
|---|---|---|---|---|---|---|---|
| Rate | 4.8% | 5.2% | 7.1% | 5.1% | 3.3% | 4.1% | 4.9% |
| Change | ↓ | ↓ | ↓ | ↑ | ↓ | ↓ | ↓ |

The Trust YTD absence levels in March 2018 (chart above) were above the overall 4.5% target at 5.3%.

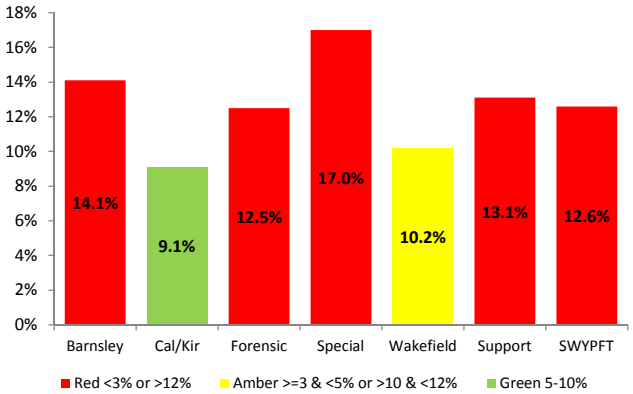
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2017 to August 2017.
During this time the Trust's absence rate was 4.93% which is below the regional average of 5.15%.

### Appraisal Data - All Staff

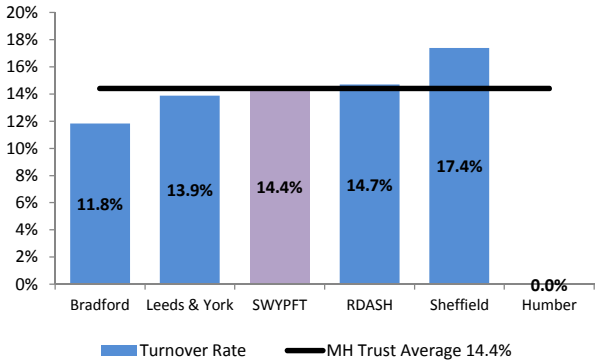



The above chart shows the appraisal rates for all staff for the Trust to the end of March 2018.
The appraisal target is 95% and over. For staff at Band 6 and above, all appraisals should be completed by the end of June and Band 5 and below, by end of September in each financial year.

### Turnover and Stability Rate Benchmark

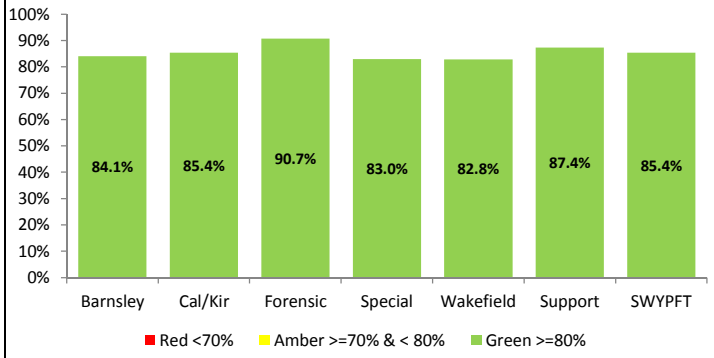



This chart shows the YTD turnover levels up to the end of March 2018.
*The turnover data excludes recently TUPE'd services




This chart shows turnover rates in MH Trusts in the region for the 12 months ending in September 2017. The turnover rate shows the percentage of staff leaving the organisation during the period.
This is calculated as: leavers/average headcount.
SWYPFT figures exclude decommissioned service changes.
Figures for Humber are not available.

### Fire Training Attendance




The chart shows the YTD fire lecture figures to the end of March 2018. The Trust continues to achieve its 80% target for fire lecture training across all BDUs.

# Workforce - Performance Wall

## Trust Performance Wall

| Month | Objective | CQC Domain | Owner | Threshold | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Improving Resources | Well Led | AD | <=4.4% | 4.8% | 4.7% | 4.7% | 4.8% | 4.9% | 4.9% | 5.0% | 5.0% | 5.1% | 5.2% | 5.3% | 5.3% |
| Sickness (Monthly) | Improving Resources | Well Led | AD | <=4.4% | 4.8% | 4.6% | 4.8% | 5.0% | 5.2% | 5.0% | 5.2% | 5.6% | 5.8% | 6.2% | 6.0% | 4.9% |
| Appraisals (Band 6 and above) 1 | Improving Resources | Well Led | AD | >=95% | 5.2% | 17.6% | 61.3% | 80.9% | 89.0% | 91.0% | 92.7% | 97.6% | 98.1% | 97.9% | 97.8% | 97.8% |
| Appraisals (Band 5 and below) | Improving Resources | Well Led | AD | >=95% | 1.9% | 5.3% | 18.4% | 31.1% | 46.2% | 75.8% | 82.7% | 95.5% | 95.7% | 95.9% | 95.9% | 96.0% |
| Aggression Management | Improving Care | Well Led | AD | >=80% | 76.4% | 75.6% | 78.1% | 76.6% | 77.0% | 77.6% | 76.4% | 79.0% | 78.0% | 77.9% | 78.2% | 79.3% |
| Cardiopulmonary Resuscitation | Improving Care | Well Led | AD | >=80% by 31/3/17 | 75.2% | 75.3% | 74.7% | 73.1% | 71.9% | 73.4% | 72.8% | 75.4% | 76.6% | 77.0% | 78.5% | 81.4% |
| Clinical Risk | Improving Care | Well Led | AD | >=80% by 31/3/17 | 64.8% | 65.3% | 69.1% | 74.6% | 77.3% | 79.2% | 80.7% | 82.3% | 82.5% | 83.8% | 85.3% | 85.1% |
| Equality and Diversity | Improving Health | Well Led | AD | >=80% | 87.3% | 86.6% | 86.0% | 86.6% | 87.1% | 85.7% | 85.4% | 87.0% | 86.9% | 88.3% | 88.9% | 88.5% |
| Fire Safety | Improving Care | Well Led | AD | >=80% | 81.5% | 82.0% | 81.5% | 81.8% | 82.6% | 82.8% | 82.8% | 83.3% | 82.4% | 83.8% | 84.6% | 85.4% |
| Food Safety | Improving Care | Well Led | AD | >=80% | 82.6% | 81.2% | 80.3% | 79.1% | 79.2% | 77.0% | 76.2% | 78.4% | 78.6% | 79.3% | 77.8% | 77.2% |
| Infection Control and Hand Hygiene | Improving Care | Well Led | AD | >=80% | 83.0% | 83.5% | 84.0% | 83.7% | 83.6% | 82.3% | 81.8% | 83.2% | 83.2% | 85.0% | 86.5% | 86.8% |
| Information Governance | Improving Care | Well Led | AD | >=95% | 92.0% | 91.7% | 91.3% | 90.4% | 89.1% | 88.3% | 86.2% | 85.9% | 83.8% | 89.2% | 95.7% | 96.5% |
| Moving and Handling | Improving Resources | Well Led | AD | >=80% | 81.1% | 77.3% | 78.8% | 79.3% | 79.3% | 79.3% | 80.7% | 81.6% | 81.9% | 84.1% | 85.4% | 85.5% |
| Mental Capacity Act/DOLS | Improving Care | Well Led | AD | >=80% by 31/3/17 | 64.9% | 69.6% | 78.0% | 82.5% | 86.1% | 87.6% | 88.9% | 90.3% | 91.1% | 91.0% | 91.1% | 90.7% |
| Mental Health Act | Improving Care | Well Led | AD | >=80% by 31/3/17 | 51.2% | 56.9% | 70.5% | 75.0% | 80.3% | 81.6% | 83.4% | 84.7% | 86.6% | 86.4% | 86.0% | 84.7% |
| No of staff receiving supervision within policy guidance | Quality & Experience | Well Led | | >=80% | 59.3% | | | 61.0% | | | 64.7% | | | 86.5% | | |
| Safeguarding Adults | Improving Care | Well Led | AD | >=80% | 88.5% | 88.0% | 86.7% | 86.2% | 86.0% | 86.3% | 86.3% | 87.4% | 87.8% | 89.0% | 89.8% | 89.9% |
| Safeguarding Children | Improving Care | Well Led | AD | >=80% | 85.5% | 84.8% | 83.6% | 84.3% | 84.7% | 84.8% | 84.1% | 85.4% | 85.1% | 86.7% | 87.5% | 87.8% |
| Sainsbury's clinical risk assessment tool | Improving Care | Well Led | AD | >=80% | 93.3% | 91.2% | 91.7% | 93.2% | 94.2% | 94.2% | 92.9% | 93.4% | 93.3% | 93.8% | 94.3% | 93.4% |
| Bank Cost | Improving Resources | Well Led | AD | - | £398k | £457k | £579k | £576k | £518k | £614k | £545k | £534k | £534k | £604k | £655k | £907k |
| Agency Cost | Improving Resources | Effective | AD | - | £501k | £426k | £500k | £457k | £446k | £435k | £515k | £531k | £430k | £465k | £563k | £555k |
| Overtime Costs | Improving Resources | Effective | AD | - | £16k | £13k | £9k | £9k | £12k | £12k | £7k | £10k | £8k | £11k | £13k | £6k |
| Additional Hours Costs | Improving Resources | Effective | AD | - | £56k | £36k | £48k | £44k | £38k | £45k | £44k | £50k | £39k | £34k | £24k | £23k |
| Sickness Cost (Monthly) | Improving Resources | Effective | AD | - | £476k | £504k | £487k | £493k | £527k | £499k | £547k | £550k | £594k | £633k | £532k | £483k |
| Business Miles | Improving Resources | Effective | AD | - | 289k | 245k | 285k | 299k | 267k | 283k | 291k | 265k | 305k | 271k | 275k | 230k |

*1 - this does not include data for medical staffing.*

# Workforce - Performance Wall cont.…

**Notes:**

**Green Compliance Status:**
• Cardio Pulmonary Resuscitation (CPR) – 81.4% 3% increase on last month. This is the 5th consecutive month that CPR compliance has increased. This month CPR has moved from Amber compliance to Green. The Resus Team have introduced a number of initiatives to continue to improve compliance – CPR training (ILS) is now incorporated in the Aggression Management/Physical Interventions training.
• Mental Health Act (MHA) – 84.7% 1.3% decline in compliance from last month. The Trust has begun work developing MHA Elearning courses to meet the refresher compliance requirement in the coming years. New registered clinical staff will be required to attend face to face classroom training to meet their initial competency requirement. There will be the option for non-registered clinical staff to attend face to face classroom training or completing an E-Learning course
• Mental Capacity Act – 90.7% no significant change in compliance from last month. The Trust has developed E-Learning refresher courses. This now provides the resource for the refresher compliance requirement. New registered clinical staff will be required to attend face to face classroom training to meet their initial competency requirement. There will be the option for non-registered clinical staff to attend face to face classroom training or complete the E-Learning course
• Equality and Diversity – 88.5% no significant change on last month.
• Fire Safety – 85.4% 1% increase on last month. The 95% compliance requirement for ward based staff is monitored at service level. There has been progress to towards a local 95% fire training target for inpatient areas for 18/19. Currently inpatient areas overall fire training rate is 86.4% as at the end of March 2018.
• Infection Control and Hand Hygiene – 86.8% slight increase on last month
• Safeguarding Adults – 89.9% no significant change on last month
• Safeguarding Children – 87.8% no change on last month. Additional work has been undertaken by the safeguarding team to target 'hotspot' areas
• Sainsbury's Tool – 93.4% 1% decline on last month
• Clinical Risk – 85.1% no significant change on last month. As well as the E-Learning provision, bespoke face to face training has been facilitated for a number of services, giving the opportunity for a collective learning experience through sharing knowledge and exploring scenarios
• Data Security Awareness Level 1 (formally IG) – 96.5% ¾ % increase on last month
• Moving and Handling – 85.5% no significant change on last month. This figure may be compromised by the suspension of training in Barnsley BDU due to the closure of the training room at Priory Day Unit; an alternative venue has been agreed but requires some minor works. This should be completed by the end of April with training resuming in the BDU in early May. Alternative training dates have been offered at Fieldhead Hospital in order to offset some of the loss however travel may be an issue for some staff.

**Amber Compliance Status:**
• Food Safety – 77.2% ½ % decline on last month. The Food Safety team are currently reviewing staff groups for Food Safety training and methods of training, which will aim to target training at staff groups according to their role
• Aggression Management – 79.3% 1% increase from last month. The Managing Aggression and Violence (MAV) team continue to put on extra training sessions to the ones already scheduled to meet demand. The Aggression Management/Physical Interventions is at 87.3% compliance (Forensic services at 88.8%).
The sub 80% overall rating is compromised by 74.5% Personal Safety and Breakaway-Non Clinical, and 77% De-escalation and Breakaway-Clinical, although these have both improved compliance this month

**Red Compliance Status:**
No mandatory training subjects were in red compliance for this period

**Sickness**
• The Trusts year end position is 5.3%, which continues to be above the Trust's threshold.
• BDUs continue to focus on long term sickness and the recent staffing summit identified some further potential areas which are being explored that may assist with reducing sickness absence.
• Inpatient areas sickness rates are an area for focus and a Health and Wellbeing trainer has been appointed to focus on supporting staff in these areas.
• A system of immediate referral into Occupational Health using E-Rostering has been developed for absence due to Musculo-skeletal and Stress.
• A coordinated system for reasonable adjustments or redeployment for staff is being finalised to support people to remain at work
• Further training support is being rolled for managers on wellbeing and effective absence management.
• The Trust has introduced a fast track facility for episodes of sickness related to musculoskeletal and stress management.
• Pilots are taking place in Wakefield and Forensic BDUs to deep dive into the absences.
• Workshops have been established for managers to assist with the management and sickness review process with a focus on wellbeing and attendance.
• The Trust has launched the new Middleground Programme focused on creating Health Teams.
• Staff counselling is now fully recruited to and waiting times have reduced significantly.
• New valued based appraisal has a stronger focus on health and wellbeing
• Wellbeing group established in Forensic Services and plan to roll these out across all BDUs

# Publication Summary

**This section of the report identifies any national guidance that may be applicable to the Trust.**

**Department of Health**

The government's mandate to NHS England for 2018-19
This mandate sets NHS England's objectives and budget, and helps to ensure that the NHS is accountable to parliament and the public. Building on the multi-year approach taken to setting the mandate since 2016, it continues to set objectives and goals to 2020, as well as some specific objectives for NHS England to deliver in 2018/19.

Click here for link to mandate

**NHS England**

The Improving Access to Psychological Therapies (IAPT) pathway for people with long-term physical health conditions and medically unexplained symptoms
From April 2018 all CCGs are expected to expand IAPT services integrated into physical health care pathways. This document supports this expansion by setting out the treatment pathway that underpins the access and waiting time standards, which all services should seek to measure themselves against.

Click here for link to guidance

**NHS England**

NHS England funding and resource: 2018/19: supporting 'Next steps for the NHS five year forward view'
This guidance contains information about NHS England's funding in 2018/19 and sets out how NHS England will, through the distribution of funding, people and resources, support the next steps to transform local health and care systems.

Click here for guidance

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

Mixed-sex accommodation breaches: February 2018

Direct access audiology waiting times: January 2018

Out of area placements in mental health services: January 2018

Mental health services monthly statistics: final December 2017, provisional January 2018

NHS sickness absence rates: November 2016

NHS workforce statistics: December 2017

Reports on the use of Improving Access to Psychological Therapies services, England: December 2017

Diagnostic imaging dataset: November 2017

Community services statistics for children, young people and adults: December 2017

# Publication Summary

**This section of the report identifies any national guidance that may be applicable to the Trust.**

NHS Improvement provider bulletin: 21 March 2018:
• Future of patient safety investigation
• Agenda for change pay structure terms & conditions review
• Framework agreements for agency staff

NHS Improvement provider bulletin: 28 March 2018:
• Learning from deaths (learning disability)
• NHSI/NHSE working closer together
• Model to support continuous improvement of mental health services
• NHS heroes awards

NHS Improvement provider bulletin: 4 April 2018

NHS Improvement provider bulletin: 11 April 2018:
• Cyber requirements confirmation
• Aspiring Chief Operating Officer programme

South West Yorkshire Partnership NHS Foundation Trust

# Finance Report

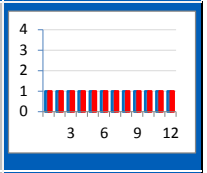
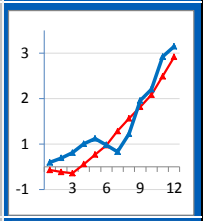
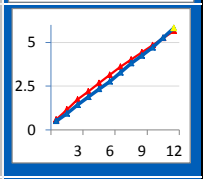
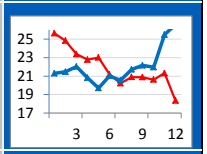
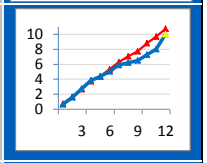
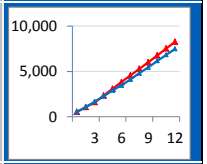
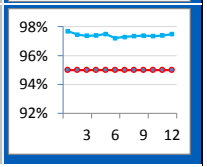
## Month 12
## (2017 / 18)
## Appendix 1

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

# Contents

## 1.0 Executive Summary / Key Performance Indicators

| | Performance Indicator | Year End Position | Narrative | Trend |
|---|---|---|---|---|
| 1 | NHS Improvement Finance Rating | 1 | The NHS Improvement financial and use of resources risk rating is maintained at 1 for the 12 months to the end of March 2018. |  |
| 2 | Normalised Surplus (inc STF) | £2.6m | March 2018 finance performance excluding STF is broadly in line with plan at a deficit of £0.05m. Including STF this is a surplus of £0.2m. The year end surplus excluding STF is £1.1m, including STF the surplus is £2.6m. Delivery of the year-end surplus was only possible with significant non-recurrent measures. |  |
| 3 | Agency Cap | £5.8m | Agency expenditure in March 2018 was above average for the year and NHS Improvement cap at £0.6m. The year end total of £5.8m exceeds the NHSI Agency cap by £161k (3%), but it is £4.0m lower (41%) than prior year. |  |
| 4 | Cash | £26.6m | The Trust cash position is £8.2m above plan in March with continued focus on working capital management and lower than plan, and timing of capital expenditure, combined with disposal proceeds. |  |
| 5 | Capital | £10m | Capital Expenditure is £0.7m lower than plan. Spend in year has continued to focus on the Fieldhead development along with other Estate requirements and IT infrastructure. |  |
| 6 | Delivery of CIP | £7.5m | At year end the delivery of CIPs is £0.8m behind plan. This is in line with the forecast. |  |
| 7 | Better Payment | 97% | This performance is based upon a combined NHS / Non NHS value. |  |

| | | |
|---|---|---|
| Red | Variance from plan greater than 15% | Plan |
| Amber | Variance from plan ranging from 5% to 15% | Actual |
| Green | In line, or greater than plan | Forecast |

# 1.1 NHS Improvement Finance Rating

The Trust is regulated under the Single Oversight Framework and the financial metric is based on the Use of Resources calculation as outlined below. The Single Oversight Framework is designed to help NHS providers attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right.

NHS Improvement has provided an updated Single Oversight Framework for 2018 / 2019 and beyond. There is limited impact on the finance rating.

| | | | Actual Performance | | Plan - Month 12 | |
|---|---|---|---|---|---|---|
| Area | Weight | Metric | Score | Risk Rating | Score | Risk Rating |
| Financial Sustainability | 20% | Capital Service Capacity | 3.4 | 1 | 3.4 | 1 |
| | 20% | Liquidity (Days) | 20.4 | 1 | 10.6 | 1 |
| Financial Efficiency | 20% | I & E Margin | 1.2% | 1 | 1.1% | 1 |
| Financial Controls | 20% | Distance from Financial Plan | 0.1% | 1 | 0.0% | 1 |
| | 20% | Agency Spend | 2.86% | 2 | -2.5% | 1 |
| **Weighted Average - Financial Sustainability Risk Rating** | | | | 1 | | 1 |

**Impact**

The current overall risk rating is 1 which is the highest possible score. The Trust's I & E Margin has exceeded 1% at month 12 achieving a risk rating of 1. The agency spend exceeds the plan by 2.9% and achieves a risk rating of 2.

**Definitions**

**Capital Servicing Capacity** - the degree to which the Trust's generated income covers its financing obligations; rating from 1 to 4 relates to the multiple of cover.

**Liquidity** - how many days expenditure can be covered by readily available resources; rating from 1 to 4 relates to the number of days cover.

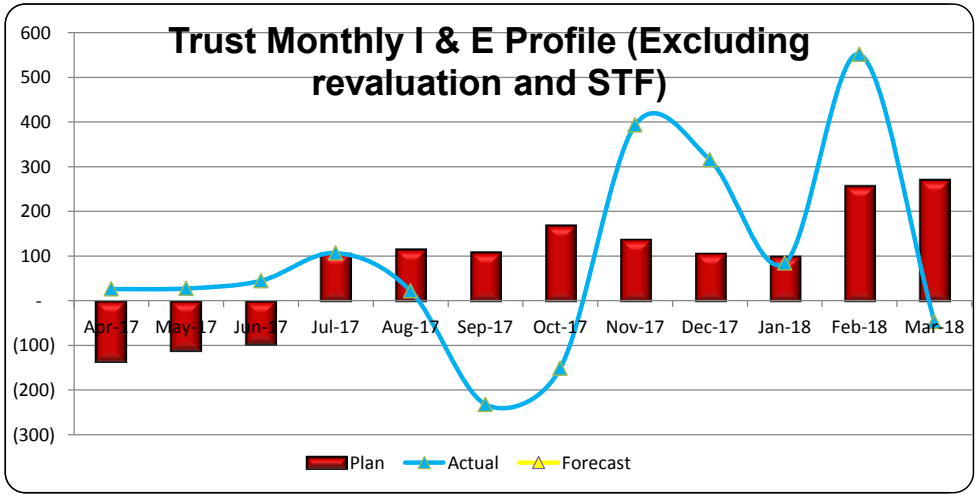
**I & E Margin** - the degree to which the organisation is operating at a surplus/deficit

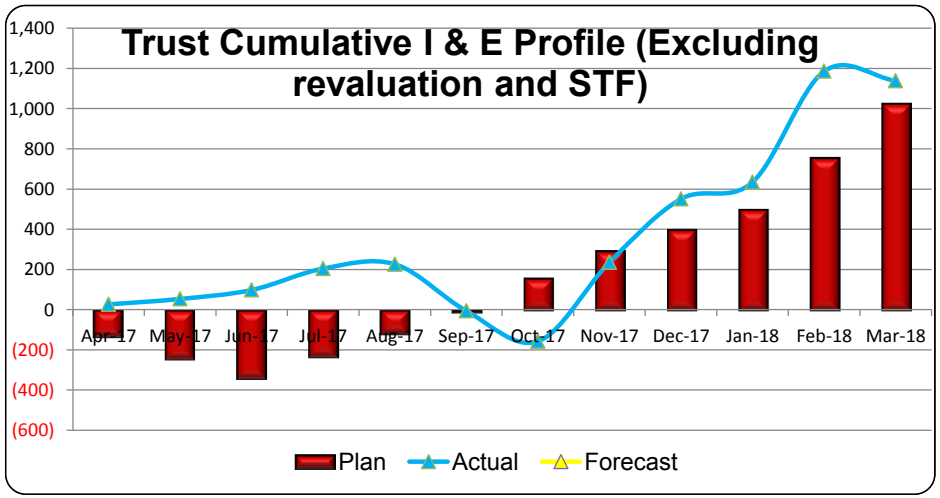
**Distance from plan** - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

**Agency Cap** - A cap of £5.6m has been set for the Trust in 2017 / 2018. This metric compares performance against this cap.

# 2.0 Income & Expenditure Position 2017 / 2018

| Budget Staff | Actual worked | Variance | | This Month Budget | This Month Actual | This Month Variance | Description | Year to Date Budget | Year to Date Actual | Year to Date Variance | Annual Budget | Forecast Outturn | Forecast Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **WTE** | **WTE** | **WTE** | **%** | **£k** | **£k** | **£k** | | **£k** | **£k** | **£k** | **£k** | **£k** | **£k** |
| | | | | | | | | | | | | | |
| | | | | 17,512 | 16,739 | (773) | Clinical Revenue | 207,295 | 204,951 | (2,343) | 207,295 | 204,951 | (2,343) |
| | | | | **17,512** | **16,739** | **(773)** | **Total Clinical Revenue** | **207,295** | **204,951** | **(2,343)** | **207,295** | **204,951** | **(2,343)** |
| | | | | 1,283 | 1,391 | 108 | Other Operating Revenue | 14,098 | 14,290 | 193 | 14,098 | 14,290 | 193 |
| | | | | **18,794** | **18,130** | **(664)** | **Total Revenue** | **221,392** | **219,242** | **(2,151)** | **221,392** | **219,242** | **(2,151)** |
| | | | | | | | | | | | | | |
| 4,254 | 4,196 | (58) | 1.4% | (14,193) | (14,087) | 106 | Pay Costs | (170,484) | (166,257) | 4,226 | (170,484) | (166,257) | 4,226 |
| | | | | (3,564) | (4,474) | (909) | Non Pay Costs | (41,461) | (44,219) | (2,758) | (41,461) | (44,219) | (2,758) |
| | | | | (63) | 1,112 | 1,175 | Provisions | 428 | 1,553 | 1,125 | 428 | 1,553 | 1,125 |
| **4,254** | **4,196** | **(58)** | **1.4%** | **(17,820)** | **(17,449)** | **372** | **Total Operating Expenses** | **(211,517)** | **(208,923)** | **2,594** | **(211,517)** | **(208,923)** | **2,594** |
| | | | | | | | | | | | | | |
| **4,254** | **4,196** | **(58)** | **1.4%** | **974** | **681** | **(293)** | **EBITDA** | **9,875** | **10,319** | **444** | **9,875** | **10,319** | **444** |
| | | | | (426) | (468) | (43) | Depreciation | (5,500) | (5,852) | (352) | (5,500) | (5,852) | (352) |
| | | | | (283) | (270) | 13 | PDC Paid | (3,397) | (3,393) | 4 | (3,397) | (3,393) | 4 |
| | | | | 4 | 10 | 6 | Interest Received | 45 | 65 | 20 | 45 | 65 | 20 |
| **4,254** | **4,196** | **(58)** | **1.4%** | **269** | **(47)** | **(316)** | **Normalised Surplus / (Deficit) Excl.STF** | **1,023** | **1,139** | **116** | **1,023** | **1,139** | **116** |
| | | | | 162 | 278 | 116 | STF | 1,394 | 1,510 | 116 | 1,394 | 1,510 | 116 |
| **4,254** | **4,196** | **(58)** | **1.4%** | **431** | **230** | **(201)** | **Normalised Surplus / (Deficit) Incl SFT** | **2,417** | **2,648** | **231** | **2,417** | **2,648** | **231** |
| | | | | | | | | | | | | | |
| | | | | 0 | (36) | (36) | Revaluation of Assets | 0 | (944) | (944) | 0 | (944) | (944) |
| **4,254** | **4,196** | **(58)** | **1.4%** | **431** | **195** | **(236)** | **Surplus / (Deficit)** | **2,417** | **1,704** | **(713)** | **2,417** | **1,704** | **(713)** |



# Income & Expenditure Position 2017 / 2018

2017 / 2018 has been extremely challenging financially. A better than plan position has been delivered through non-recurrent benefits including gains from the disposal of Trust properties.

**Month 12**

The March position is a pre STF deficit of £47k. The normalised year end position is a pre STF surplus of £1,139k and a post STF surplus of £2,648k. This is £231k ahead of plan. The key headlines are below.

Out of area expenditure was the highest in the year for both PICU and Acute services and was the key driver behind the month 12 deficit position. Otherwise, month 12 is similar to the trend throughout the year with underspends on pay and non clinical non pay areas, such as travel and office costs, being offset by out of area bed costs and income lower than plan. Shortfalls within the Trust CIP programme continue to be met within the overall bottom line position.

The gain reported in month 11 from the disposal of CNDH and Birdwell properties of £353k has largely been offset by the high month 12 out of area costs.

**Income**

Income for the year is £2.3m lower than plan with the full breakdown on page 7. This is primarily due to changes in commissioned services, particularly Intermediate Care.

The majority of income has been invoiced and paid by commissioners although Quarter 4 CQUIN income remains estimated. This will be agreed within commissioners during April 2018.

**Pay Expenditure**

The Trust continues to run with a number of vacancies and utilises temporary (both internal bank and external agency) staff to meet clinical and service requirements. The most significant pay savings year to date are within Nursing, Medical and Psychology. Agency expenditure in March remains high within several inpatient services in response to high acuity levels. The NHSI agency cap for 2017/18 was exceeded by £161k (3%).

**Non Pay Expenditure**

March out of area bed spend was £729k, this is the highest monthly spend in the last 3 years. The cumulative overspend is now £3.7m. Drugs expenditure and clinical supplies such as dressings also remain pressures. These are currently being partly offset by non clinical spend areas such as travel, office costs and property. Excluding out of area beds and drugs costs non-pay is showing a £0.3m saving against plan.

# Income Information

The table below summarises the year to date and forecast income by commissioner group. This is identified as clinical revenue within the Trust income and expenditure position (page 5). The majority of Trust income is secured through block contracts and therefore there has traditionally been little variation to plan.

The budget values are reconciled against signed and agreed contracts with any movement highlighted.

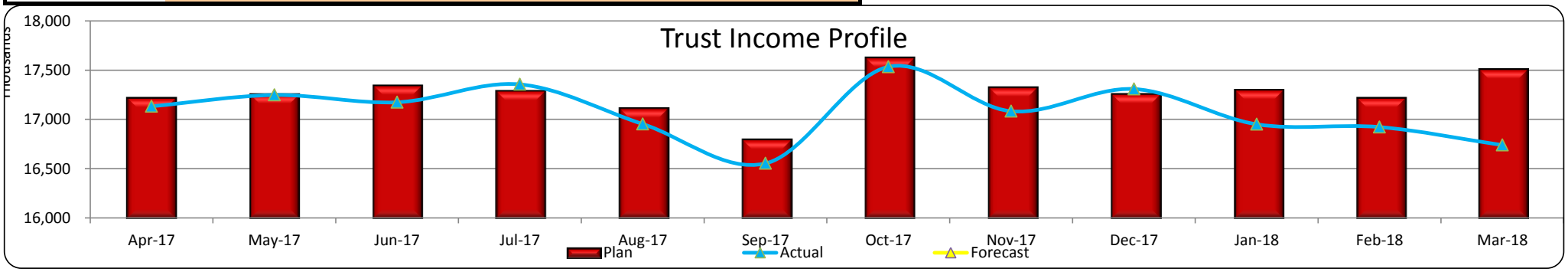
The year to date and forecast variances are shown below. This highlights the most significant variance relates to changes in income relating to Intermediate Care. Delivery of this service has changed in year and forms part of our ongoing Alliance / Accountable Care system arrangement.

The majority of this income has been raised and paid by commissioners. Outstanding accruals relate to Quarter 4 CQUIN performance which is yet to be fully agreed with commissioners.

Other commissioners are highlighted as £518k better than plan. Of this £426k is from the sale of Trust beds to non local commissioners.

| Commissioner | Yend End Position | | | Variance Headlines | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | CQUIN | Other | Total |
| | £k | £k | £k | £k | £k | £k |
| CCG | 151,611 | 151,142 | (469) | (203) | (266) | (469) |
| Specialist Commissioner | 23,661 | 23,661 | (0) | 0 | (0) | (0) |
| Alliance | 13,712 | 11,478 | (2,233) | 0 | (2,233) | (2,233) |
| Local Authority | 4,970 | 4,851 | (119) | | (119) | (119) |
| Partnerships | 6,879 | 6,838 | (40) | (76) | 35 | (40) |
| Other | 6,463 | 6,980 | 518 | 0 | 518 | 518 |
| **Total** | **207,295** | **204,951** | **(2,343)** | **0** | **(279)** | **(2,064)** | **(2,343)** |

| CQUIN Risk - Summary | |
|---|---|
| | Forecast CQUIN Shortfall |
| Wellbeing Improvement | 136 |
| Ill Health by Risky behaviour | 18 |
| Cardio Metabolic Assessment | 36 |
| Primary Care Collaboration | 13 |
| **Total** | **203** |



# 2.1 Pay Information

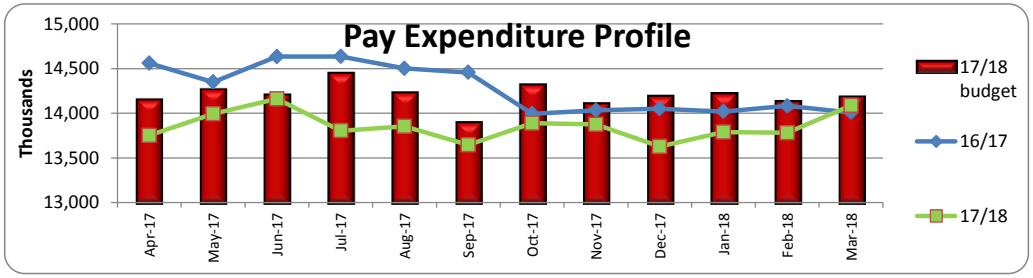
Our workforce is our greatest asset and one in which we continue to invest in ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for circa 75% of total Trust expenditure.

The Trust workforce strategy continues to be developed but current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

| | Apr-17 £k | May-17 £k | Jun-17 £k | Jul-17 £k | Aug-17 £k | Sep-17 £k | Oct-17 £k | Nov-17 £k | Dec-17 £k | Jan-18 £k | Feb-18 £k | Mar-18 £k | Total £k |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Substantive** | 12,841 | 13,094 | 13,040 | 12,842 | 12,850 | 12,509 | 12,791 | 12,771 | 12,616 | 12,688 | 12,491 | 12,432 | **152,964** |
| **Bank & Locum** | 411 | 472 | 620 | 505 | 558 | 697 | 583 | 575 | 583 | 635 | 727 | 1,099 | **7,465** |
| **Agency** | 501 | 426 | 500 | 457 | 446 | 439 | 515 | 531 | 430 | 465 | 563 | 555 | **5,828** |
| **Total** | **13,752** | **13,992** | **14,161** | **13,804** | **13,854** | **13,645** | **13,889** | **13,876** | **13,629** | **13,788** | **13,781** | **14,087** | **166,257** |
| 16/17 | 14,559 | 14,350 | 14,633 | 14,634 | 14,502 | 14,456 | 13,994 | 14,034 | 14,050 | 14,020 | 14,081 | 14,008 | **171,321** |
| Bank as % | 3.0% | 3.4% | 4.4% | 3.7% | 4.0% | 5.1% | 4.2% | 4.1% | 4.3% | 4.6% | 5.3% | 7.8% | 4.5% |
| Agency as % | 3.6% | 3.0% | 3.5% | 3.3% | 3.2% | 3.2% | 3.7% | 3.8% | 3.2% | 3.4% | 4.1% | 3.9% | 3.5% |

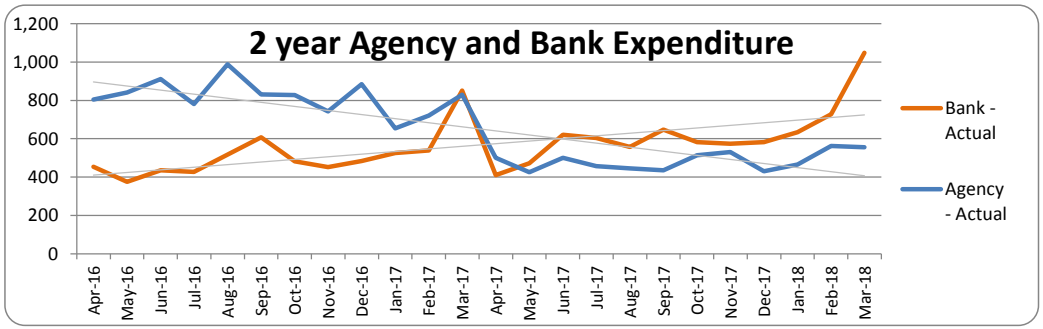
**Year to Date expenditure - by staff group**

| | Substantive £k | Temp £k | Agency £k | Total £k |
|---|---|---|---|---|
| Medical | 17,759 | 468 | 2,744 | 20,970 |
| Nursing Registered | 53,371 | 2,575 | 642 | 56,588 |
| Nursing | 17,360 | 3,414 | 1,380 | 22,154 |
| Other | 38,994 | 391 | 1,007 | 40,392 |
| Admin | 25,437 | 665 | 51 | 26,153 |
| **Total** | **152,920** | **7,513** | **5,824** | **166,257** |




**March WTE Analysis**

| | Budgeted | Contracted | Bank | Agency | Variance |
|---|---|---|---|---|---|
| Medical | 212 | 168 | 2 | 18 | (24) |
| Qualified Nursing | 1,436 | 1,269 | 95 | 15 | (57) |
| Unqualified Nursing | 696 | 608 | 184 | 49 | 145 |
| Other Clinical | 848 | 773 | 9 | 11 | (54) |
| A & C | 839 | 757 | 28 | 1 | (54) |
| Other | 337 | 288 | 10 | 2 | (37) |
| Staff Vacancy Factor | (113) | 0 | 0 | 0 | 113 |
| **Total** | **4,254** | **3,863** | **328** | **95** | **32** |




**Key Messages**

Both 2016/17 and 2017/18 have seen an increased focus on reducing agency staffing. The graph above shows the downward trend in the use of agency staffing until September 2017 when it increased as a result of additional Agency Medical usage to cover vacancies and initiatives to improve access in some services. The recent increased expenditure on Bank and Agency is driven by increases in medical and nursing spend to cover vacancies and high acuity levels. Some agency staff have moved to bank posts and a more moderate increase in month on month bank usage can be seen. Bank has increased sharply in March, this is partly due to the timing of bank payments, acuity levels and bank shifts covering annual leave taken in March.

The WTE Analysis table above presents the budgeted WTE across staffing categories and demonstrates that whilst overall agency and bank usage are covering a significant proportion of gaps in services particularly in nursing, the actual staffing profile is currently altered from plan with the use of temporary staff.

## 2.1 Agency Expenditure Focus

**The NHS Improvement agency cap is breached by 3%**

**Agency levels are expected to remain at current high levels as we move into 2018/19**

Agency costs continue to remain a focus for the NHS nationally and for the Trust. As such separate analysis of agency trends are presented below.

The financial implications, alongside clinical and other considerations, continues to be a high priority area for the Trust. 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.

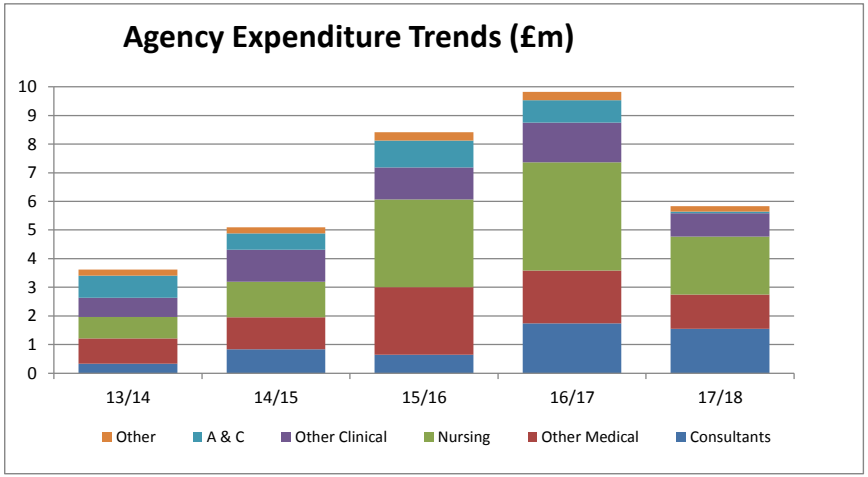
The Trust had experienced increased levels of agency spend rising from £3.6.m in 2013 / 2014 to £9.8m in 2016 / 2017. This increase was across all staffing groups and is shown in the graph to the right.

These trends were being experienced nationally within the NHS and as a result NHS Improvement introduced a number of metrics and guidance designed to support Trusts reducing their reliance and spend on agency staff. One of these measures was the introduction of a maximum agency cap (as monitored within the Trusts risk rating). The Trust cap for 2016 / 2017 was £5.1m and was breached by 93%.

The realisation of a number of actions from work streams established in 2016 / 2017 has resulted in reduced agency spend in the current year. These can be allocated to 2 main themes :

* Reduction in the number of agency staff used

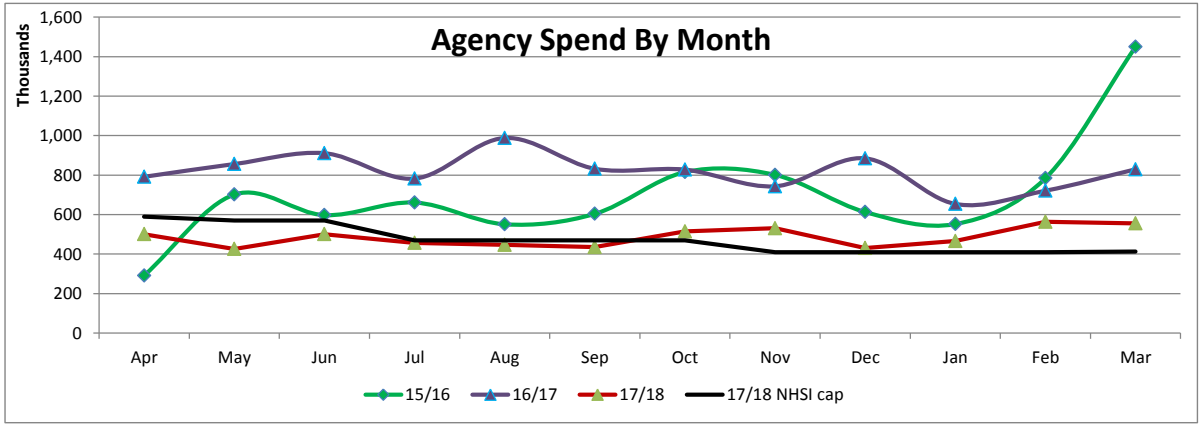
* Reduction in the hourly rate paid. In particular this relates to qualified nursing staff who are now all paid within the NHS Improvement capped rates. 14 out of 17 medical locums continue to be paid higher than the NHSI caps. These have been individually approved by the Trust Medical Director and are reported weekly to NHSI.




Agency expenditure in 2017/18 totals £5.8m, a reduction of £4.0m on 2016/17 with reduction in expenditure seen across all staffing groups. The most significant reductions are with Admin & Clerical and Nursing. The reduction in nursing agency expenditure is partly offset by an increase in the use of nurse bank shifts.

The NHSI agency cap was set at £5.6m for 2017/18 and has been breached by £0.2m (3%). As a result the NHSI use of resource agency risk rating is scored at 2. (1 being the highest).

Agency expenditure is forecast to remain at similar levels moving in to 2018/19. Medical agency continues to cover vacancies and Nursing agency is expected to continue at current levels in response to vacancies and acuity levels. This will exceed our cap in the early part of the year.



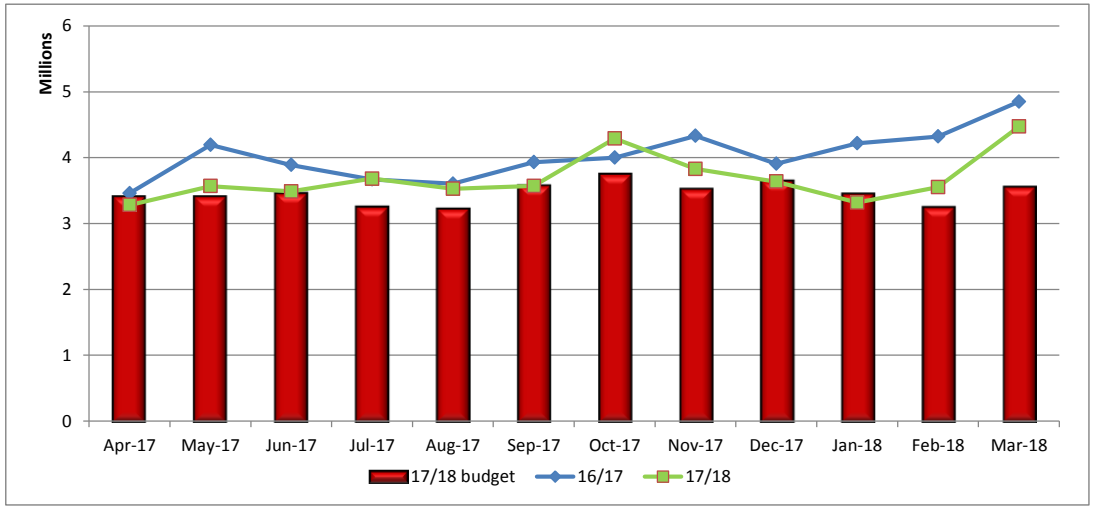
# 2.1 Non Pay Expenditure

Whilst pay expenditure represents approximately 75% of all Trust non pay expenditure presents a number of key financial challenges. This analysis focusses on non pay expenditure within the BDUs and Corporate Services and therefore excludes provisions and capital charges (depreciation and PDC).

The Trust has spent considerably less on non pay compared to last year. For the year to date this is £4.2m less than the same period in 2016 / 2017. This is driven by a number of key areas which are highlighted below. Excluding the impact of out of area and drugs a saving against plan of £229k has been achieved in 2017/18.

| | Apr-17 £k | May-17 £k | Jun-17 £k | Jul-17 £k | Aug-17 £k | Sep-17 £k | Oct-17 £k | Nov-17 £k | Dec-17 £k | Jan-18 £k | Feb-18 £k | Mar-18 £k | Total £k |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2017 / 2018** | 3,281 | 3,568 | 3,488 | 3,681 | 3,529 | 3,570 | 4,292 | 3,829 | 3,637 | 3,318 | 3,552 | 4,474 | **44,219** |
| **2016 / 2017** | 3,459 | 4,193 | 3,890 | 3,671 | 3,604 | 3,931 | 4,002 | 4,331 | 3,909 | 4,217 | 4,322 | 4,849 | **48,379** |

| Non Pay Category | Budget YTD £k | Actual YTD £k | Variance £k |
|---|---|---|---|
| Clinical Supplies | 3,001 | 3,418 | (417) |
| Drugs | 3,029 | 3,720 | (691) |
| Healthcare subcontracting | 3,666 | 5,962 | (2,296) |
| Hotel Services | 2,081 | 1,742 | 339 |
| Office Supplies | 4,264 | 4,727 | (463) |
| Other Costs | 4,446 | 4,288 | 158 |
| Property Costs | 6,683 | 6,795 | (111) |
| Service Level Agreements | 6,030 | 6,057 | (27) |
| Training & Education | 805 | 781 | 24 |
| Travel & Subsistence | 4,381 | 3,888 | 493 |
| Utilities | 1,536 | 1,313 | 223 |
| Vehicle Costs | 1,538 | 1,528 | 10 |
| **Total** | **41,461** | **44,219** | **(2,758)** |
| **Total Excl OOA and Drugs** | **34,766** | **34,537** | **229** |




**Key Messages**

There is significant additional non pay expenditure within March 2018; £861k higher than the average of the 11 months prior.

Of this Healthcare subcontracting, which relates to the purchase of additional bed capacity, accounts for £433k. This value includes commissioner commissioned activity which is provided through this method. The Out of Area focus provides further details on this.

Drugs continue to present a significant financial pressure. The changes to the supply of drugs to the Trust are now embedded and actions are commencing to identify savings opportunities. Drugs expenditure analysis has also highlighted the impact that changes in drugs prices (for example increase in drug costs due to concessions applied to two widely prescribed drugs) which is adding additional cost.

Clinical Supplies are highlighted as £417k overspent in year. Key areas here include cost pressures on disability living aids (£215k over plan). This is being addressed with commissioners to ensure that services are appropriately funded.

Office Supplies are also a key overspend. The main issue relates to additional licence charges being applied by Microsoft (£466k additional costs in 2017 / 18).

Cost reductions and savings are being made where ever possible and have focussed on non-clinical areas such as travel and office supplies.

# 2.1 Out of Area Expenditure Focus

In this context the term Out of Area expenditure refers to spend incurred in order to provide clinical care to Service Users in non-Trust facilities. The reasons for taking this course of action can often be varied but some key trends 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 footprint.

This analysis excluded activity relating to Locked Rehab in Barnsley.

**Out of Area Expenditure Trend (£)**

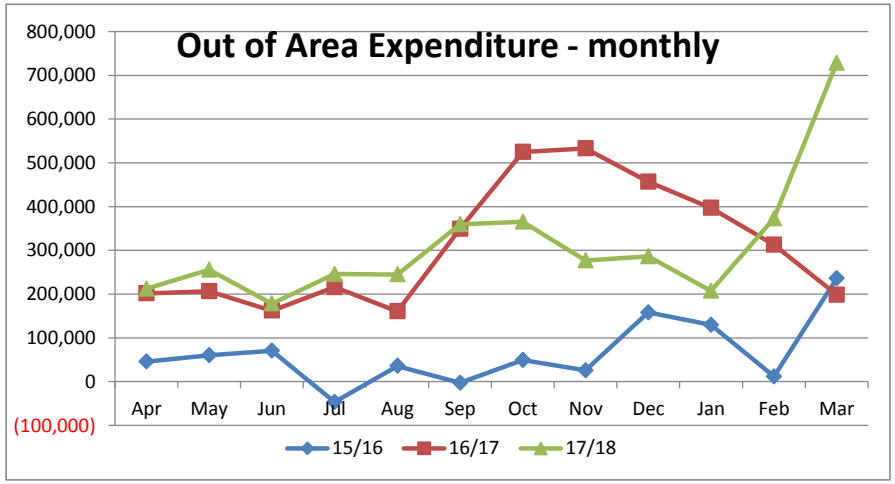
| | Apr £000 | May £000 | Jun £000 | Jul £000 | Aug £000 | Sep £000 | Oct £000 | Nov £000 | Dec £000 | Jan £000 | Feb £000 | Mar £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15/16 | 46 | 60 | 71 | (47) | 36 | (3) | 49 | 25 | 158 | 130 | 12 | 236 | **772** |
| 16/17 | 202 | 206 | 162 | 216 | 160 | 349 | 525 | 533 | 457 | 397 | 313 | 198 | **3,718** |
| 17/18 | 212 | 255 | 178 | 246 | 245 | 359 | 365 | 277 | 286 | 208 | 373 | 729 | **3,733** |

**Bed Day Trend Information**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15/16 | 104 | 152 | 192 | 190 | 246 | 42 | 92 | 119 | 180 | 338 | 439 | 504 | **2,598** |
| 16/17 | 294 | 272 | 343 | 310 | 216 | 495 | 755 | 726 | 679 | 624 | 416 | 364 | **5,494** |
| 17/18 | 282 | 367 | 253 | 351 | 373 | 427 | 479 | 434 | 414 | 276 | 626 | 762 | **5,044** |

**Bed Day Information 2017 / 2018 (by category)**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PICU | 199 | 168 | 168 | 169 | 195 | 216 | 239 | 314 | 216 | 153 | 242 | 300 | **2,579** |
| Acute | 83 | 192 | 85 | 182 | 148 | 181 | 209 | 119 | 168 | 92 | 356 | 431 | **2,246** |
| Gender | 0 | 7 | 0 | 0 | 30 | 30 | 31 | 1 | 30 | 31 | 28 | 31 | **219** |



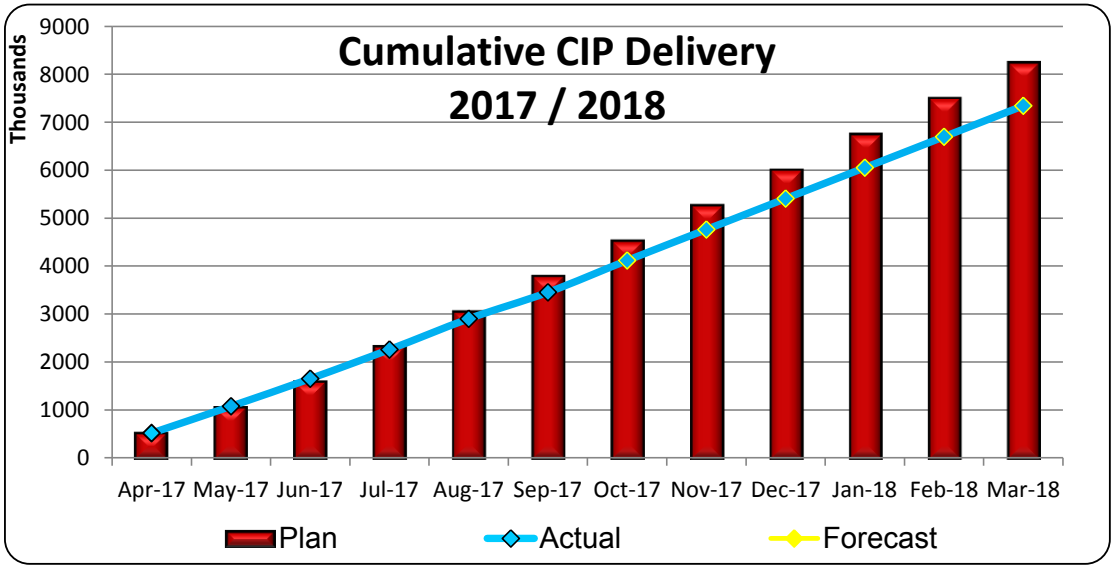

Out of Area placements in March 2018 represent the highest single month for bed day usage in the 3 year period covered above. Overall placements totalled 762 days in March and £729k.

The financial cost is proportionately greater in March with an average bed day price of £950 compared to an average of £675 over January and February 2018.

This is partially due to the increase in PICU beds which typically cost more than an acute but the main reason is charges for additional specialist nursing charges which are being incurred to support the needs of these clients.

# 2.1 Cost Improvement Programme 2017 / 2018

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k | £k |
| Target - Cumulative | 537 | 1,074 | 1,610 | 2,341 | 3,072 | 3,809 | 4,546 | 5,283 | 6,021 | 6,768 | 7,515 | 8,262 | 8,262 | 8,262 |
| Delivery as originally planned | 401 | 809 | 1,272 | 1,769 | 2,261 | 2,744 | 3,286 | 3,821 | 4,330 | 4,889 | 5,398 | 5,907 | 5,907 | 5,907 |
| Mitigations - Recurrent & Non-Recurrent | 116 | 266 | 378 | 490 | 639 | 706 | 829 | 974 | 1,117 | 1,267 | 1,418 | 1,568 | 1,568 | 1,568 |
| Total Delivery | **516** | **1,075** | **1,650** | **2,259** | **2,900** | **3,450** | **4,115** | **4,794** | **5,447** | **6,157** | **6,816** | **7,475** | **7,475** | **7,475** |
| Variance | (20) | 1 | 40 | (82) | (173) | (359) | (431) | (489) | (574) | (611) | (699) | (787) | (787) | (787) |




The Trust identified a CIP programme for 2017 / 18 which totals £8.3m. This included £1.6m of unidentified savings at the beginning of the year.

The 2017 / 18 Cost Improvement Programme has delivered savings totalling £7.5m. This is £0.8m behind plan. The majority (79%) has been delivered in line with original savings plans. Overall any shortfall has been managed within the Trust bottom line.

Shortfall continues to be managed within the overall financial position and focus continues on finalising savings requirements for 2018 / 19. New schemes remain challenging.

# 3.0 Balance Sheet 2017 / 2018

| | 2016 / 2017 £k | Plan (YTD) £k | Actual (YTD) £k | Note |
|---|---|---|---|---|
| Non-Current (Fixed) Assets | 111,199 | 115,133 | 116,853 | 1 |
| **Current Assets** | | | | |
| Inventories & Work in Progress | 166 | 215 | 232 | |
| NHS Trade Receivables (Debtors | 2,138 | 2,099 | 1,395 | 2 |
| Other Receivables (Debtors) | 8,289 | 7,059 | 5,354 | 3 |
| Cash and Cash Equivalents | 26,373 | 18,352 | 26,559 | 4 |
| **Total Current Assets** | **36,966** | **27,725** | **33,540** | |
| **Current Liabilities** | | | | |
| Trade Payables (Creditors) | (7,213) | (5,834) | (6,205) | 5 |
| Capital Payables (Creditors) | (1,157) | (752) | (1,142) | 5 |
| Accruals | (9,912) | (10,557) | (9,520) | 6 |
| Deferred Income | (754) | (950) | (670) | |
| **Total Current Liabilities** | **(19,036)** | **(18,093)** | **(17,537)** | |
| **Net Current Assets/Liabilities** | **17,929** | **9,632** | **16,002** | |
| **Total Assets less Current Liabilities** | **129,128** | **124,765** | **132,855** | |
| Provisions for Liabilities | (7,550) | (4,763) | (6,490) | |
| **Total Net Assets/(Liabilities)** | **121,578** | **120,002** | **126,365** | |
| Taxpayers' Equity | | | | |
| Public Dividend Capital | 43,665 | 43,665 | 44,015 | |
| Revaluation Reserve | 18,766 | 18,413 | 21,677 | |
| Other Reserves | 5,220 | 5,220 | 5,220 | |
| Income & Expenditure Reserve | 53,928 | 52,704 | 55,453 | 7 |
| **Total Taxpayers' Equity** | **121,578** | **120,002** | **126,365** | |

The Balance Sheet analysis compares the current month end position to that within the annual plan. The previous year end position is included for information.

1. Capital expenditure is detailed on page 15. Overall spend is less than plan but the asset value has increased due to the impact of the annual revaluation exercise.

2. As far as possible physical invoices have been raised with the majority paid supporting a lower than planned level of NHS debts and a better than plan cash position.

3. Other invoices have also been raised meaning accrued income has reduced from £4.8m to £2.2m in month. Many have also been paid as non-NHS debtors have remained the same as in February 2018.

4. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 17.

5. Creditors continue to be paid in a timely manner as demonstrated by the Better Payment Practice Code.

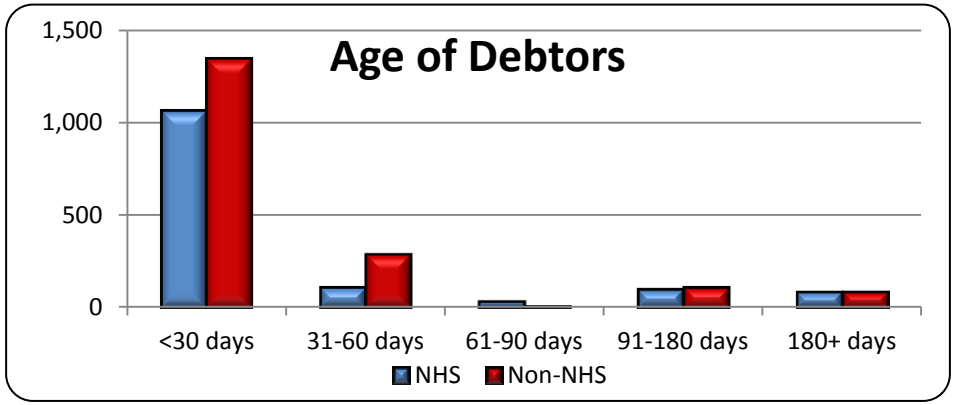
6. Accruals remain lower than planned.

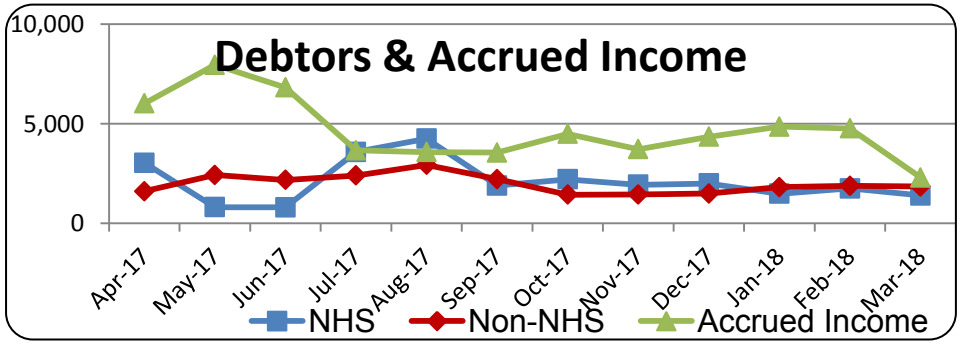
7. This reserve represents year to date surplus plus reserves brought forward.

# 3.0 Debtors

**Debtor management forms a key part of the Trust cash management process.**

**Debtors remain at a low level. Accrued Income is reduced as year end invoices have been raised.**




The Trust has continued to proactively chase all outstanding debts as part of its cash management process.

The intention of this review, and dialogue with outstanding debtors, is to reduce the length of time taken to receive cash payment and also identify and resolve any issues at the earliest possible opportunity.

This review is undertaken alongside an assessment of accrued income. This ensures that invoices are being raised in a timely fashion. Based upon values this will either be monthly or quarterly in arrears.

The majority of outstanding debtors, as at the end of March 2018, are less than 60 days (86%). Debts older than 180 days have reduced from £193k to £173k.

All outstanding debts have been reviewed to ensure that a recovery plan is in place. This includes discussions with other organisations to ensure we understand the reason for non-payment and therefore can take appropriate steps to resolve.

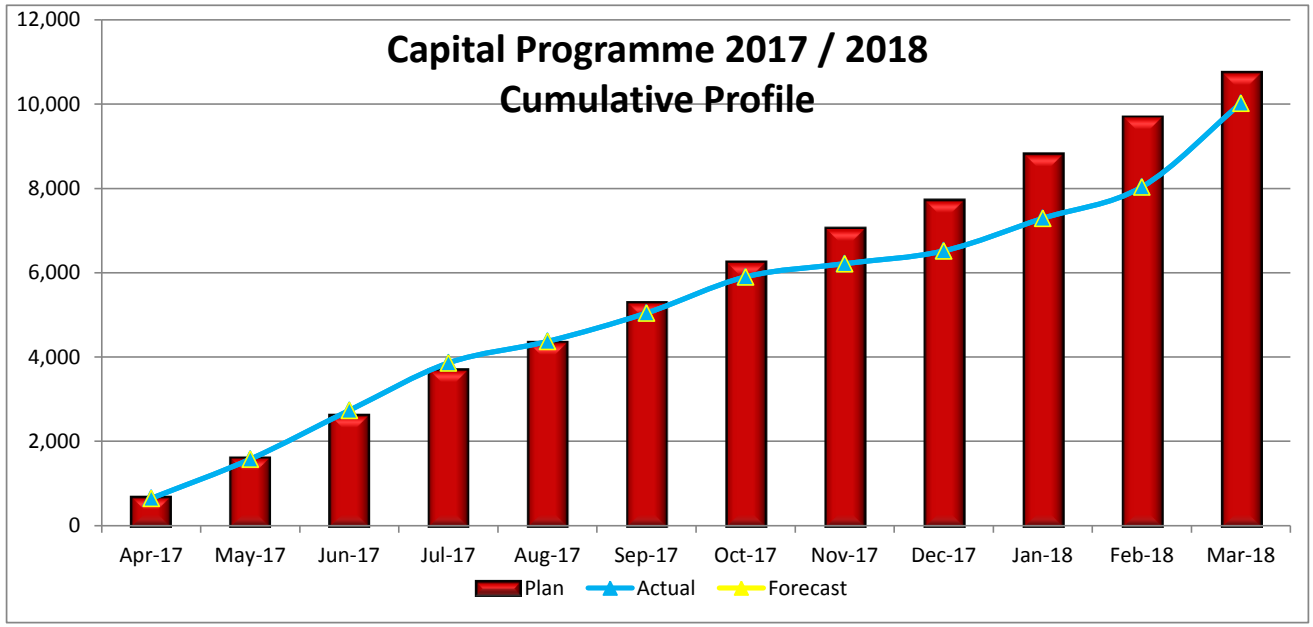
The in year profile of debtors is shown to the left. Accrued income has been added for context with invoices continuing to be raised in a timely manner.

Income has been reviewed and physical invoices raised as far as possible. The largest remaining accrued income relates to Quarter 4 STF and CQUIN.

# 3.1 Capital Programme 2017 / 2018

| | Annual Budget £k | Year to Date Plan £k | Year to Date Actual £k | Year to Date Variance £k | Forecast Actual £k | Forecast Variance £k | Note |
|---|---|---|---|---|---|---|---|
| **Maintenance (Minor) Capital** | | | | | | | |
| Facilities & Small Schemes | 1,558 | 1,558 | 1,388 | (169) | 1,388 | (169) | 3 |
| Equipment Replacement | 44 | 44 | 99 | 54 | 99 | 54 | |
| IM&T | 2,121 | 2,121 | 1,650 | (471) | 1,650 | (471) | 4 |
| **Major Capital Schemes** | | | | | | | |
| Fieldhead Non Secure | 7,030 | 7,030 | 6,952 | (78) | 6,952 | (78) | 2 |
| VAT Refunds | 0 | 0 | (68) | (68) | (68) | (68) | |
| **TOTALS** | **10,753** | **10,753** | **10,022** | **(731)** | **10,022** | **(731)** | 1 |

**2017 / 18 has seen continued investment in Trust Estate, Equipment and Information Management and Technology**




**Capital Expenditure 2017 / 2018**

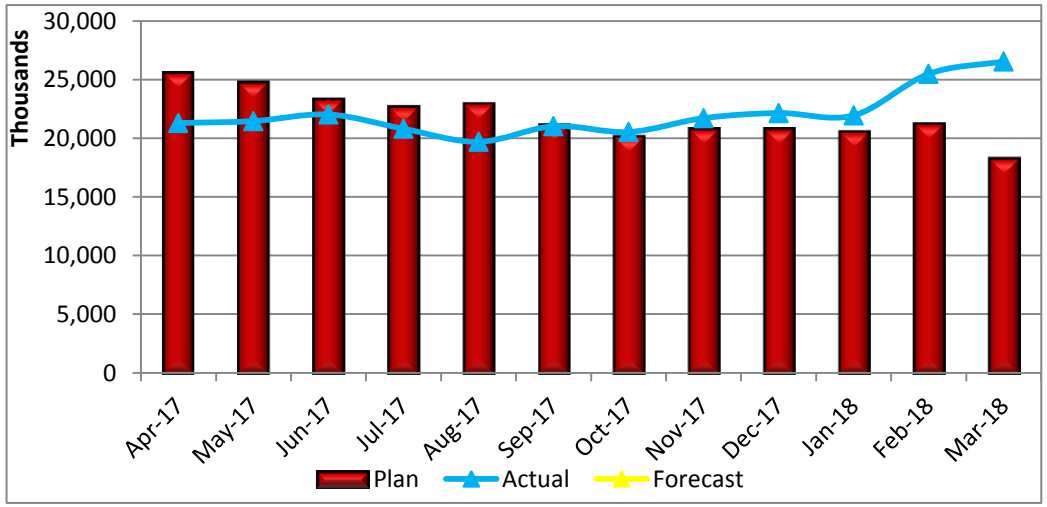
1. The 2017 / 18 year end position is £0.7m lower than plan (7%).This is primarily within IM & T.

2. During 2017 / 18 the first patient area of the Unity Centre has opened. Work continues on the next phase.

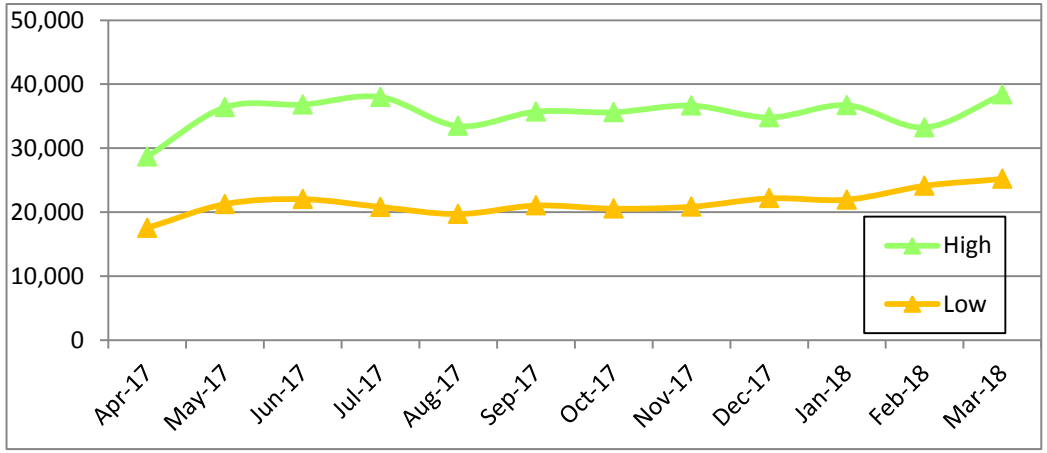
3. In year there have been changes to the facilities and small schemes to ensure that they respond to the needs of service users and meet appropriate standards. This has been managed within the financial envelope.

4. Initial works on the core Trust IT infrastructure modernisation programme have begun (overall 3 year programme). Development has also taken place on the Trust clinical portal and, through additional national funding, Trustwide Wi-Fi.

# 3.2 Cash Flow & Cash Flow Forecast 2017 / 2018




| | Plan £k | Actual £k | Variance £k |
|---|---|---|---|
| Opening Balance | 25,495 | 26,373 | |
| Closing Balance | 18,352 | 26,559 | 8,207 |




**Cash is £8.2m ahead of plan. Focus remains on maximising cash especially through effective debt management.**

Cash is ahead of plan mainly due to lower than plan debtors. March 2018 and Quarter 4 invoices have been raised and paid prior to 31st March 2018. Cash is expected to reduce in April and May 2018 whilst Quarter 1 charges are agreed.

A detailed reconciliation of working capital compared to plan is presented on page 17.

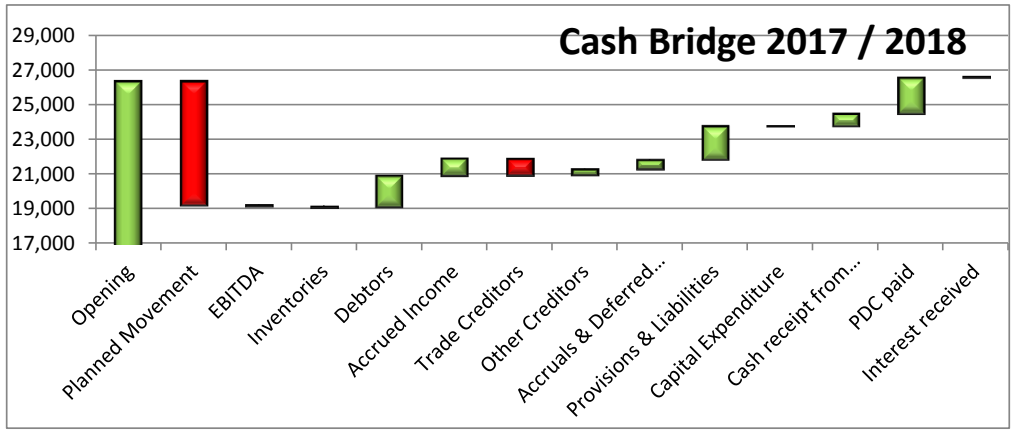
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

| | |
|---|---|
| The highest balance is: | £38.4m |
| The lowest balance is: | £25.2m |

This reflects cash balances built up from historical surpluses.

# 3.3 Reconciliation of Cashflow to Cashflow Plan

| | Plan £k | Actual £k | Variance £k | Note |
|---|---|---|---|---|
| **Opening Balances** | **25,495** | **26,373** | 878 | 1 |
| Surplus (Exc. non-cash items & revaluation) | 11,476 | 11,417 | (59) | |
| *Movement in working capital:* | | | | |
| Inventories & Work in Progress | 0 | (66) | (66) | |
| Receivables (Debtors) | (700) | 1,110 | 1,810 | 2 |
| Accrued Income / Prepayments | (204) | 799 | 1,003 | 5 |
| Trade Payables (Creditors) | 0 | (964) | (964) | 6 |
| Other Payables (Creditors) | 0 | 350 | 350 | |
| Accruals & Deferred income | (1,000) | (475) | 525 | 3 |
| Provisions & Liabilities | (3,000) | (1,060) | 1,940 | |
| *Movement in LT Receivables:* | | | | |
| Capital expenditure & capital creditors | (10,753) | (10,037) | 716 | |
| Cash receipts from asset sales | 390 | 2,483 | 2,093 | 4 |
| PDC Dividends paid | (3,397) | (3,437) | (40) | |
| PDC Dividends received | | | 0 | |
| Interest (paid)/ received | 45 | 65 | 20 | |
| **Closing Balances** | **18,352** | **26,559** | **8,207** | |




The plan value reflects the March 2017 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. Brought forward cash position was higher than planned.

2. Debtors have been addressed throughout the course of the year and have remained lower than planned. Additional actions in 2018 / 19 will continue to challenge this.

3. Invoices have been chased ahead of year end and but overall, mainly due to Out of Area invoices, remain higher than plan.

4. The Trust has sold 4 assets during 2017 / 2018 with cash receipts totaling £2.5m. Of these 2 had been originally planned for cash receipts to be during 2018 / 19 s highlighted by the £2.1m variance to plan.

5. Accrued income has significantly reduced in March 2018 as invoices are raised ahead of year end. Due to timing many have also been paid prior to year end.

Factors which decrease the cash position against plan:

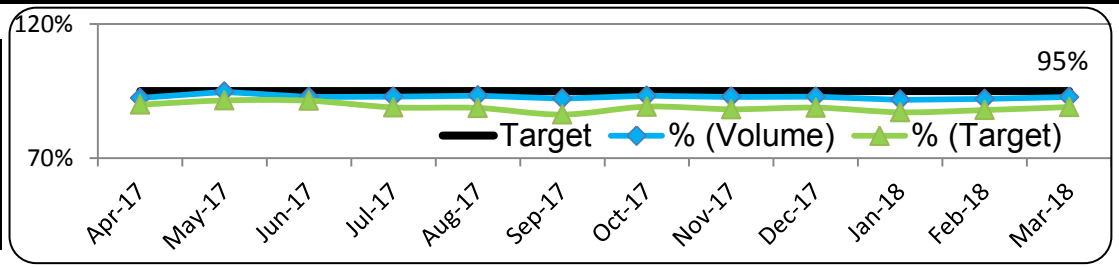
6. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code.

The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

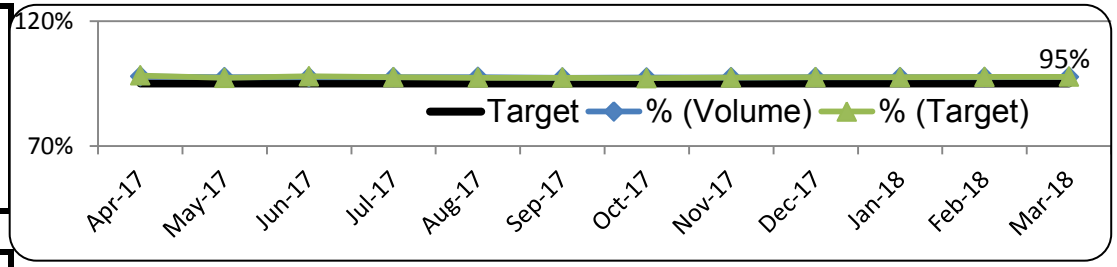
# 4.0 Better Payment Practice Code

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.
In November 2008 the Trust adopted a Government request for Public Sector bodies to pay local Suppliers within 10 days. This is not mandatory for the NHS.
The team continue to review reasons for non delivery of the 95% target and identify solutions to problems and bottlenecks in the process. Overall year to date progress remains positive.

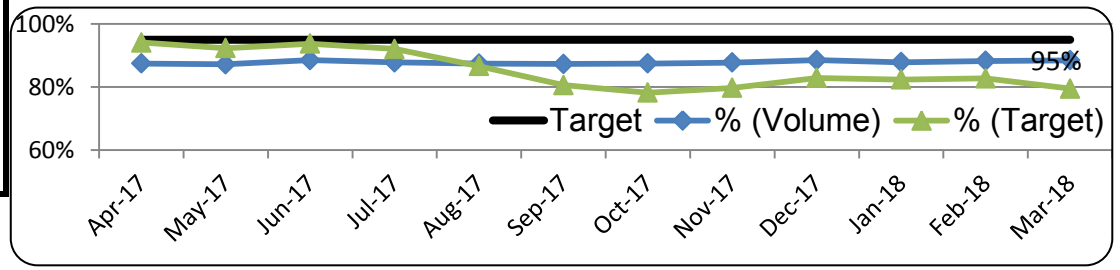
| NHS | Number % | Value % |
|---|---|---|
| Year to February 2018 | 92% | 88% |
| Year to March 2018 | 93% | 89% |




| Non NHS | Number % | Value % |
|---|---|---|
| Year to February 2018 | 98% | 98% |
| Year to March 2018 | 98% | 98% |




| Local Suppliers (10 days) | Number % | Value % |
|---|---|---|
| Year to February 2018 | 88% | 83% |
| Year to March 2018 | 88% | 79% |



# 4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000.

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.
The transparency information for the current month is shown in the table below.

| Date | Expense Type | Expense Area | Supplier | Transaction Number | Amount (£) |
|---|---|---|---|---|---|
| 27-Feb-18 | Property Rental | Calderdale | Calderdale and Huddersfield NHS Foundation Trust | 3064791 | 219,053 |
| 20-Feb-18 | Drugs FP10´s | Trustwide | NHSBSA Prescription Pricing Division | 3063357 | 58,423 |
| 26-Mar-18 | Staff Recharge | Trustwide | Leeds and York Partnership NHS FT | 3067019 | 46,897 |
| 21-Mar-18 | Staff Recharge | Trustwide | Leeds and York Partnership NHS FT | 3066453 | 46,504 |
| 14-Mar-18 | Property Rental | Barnsley | Community Health Partnerships | 3065763 | 32,445 |
| 05-Mar-18 | Property Rental | Wakefield | Mid Yorkshire Hospitals NHS Trust | 3064585 | 31,010 |
| 23-Mar-18 | Property Rental | Wakefield | Mid Yorkshire Hospitals NHS Trust | 3066710 | 31,010 |
| 23-Mar-18 | Property Rental | Calderdale | Calderdale and Huddersfield NHS Foundation Trust | 3066737 | 30,525 |
| 10-Jan-18 | Radiology | Barnsley | Barnsley Hospital NHS Foundation Trust | 3059237 | 28,000 |
| 10-Jan-18 | Radiology | Barnsley | Barnsley Hospital NHS Foundation Trust | 3059236 | 25,000 |

# 4.2 Glossary

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

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

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

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

* 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 - This is the surplus we expect to make for the financial year

* Target Surplus - This is the surplus 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. For 2016 / 2017 the Trust were set a control total surplus.

* 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.

* IFRS - International Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

# Appendix 2 - Workforce - Performance Wall

## Barnsley District

| Month | Objective | CQC Domain | Owner | Threshold | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.5% | 4.80% | 4.90% | 5.00% | 5.10% | 5.20% | 5.10% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.5% | 5.20% | 5.90% | 5.90% | 5.50% | 5.90% | 4.80% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 87.50% | 95.40% | 96.90% | 96.60% | 96.60% | 96.70% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 75.60% | 94.50% | 94.50% | 94.50% | 94.30% | 94.30% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 77.80% | 79.10% | 77.60% | 77.40% | 77.50% | 77.90% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 74.40% | 75.80% | 78.80% | 77.20% | 78.70% | 80.70% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 88.80% | 88.10% | 87.40% | 87.40% | 88.00% | 88.90% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 88.60% | 89.10% | 89.30% | 91.00% | 92.40% | 91.40% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 78.20% | 77.50% | 77.40% | 81.00% | 82.00% | 84.10% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 65.00% | 62.60% | 62.50% | 66.40% | 62.90% | 63.30% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 81.70% | 82.20% | 81.70% | 84.40% | 85.20% | 85.60% |
| Information Governance | Resources | Well Led | AD | >=95% | 82.40% | 83.40% | 82.30% | 88.40% | 95.90% | 96.80% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 82.10% | 82.70% | 81.80% | 84.00% | 84.70% | 83.90% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 87.60% | 87.60% | 87.50% | 88.00% | 88.70% | 89.20% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 85.00% | 85.60% | 84.50% | 85.80% | 86.70% | 87.90% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 94.90% | 95.30% | 94.50% | 94.00% | 94.30% | 93.20% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 82.10% | 83.60% | 84.40% | 84.30% | 84.20% | 83.30% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 74.00% | 74.30% | 78.10% | 78.60% | 77.80% | 76.30% |
| Agency Cost | Resources | Effective | AD | | £101k | £68k | £68k | £105k | £104k | £87k |
| Overtime Costs | Resources | Effective | AD | | £2k | £4k | £3k | £4k | £3k | £1k |
| Additional Hours Costs | Resources | Effective | AD | | £25k | £29k | £19k | £17k | £11k | £13k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £170k | £174k | £182k | £163k | £151k | £132k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 106.6 | 111.4 | 158.6 | 191.9 | 166.3 | 166.5 |
| Business Miles | Resources | Effective | AD | | 106k | 89k | 107k | 101k | 90k | 90k |

## Calderdale and Kirklees District

| Month | Objective | CQC Domain | Owner | Threshold | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.5% | 4.7% | 4.8% | 4.9% | 5.1% | 5.3% | 5.3% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.5% | 5.3% | 5.7% | 5.9% | 6.9% | 6.5% | 5.2% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 93.7% | 97.6% | 97.9% | 97.9% | 97.9% | 97.9% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 84.5% | 95.2% | 95.6% | 95.8% | 96.0% | 95.9% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 75.8% | 78.9% | 76.8% | 76.0% | 77.6% | 78.5% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 72.4% | 74.3% | 72.9% | 73.1% | 75.1% | 78.7% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 79.9% | 81.7% | 82.4% | 84.2% | 87.5% | 86.7% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 81.1% | 84.1% | 83.9% | 86.9% | 86.8% | 87.8% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 81.6% | 81.4% | 80.7% | 83.4% | 84.3% | 85.4% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 76.3% | 81.1% | 82.4% | 83.3% | 80.3% | 79.6% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | | >=80% | 81.7% | 83.1% | 82.7% | 85.2% | 86.5% | 87.2% |
| Information Governance | Resources | Well Led | AD | >=95% | 87.4% | 85.0% | 84.9% | 94.1% | 98.5% | 98.3% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 75.6% | 77.8% | 79.3% | 83.0% | 84.1% | 84.3% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 81.7% | 84.5% | 85.5% | 86.8% | 89.8% | 89.6% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 79.0% | 79.6% | 78.5% | 82.4% | 84.5% | 85.1% |
| Sainsbury's clinical risk assessment | Quality & Experience | Well Led | AD | >=80% | 93.8% | 94.1% | 94.0% | 95.1% | 95.6% | 95.1% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 90.9% | 92.6% | 92.9% | 92.7% | 93.1% | 92.9% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 88.2% | 89.6% | 90.4% | 90.2% | 90.5% | 89.8% |
| Agency Cost | Resources | Effective | AD | | £101k | £139k | £92k | £108k | £131k | £133k |
| Overtime Costs | Resources | Effective | AD | | £2k | £6k | £5k | £2k | £8k | £4k |
| Additional Hours Costs | Resources | Effective | AD | | £0k | £3k | £2k | £1k | £1k | £1k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £128k | £127k | £138k | £167k | £139k | £118k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 72.7 | 66.0 | 63.0 | 62.8 | 67.8 | 62.8 |
| Business Miles | Resources | Effective | AD | | 68k | 56k | 64k | 65k | 69k | 53k |

# Appendix - 2 - Workforce - Performance Wall cont....

## Forensic Services

| Month | Objective | CQC Domain | Owner | Threshold | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=5.4% | 6.1% | 6.3% | 6.4% | 6.6% | 6.8% | 6.8% |
| Sickness (Monthly) | Resources | Well Led | AD | <=5.4% | 7.3% | 7.6% | 7.4% | 8.4% | 8.4% | 7.1% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 96.2% | 98.7% | 98.7% | 98.7% | 98.7% | 98.7% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 84.0% | 97.8% | 97.7% | 97.7% | 97.7% | 98.0% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 84.3% | 85.5% | 85.7% | 86.3% | 84.9% | 84.9% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 73.5% | 76.5% | 79.4% | 80.4% | 82.1% | 86.6% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 79.9% | 83.2% | 82.9% | 86.0% | 86.9% | 85.8% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 86.2% | 87.6% | 87.1% | 88.4% | 88.8% | 89.5% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 86.9% | 89.0% | 90.4% | 91.8% | 88.8% | 90.7% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 85.1% | 87.1% | 86.0% | 84.7% | 87.3% | 85.3% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 86.0% | 87.3% | 85.4% | 86.5% | 89.2% | 91.4% |
| Information Governance | Resources | Well Led | AD | >=95% | 89.3% | 90.3% | 87.2% | 89.8% | 95.6% | 96.4% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 86.7% | 88.0% | 87.5% | 88.9% | 89.0% | 90.9% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 89.5% | 89.0% | 89.0% | 91.8% | 89.7% | 89.2% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 84.0% | 85.6% | 87.1% | 87.4% | 86.6% | 86.3% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 70.4% | 76.9% | 77.8% | 100.0% | 94.7% | 86.4% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 91.0% | 92.1% | 92.6% | 92.0% | 92.2% | 91.9% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 84.5% | 84.4% | 86.5% | 85.7% | 85.5% | 83.9% |
| Agency Cost | Resources | Effective | AD | | £60k | £47k | £30k | £26k | £36k | £35k |
| Overtime Costs | Resources | Effective | AD | | | £0k | £0k | £0k | £0k | £0k |
| Additional Hours Costs | Resources | Effective | AD | | £2k | £1k | £1k | £3k | £1k | £0k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £67k | £71k | £72k | £82k | £72k | £65k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 37.4 | 35.4 | 36.6 | 42.1 | 45.7 | 45.4 |
| Business Miles | Resources | Effective | AD | | 8k | 7k | 12k | 8k | 6k | 4k |

## Specialist Services

| Month | Objective | CQC Domain | Owner | Threshold | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.5% | 5.8% | 5.6% | 5.7% | 5.7% | 5.6% | 5.6% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.5% | 5.9% | 4.7% | 5.9% | 6.2% | 4.7% | 5.1% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 92.5% | 99.5% | 99.5% | 99.4% | 99.4% | 99.4% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 79.3% | 100.0% | 100.0% | 100.0% | 100.0% | 99.0% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 74.3% | 76.3% | 74.4% | 71.9% | 71.4% | 75.9% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 76.3% | 78.1% | 76.1% | 80.1% | 83.8% | 86.5% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 83.2% | 85.7% | 85.2% | 85.6% | 84.7% | 86.0% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 85.3% | 87.1% | 86.5% | 84.4% | 85.6% | 84.9% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 82.5% | 84.9% | 80.4% | 79.7% | 84.0% | 83.0% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 76.9% | 70.8% | 73.9% | 75.0% | 69.2% | 69.2% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 81.5% | 83.5% | 82.3% | 84.7% | 87.7% | 87.3% |
| Information Governance | Resources | Well Led | AD | >=95% | 87.3% | 85.3% | 82.7% | 85.7% | 95.3% | 95.3% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 78.2% | 79.9% | 79.9% | 81.1% | 84.7% | 86.1% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 85.3% | 87.8% | 88.2% | 87.0% | 88.9% | 89.0% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 86.7% | 86.6% | 86.5% | 87.5% | 87.3% | 87.3% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 91.6% | 91.9% | 91.6% | 91.0% | 91.6% | 91.0% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 91.7% | 92.8% | 93.6% | 92.9% | 92.0% | 92.5% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 86.1% | 87.3% | 88.4% | 87.1% | 85.5% | 84.1% |
| Agency Cost | Resources | Effective | AD | | £181k | £196k | £148k | £153k | £174k | £182k |
| Overtime Costs | Resources | Effective | AD | | £0k | £0k | | £5k | £0k | |
| Additional Hours Costs | Resources | Effective | AD | | £1k | £2k | £1k | £3k | £1k | £1k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £64k | £50k | £66k | £67k | £42k | £64k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 51.7 | 39.3 | 52.4 | 54.0 | 50.8 | 53.3 |
| Business Miles | Resources | Effective | AD | | 34k | 44k | 46k | 37k | 35k | 35k |

# Appendix 2 - Workforce - Performance Wall cont....

## Support Services

| Month | Objective | CQC Domain | Owner | Threshold | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.0% | 4.3% | 4.4% | 4.4% | 4.6% | 4.6% | 4.6% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.0% | 4.3% | 4.6% | 5.0% | 5.7% | 5.4% | 4.1% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 97.1% | 98.0% | 98.0% | 98.0% | 98.0% | 98.0% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 89.8% | 95.4% | 95.8% | 96.6% | 96.6% | 96.8% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 63.4% | 69.4% | 69.8% | 72.6% | 74.9% | 77.2% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 65.5% | 85.7% | 82.1% | 96.3% | 96.3% | 92.3% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 83.9% | 87.0% | 87.0% | 87.5% | 88.1% | 87.4% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 88.0% | 89.5% | 86.6% | 87.0% | 88.0% | 87.4% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 94.9% | 99.1% | 100.0% | 100.0% | 98.1% | 98.2% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 81.2% | 83.8% | 85.4% | 85.6% | 87.0% | 87.3% |
| Information Governance | Resources | Well Led | AD | >=95% | 88.6% | 86.7% | 81.4% | 88.2% | 93.3% | 95.7% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 88.5% | 87.8% | 89.0% | 90.4% | 90.9% | 90.6% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 88.0% | 89.1% | 88.4% | 91.1% | 91.8% | 91.9% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 91.6% | 94.7% | 95.0% | 96.1% | 95.9% | 94.6% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 97.9% | 97.9% | 98.6% | 98.8% | 98.9% | 98.9% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 75.0% | 86.7% | 86.2% | 92.3% | 88.9% | 85.7% |
| Agency Cost | Resources | Effective | AD | | £12k | £5k | £4k | £1k | £5k | £1k |
| Overtime Costs | Resources | Effective | AD | | £1k | £0k | £1k | £1k | £1k | £0k |
| Additional Hours Costs | Resources | Effective | AD | | £11k | £13k | £13k | £8k | £9k | £6k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £75k | £74k | £78k | £90k | £76k | £65k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 59.2 | 58.2 | 62.7 | 57.4 | 61.0 | 64.8 |
| Business Miles | Resources | Effective | AD | | 36k | 36k | 38k | 26k | 36k | 19k |

## Wakefield District

| Month | Objective | CQC Domain | Owner | Threshold | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.6% | 5.0% | 5.0% | 5.0% | 5.0% | 5.0% | 4.9% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.6% | 4.1% | 4.9% | 4.9% | 5.6% | 4.8% | 3.3% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 97.2% | 99.4% | 99.4% | 98.9% | 98.3% | 97.8% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 88.7% | 94.4% | 94.4% | 94.4% | 95.4% | 95.2% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 81.9% | 83.5% | 83.5% | 83.9% | 82.5% | 82.1% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 65.8% | 72.0% | 75.7% | 77.4% | 75.4% | 78.9% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 72.9% | 74.3% | 75.6% | 76.3% | 77.6% | 76.7% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 86.6% | 86.5% | 85.9% | 88.0% | 87.9% | 86.6% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 86.8% | 86.7% | 87.6% | 83.4% | 84.3% | 82.8% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 69.9% | 72.7% | 71.8% | 70.9% | 68.6% | 67.4% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 80.3% | 81.2% | 83.4% | 84.4% | 85.3% | 83.7% |
| Information Governance | Resources | Well Led | AD | >=95% | 87.3% | 89.6% | 87.4% | 86.7% | 93.8% | 94.5% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 70.3% | 71.5% | 73.1% | 74.5% | 78.1% | 78.3% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 87.0% | 87.8% | 90.5% | 91.8% | 90.2% | 90.4% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 77.1% | 79.5% | 80.6% | 80.8% | 83.2% | 83.9% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 92.6% | 92.9% | 93.7% | 92.9% | 93.7% | 92.9% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 86.0% | 88.2% | 90.5% | 90.3% | 91.5% | 90.7% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 81.1% | 83.9% | 86.5% | 86.5% | 86.4% | 84.5% |
| Agency Cost | Resources | Effective | AD | | £60k | £76k | £90k | £73k | £114k | £116k |
| Overtime Costs | Resources | Effective | AD | | £2k | | | £0k | £1k | £1k |
| Additional Hours Costs | Resources | Effective | AD | | £4k | £3k | £3k | £4k | £1k | £1k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £43k | £54k | £57k | £64k | £52k | £39k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 50.4 | 48.3 | 45.0 | 55.2 | 62.3 | 60.7 |
| Business Miles | Resources | Effective | AD | | 41k | 31k | 37k | 33k | 38k | 29k |

# Glossary

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

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

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

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

*NB: The Trusts RAG rating system was reviewed by EMT during October 16 and some amendments were made to the wording and colour scheme.*

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

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 8.2

| | |
|---|---|
| **Title:** | **Customer Service Report Quarter 4 2017/18** |
| **Paper prepared by:** | Director of Nursing and Quality |
| **Purpose:** | To note feedback on experience of using Trust services received via the Customer Services function, the themes arising, learning, and action taken in response to feedback. To note also the summary Friends and Family Test results, comments and benchmarking and the number and types of requests received by the Trust under the Freedom of Information Act. |
| **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. The Trust is committed to responding openly and transparently to all requests for information under the Freedom of Information Act. |
| **Any background papers/ previously considered by:** | Trust Board approves Customer Services Policy, with the last review in June 2017. The Board also reviews feedback received via the Customer Services function on a quarterly basis. Trust Board reviews Key Performance Indicators (KPIs) on complaints management via the monthly Integrated Performance Report. Routine reporting to Business Delivery Units (BDUs) enables increased scrutiny of issues and themes, complaints investigation, response timeframes and action planning, to support service improvement in response to feedback.<br>The Customer Services Team continues to promote the function through leaflets and posters. The team also works with services and teams to encourage signposting to Customer Services as a single gateway to raise issues with the Trust. |
| **Executive summary:** | Work is underway to review the complaints investigation and sign off process to make sure that the Trust always responds in ways that ensure 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. The Director of Nursing and Quality is leading on this work which will be taken forward through the Operational Management Group.<br>Engagement with BDUs has commenced and Calderdale & Kirklees are implementing a pilot of the revised model. Customer services are currently working with colleagues in Wakefield & Barnsley BDUs to plan implementation of the updated procedure and plans are in place to meet with colleagues on the remaining BDUs.<br>Engagement events are being planned for complainants who have had |

| | |
|---|---|
| | experience of customer services. The new process will secure greater involvement of clinical leads in complaints resolution, putting the person first and centre and using feedback to support service improvement. This will also support improved timeliness in complaints handling. From Q1 2018/19 we will be moving away from the existing customer service report to a broader patient experience report.<br><br>**Customer Services Report – Quarter 4 2017/18**<br>This report provides information on feedback received through Customer Services, the themes indicated, lessons learned and action taken in response to feedback. This report supplements information provided to BDUs. In Quarter 3, there were 51 formal complaints, 75 compliments, 214 general enquiries, 166 staff contacts were responded to and there were 76 requests to access information under the Freedom of Information Act. 42 formal complaints were closed during the quarter. Most complaints contain a number of issues; the most frequently raised issues were communication, values and behaviours, patient care, Trust admin/policies/procedures and appointments.<br><br>**Key areas to note:**<br>➢ There were 3 fewer formal complaints about Trust services than in the previous quarter. There were no complaints about application of the Mental Health Act.<br>➢ The Customer Services Team continues to remind services to share compliments to ensure they are acknowledged, recorded at corporate level and best practice shared. We received 54 fewer compliments than in the previous quarter.<br>➢ The Parliamentary and Health Service Ombudsman (PHSO) was requested to review 3 complaints in the quarter.<br>➢ The Trust results for the Friends and Family Test (FFT) showed a recommend rate of 91% at March 2018. Trust results in FFT continue to be high in absolute terms and overall average.<br>➢ The Trust continues to process a substantial number of Freedom of Information requests.<br><br>This report is shared with the Members' Council, and is subject to discussion with commissioners at Quality Boards. Complaints information is also reviewed through monthly contract monitoring.<br>The information is also reviewed internally at BDU governance meetings.<br><br>**Risk Appetite**<br>The Customer Services report provides information to the Board on feedback about the quality of Trust services. Issues are escalated to the medical and nursing director and to the relevant service director to ensure action in line with the Trust's Risk Appetite Statement.<br>Reporting is being reviewed to determine how intelligence from Customer Services can be linked to other risk information. Complaint responses are reviewed by the investigator, by general managers and |

| | |
|---|---|
| | service directors and signed off by the Chief Executive. Delivery of action plans in response to learning from feedback is monitored by BDUs and overseen by service directors. |
| **Recommendation:** | **Trust Board is asked to REVIEW and NOTE the feedback received through Customer Services in Quarter 4 of financial year 2017/18.** |
| **Private session:** | Not applicable. |

NHS
South West Yorkshire Partnership
NHS Foundation Trust

# Customer Services Report Quarter 4 2017- 2018

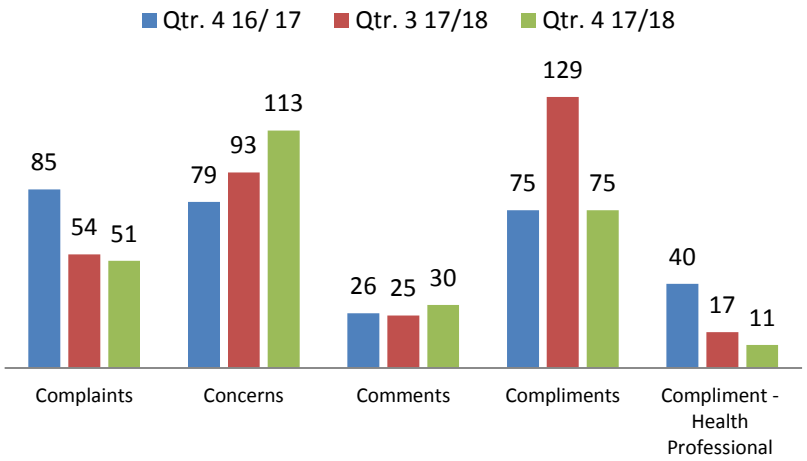
With **all of us** in mind.

# Summary:

- The Trust received **280** items of feedback in the form of complaints, concerns, comments and compliments in Qtr. 4. This is a decrease in the previous quarter when feedback totalled **318.**
- **51** formal complaints were received, a slight **decrease** on the previous quarter figure of **54**. **42** formal complaints were closed.
- **143** comments/concerns were received (**118** in the previous quarter).
- **75** compliments were received (**129** in Qtr. 3). The Customer Services team promotes the importance of submitting compliments so that they can be formally acknowledged and best practice shared.
- **214** general enquires were responded to in the period in addition to 4C's management. Sign-posting to Trust services was the most frequent enquiry. **166** staff contacts were recorded.
- ***Access to treatment or drugs*** was identified as the most frequently raised negative issue **(38).** This was followed by ***communication*** **(30),** ***values and behaviours*** **(23)**, ***clinical treatment*** **(21), appointments (14)** and ***Trust admin/policies/procedures*** **( 13)**. Most complaints contained a number of themes.
- 91% of people who completed the Friends and Family Test said they **would recommend** Trust services, 5% were unsure and 4% **would not recommend them.**

Work is underway to review the complaints investigation and sign off process to make sure that the Trust always responds in ways that extracts learning and becomes more responsive where service issues arise. This means services will see the issue first, with a supportive and thorough process second. Tim Breedon, Director of Nursing and Quality, is leading on this work which will be taken forward through the Operational Management Group and secure greater involvement of the BDU trio's in complaints resolution, putting the person first and in the centre and using feedback to support improvement.

## Trust wide

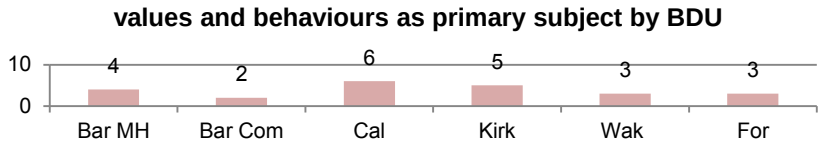



## Values and Behaviours (staff)

The Trust received 23 formal complaints in Qtr. 4 that included staff attitude as a factor. Staff attitude being the primary subject matter in 14 complaints.

Across staff groups this related to 17 nurses, 4 consultant, 2 administrative staff.

A further 14 comments and concerns were received which referenced staff attitude. These were resolved by the service line to the individual's satisfaction.




## Joint Working

National guidance emphasises the importance of organisations working together where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single response.

The Trust works with partners to ensure the complaints process is as simple and straight forward to access as possible and to ensure a joined up approach to responding to feedback about health and social care services.

The Customer Services function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. Healthwatch are provided with copies of quarterly reports and on occasion request additional information from the Trust promoting and signposting local people to the team to share feedback.

## Joint working in Qtr. 4

| | COMPLAINT | CONCERN | COMMENT |
|---|---|---|---|
| Calderdale and Huddersfield NHS Foundation NHS Trust | 0 | 2 | 0 |
| Care Quality Commission | 0 | 1 | 0 |
| Kirklees Council | 0 | 1 | 0 |
| Member of Parliament | 7 | 11 | 4 |
| Mid Yorkshire Hospital NHS Trust | 1 | 0 | 0 |
| NHS Wakefield CCG | 0 | 1 | 0 |
| Wakefield Metropolitan District Council | 0 | 1 | 0 |

## NHS Choices

The Trust recognises that NHS Choices is an external source of information about the Trust. Survey materials promote NHS Choices as an additional means to offer feedback about the Trust and its services. The website is monitored to ensure timely response to feedback is posted.

18 individuals posted comments on NHS Choices and Patient Opinion in Qtr.4. 3 positive experiences were recorded, 1 related to Kirklees IAPTS service and 2 were not identifiable. 15 negative comments were noted, 1 related to Kirklees IHBTT and 1 to Kirklees Memory Service (OPS) and 13 negative comments did not identify the service the feedback related to.

The Trust acknowledges feedback to the site and offers contact details should the author wish to discuss their concerns directly with the Trust. Follow up in this way is limited.

## PHSO

**The PHSO was requested to review three new complaints about Trust services in Qtr. 4:**

- **One complaint related to inappropriate discharge planning and issues with lack of clear or accurate information provided to carers. - Acute Inpatients (Adult) Calderdale and Kirklees BDU.**
- **One complainant was unhappy with care provided to his wife from the ward and unnecessary medication changes which resulted in lack of support from services. - General Community Inpatient ward - Barnsley BDU**
- **One complainant was not satisfied with the support that her daughter was receiving and believed the treatment was not appropriate to her daughters diagnosis. -Community Services - Adult Calderdale and Kirklees BDU.**

**Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. Information requested by the Ombudsman in relation to the above was provided within the prescribed timeframe. It can take a number of months before the Ombudsman is in a position to advise the Trust on its decisions (due to the volume of referrals received by PHSO).**

## Mental Health Act

There were no complaints raised with the Trust during Qtr. 4 regarding detention under the Mental Health Act.

When complaints are made about application of the Act, these are reported to the Mental Health Act Sub Committee of the Trust Board.

## Care Quality Commission (CQC)

During Quarter 4 the Trust received no requests for information from the CQC

## Information Commissioner's Office (ICO)

The Trust currently has one complaints with them regarding the lack of information provided to the requester in response to a Freedom of Information request.

- One complaint is from a requester who has escalated a decision notice given by the ICO not upholding their complaint to a Tribunal. The Trust waits the decision – no further action needed.

## Equality Data

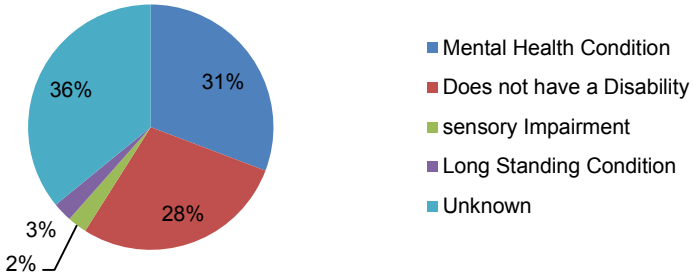
Equality data is an indicator of who accesses the complaints process. **It is about the person raising the issue, who is not necessarily the person receiving services**. Data is captured, where possible, at the time a formal complaint is made, or as soon as telephone contact is made following receipt of any written concerns. 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. We offer assurance that providing data has no impact on care and treatment or on the progression of a complaint.

52 complaints were closed. Complaints were raised by service users (21), and carers/ and/ or family members (18) and by third party (13) . Equality data was collected for 39 contacts, 1 complainant declined to provide equality data. Data is not collected about third party agents. Data was not collected for 14.

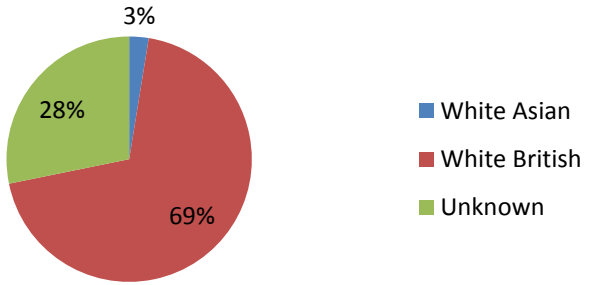
The Team continues to explore best practice in equality data capture, both internally with teams and externally with partner organisations and networks, and incorporates any learning into routine processes.

The pie charts show, where information was provided, the breakdown in respect of ethnicity, gender, disability, age and sexual orientation. Equality data is collated Trust wide.

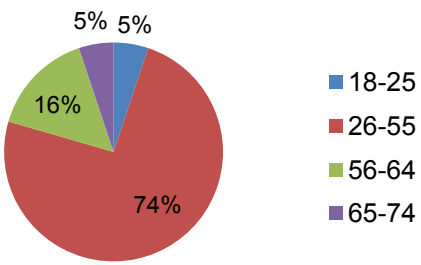
### Trust wide - Disability



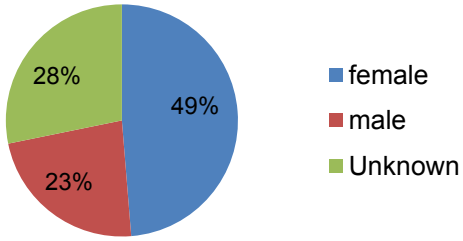

### Trust wide - Ethnicity



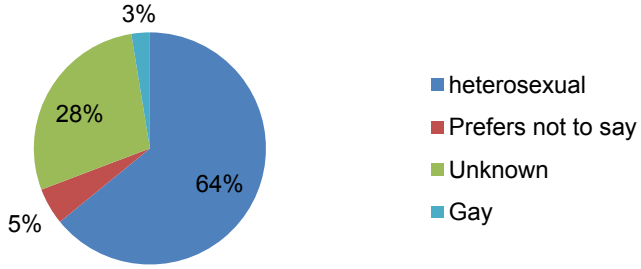

### Trust wide - age




### Trust wide - Gender

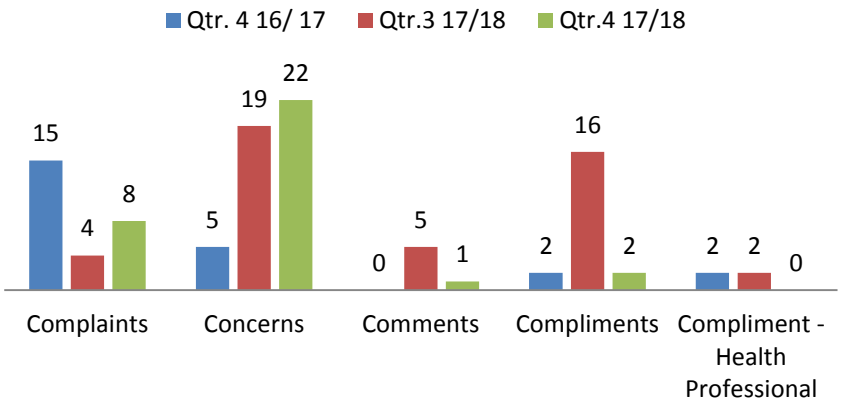



### Trust wide - sexual orientation

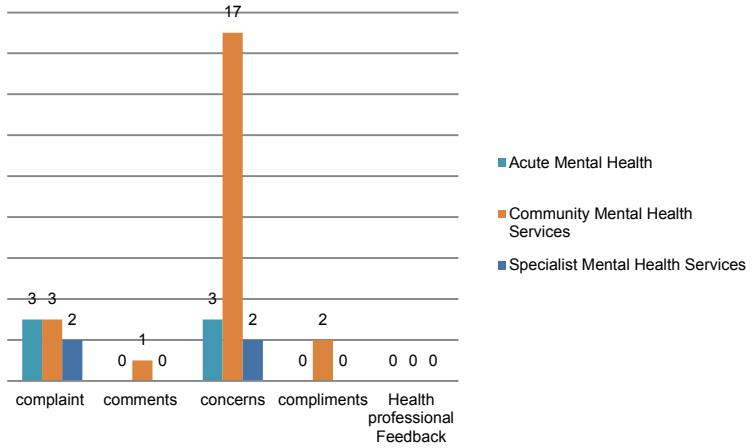


# Barnsley Business Delivery Unit
# Mental Health Services

## Number of Issues




## Issues by service line




## Learning:

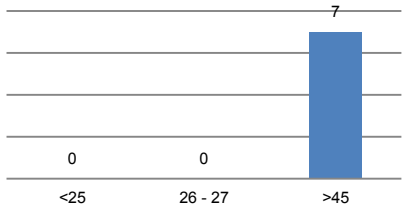
- Explanation provided regarding why service user was encouraged to attend appointments in clinic as part of the treatment for anxiety. Apology also provided regarding why appointments with care coordinator needed to be cancelled at short notice due to staff being on call. - **Core Team**
- Staff to ensure that all conversations with service users and family members regarding diagnosis should be documented. The Trust will also review the use of the term "discharge planning" when a person is simply moving between teams as this can cause unnecessary distress. **– Enhanced Pathway**

**Top Five Themes**

1. **Access to treatment and drugs**
2. **Clinical treatment**
3. **Values and behaviours**
4. **Communications**
5. **Admission and discharge**

''Staff showed their constant care and the strategies they provided proved to be second to none. I feel they are a vital attribute to the team''
**Core Team**

## Response times

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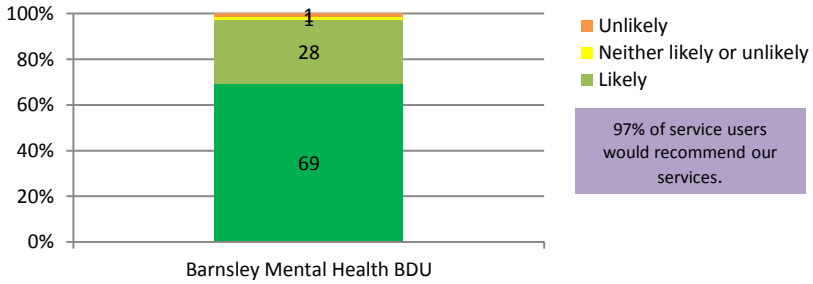
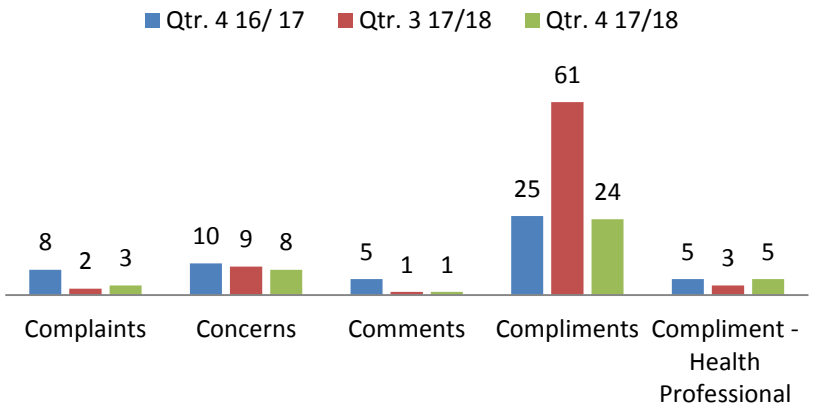
## The NHS Friends and Family Test



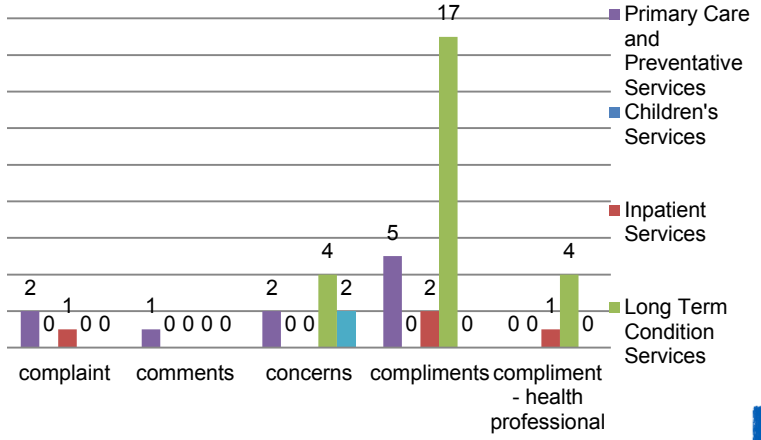

97% of service users would recommend our services.

# Barnsley Business Delivery Unit
# General Community Services

## Number of Issues




## Issues by service line




**Learning:**

- Explanation provided as to why oxygen and carbon dioxide were required and reassurance given that physical health monitoring was completed and due to deterioration in service user health a transfer to hospital was indicated.- **Ward 5, Mount Vernon**
- Service acknowledge that complainant has experienced difficulties with clear communication from care home and Trust services. Staff reminded of the importance of clear communication with service users and their carers and to check understanding **– District Nursing**

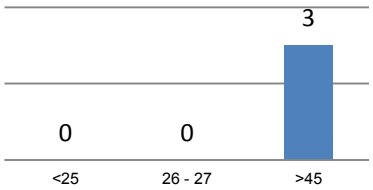
**Top Five Themes**

1. **Appointments**
2. **Communications**
3. **Values and behaviours**
4. **Clinical treatment**
5. **Prescribing**

"Staff are friendly, courteous and professional in their approach. This is very important to relatives who are looking for trust and reassurance during this difficult period"
**Neuro Rehab Unit**

Thanks for supporting me in my hour of need. I was so pleased I had someone to turn to.
**Palliative Care**

## Response times

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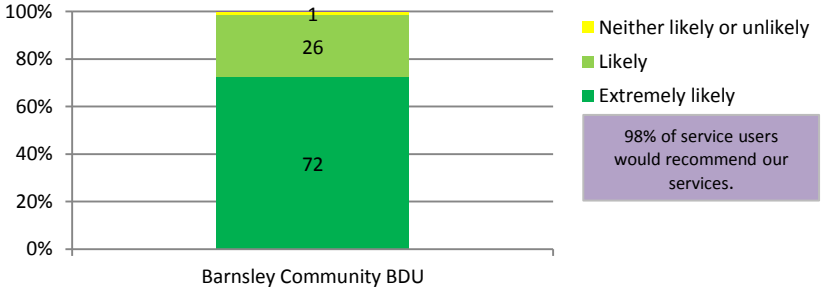
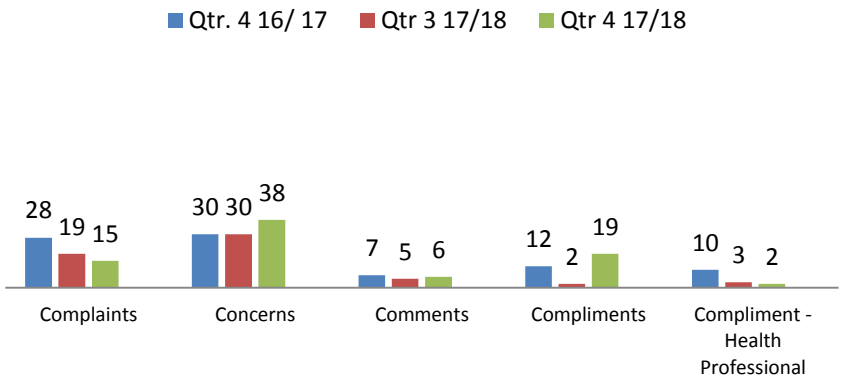


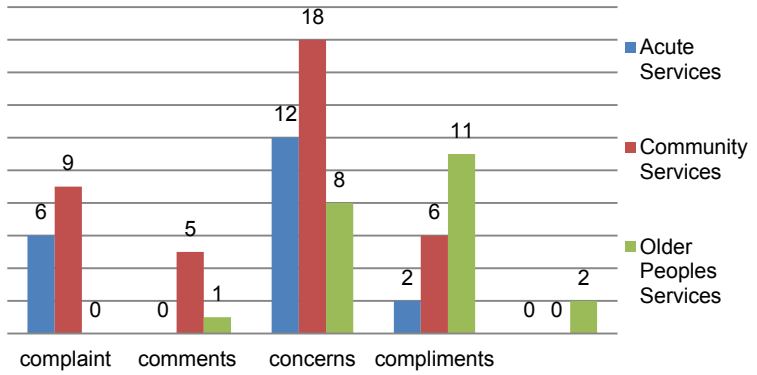

98% of service users would recommend our services.

# Calderdale & Kirklees Business Delivery Unit

## Number of Issues




## Issues by service line




### Learning:

- Services to check when rescheduling appointments that the new appointment times are convenient for the service user. **– Calderdale IAPTS**

- Service agreed to a 3 month transition period for another member of staff to support service user and for service to clearly communicate this to family – **CMHT (North Kirklees)**

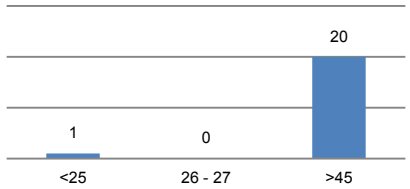
**Top Five Themes**

1. **Access to treatment or drugs**
2. **Communications**
3. **Patient care**
4. **Values and behaviours**
5. **Admission and discharge**

"You have been kind, patient and caring and kept me fully updated with the progress of my mother. You have done a fantastic job"
**Beechdale ward**

Thanks to staff for their dedication. They have made such a difference to the life of a service user.
**Enfield Down – Rehab unit**

## Response times




BDUs receive monthly reports on [illegible]ts management and learning from cl[illegible] cases. The time taken to prepare letters from investigation toolkits has increased due to staff vacancies within the customer services team. Action is being taken to mitigate the delay. Scrutiny of issues and responses has also added to response times. Customer Services staff keep complainants updated on progress.

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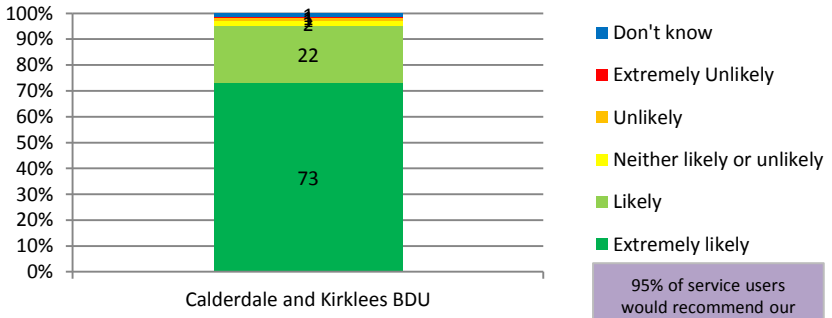
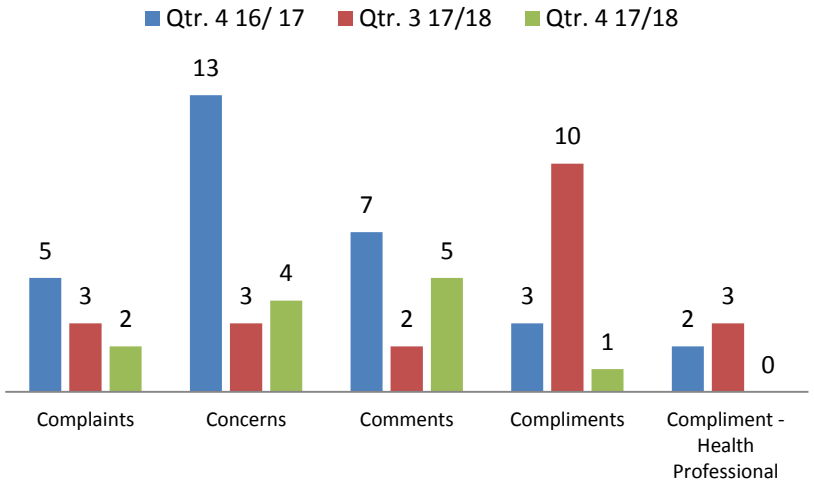


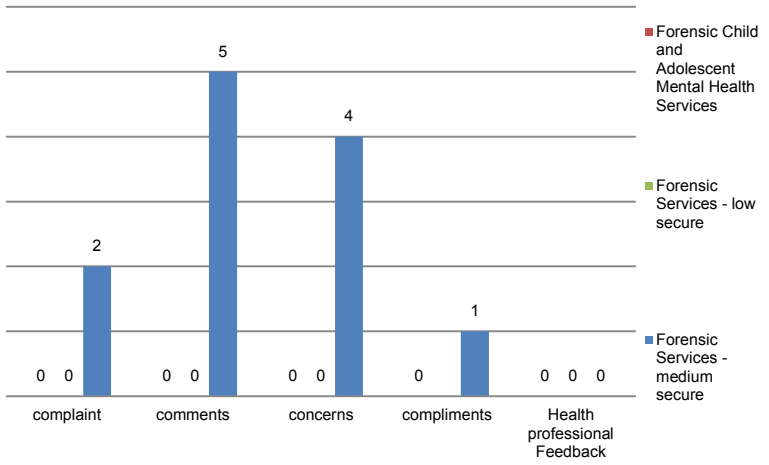

95% of service users would recommend our services.

# Forensic Business Delivery Unit

## Number of Issues




## Issues by service line




## Learning:

- Staff to ensure that all service users have access to a copy of the personal property procedure and to check understanding of this – **Bronte ward. Newton Lodge**

**Top Five Themes**

1. Facilities
2. Values and behaviours
3. Admission and discharge
4. Communications
5. Clinical treatment

''Staff on the ward are so calm, caring and professional when caring for my relative''
**Bronte ward**
**Newton Lodge**

**No complaints were closed during this quarter**

BDUs receive monthly reports on complaints management and learning from closed cases. The time taken to prepare letters from investigation toolkits has increased due to staff vacancies within the customer services team. Action is being taken to mitigate the delay. Scrutiny of issues and responses has also added to response times. Customer Services staff keep complainants updated on progress.

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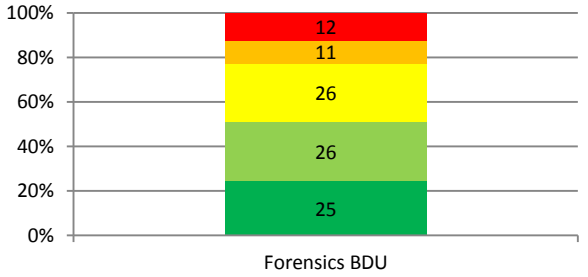
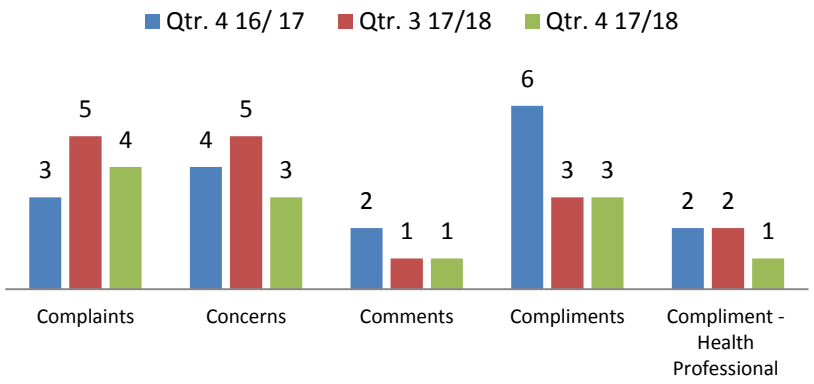


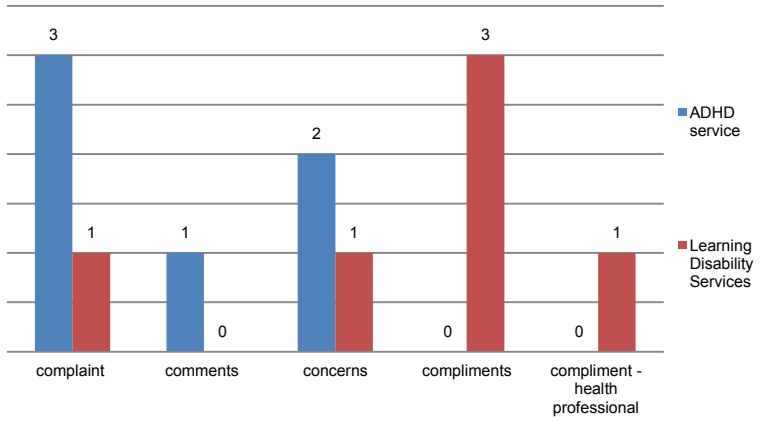

93% of service users would recommend our services.

# Specialist Services Business Delivery Unit excluding CAMHS

## Number of Issues




## Issues by service line




## Learning:

- Service to ensure that a full explanation of the purpose of health records and standards professionals have to adhere to when completing entries is provided to service users. Also to ensure that details are provided for making an addendum if service user is unhappy with information recorded **– ADHD service.**

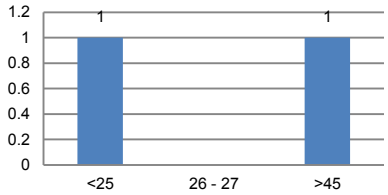
## Top Four Themes

1. **Appointments**
2. **Clinical treatment**
3. **Communications**
4. **Commissioning**

''The care and understanding the service have provided to my family is outstanding. Anyone who has gone through the grief of putting a loved one into a care home will know its one of the hardest things to do''

**Barnsley Intensive Support Team (PLD)**

## Response times

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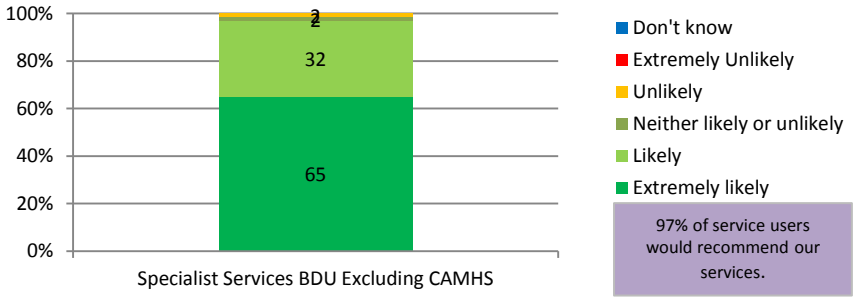
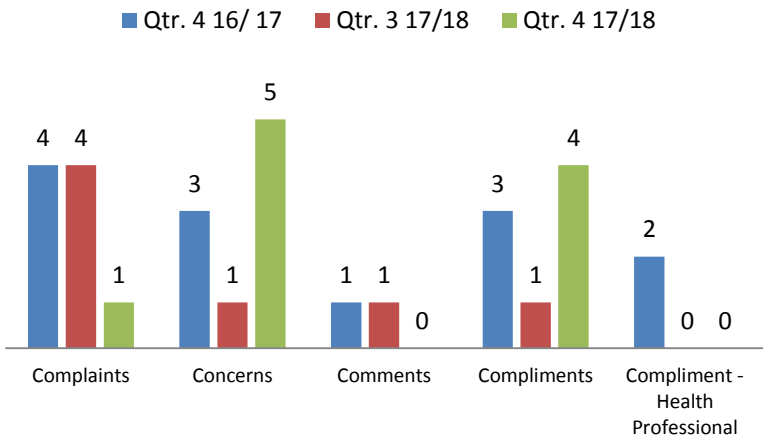



97% of service users would recommend our services.

# Child and Adolescent Mental Health Services - Barnsley

## Number of Issues




## What was good about your experience?

*"Helped me on the right path in my life. Good to have someone to talk to and give advice/help."*

*"Friendly staff, felt I was taken seriously and further advice and help offered."*

*"Therapist calmly went through things with me and gave a clear plan and important advice."*

## What would have made your experience better?

*"A quicker appointment for the next one."*

*"Better parking provision."*

*"Refreshments."*

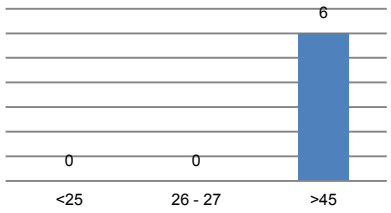
## Learning:

- Service to ensure that benefits of coordinated working with schools is clearly explained so carers and parents have required information to make informed decisions – **CAMHS Barnsley**

## Top Four Themes

1. **Access to treatment and drugs**
2. **Appointments**
3. **Admission and discharge**
4. **Clinical treatment**

## Response times

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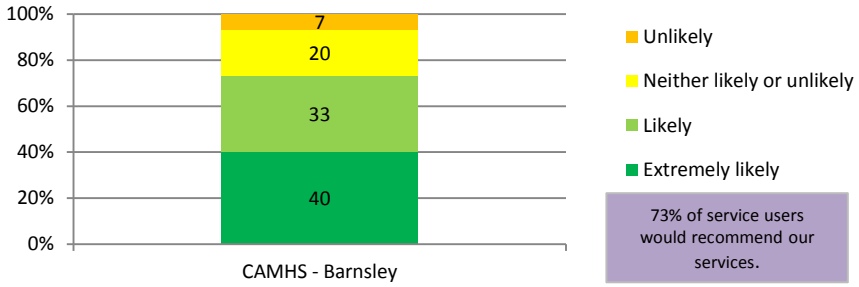
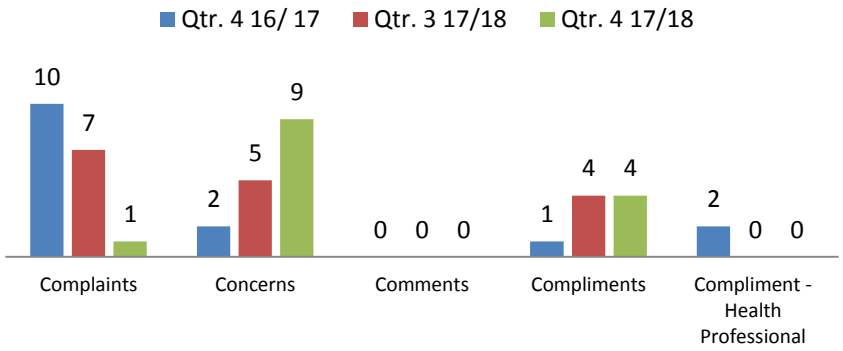



73% of service users would recommend our services.

# Child and Adolescent Mental Health Services – Calderdale & Kirklees

## Number of Issues




## What was good about your experience?

*"Staff were caring, supportive and professional. I was listened to and supported at all times."*

*"Lovely counsellor, easy to talk to, very relaxed. My child was able to discuss her issues."*

*"Being able to let all my fears and worries out, crying without feeling I had to hide my tears."*

## What would have made your experience better?

*"It takes too long to get an appointment."*

*"To have been offered counselling sooner."*

*"Longer course time."*

*"Quicker waiting times for follow up."*

## Learning:

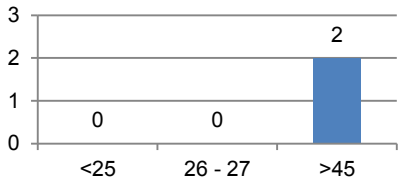
- The service has introduced clinically led rather than medically led screening clinics in an effort to reduce waiting times for assessments **– CAMHS Calderdale.**
- Staff reminded of the importance of clearly communicating with service users and carers any decisions made **– CAMHS Kirklees.**

**Top FiveThemes**

1. Communications
2. Access to treatment or drugs
3. Patient care
4. Appointments
5. Prescribing

''The staff have gone above and beyond to support our son in helping him to understand himself and how he should behave in the world, a world which he has often found confusing''
**CAMHS - Kirklees**

## Response times

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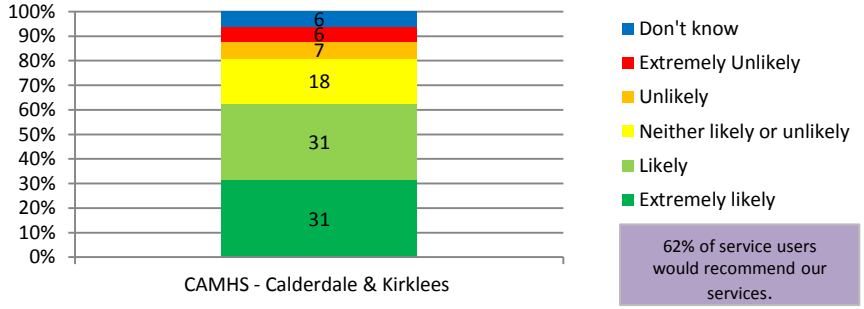
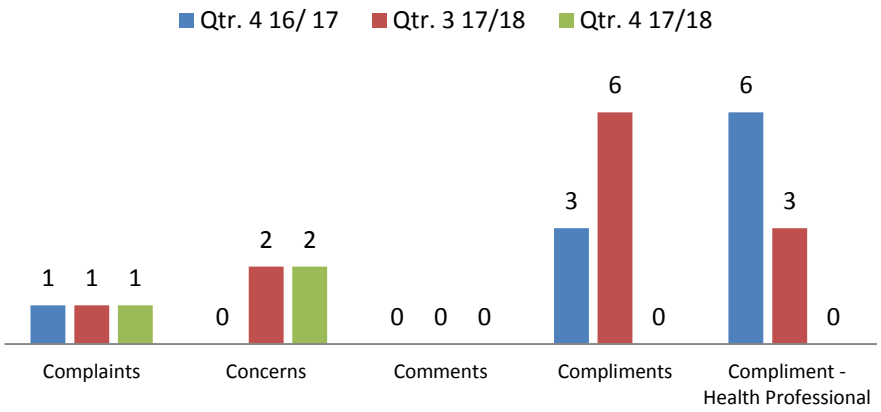



62% of service users would recommend our services.

# Child and Adolescent Mental Health Services - Wakefield

## Number of Issues




## What was good about your experience?

*That we can tell our CAMHS worker how we feel.*

*It calms you down and makes you feel relaxed.*

*Great communication and great listeners.*

## Learning:

- Clear explanation provided by service regarding national funding issues in terms of provision specialist eating disorder services **– CAMHS Crisis Team.**

**Top Two Themes**

1. Access to treatment and drugs
2. Trust admin/policies and procedures

## What would have made your experience better?

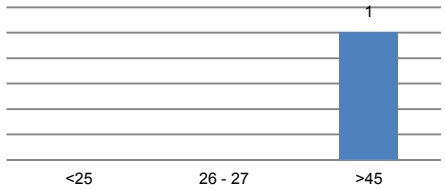
Cut wait times

*"More regular appointments."*

*"Maybe having the option of venue e.g. home visit/college."*

*"More sessions."*

## Response times

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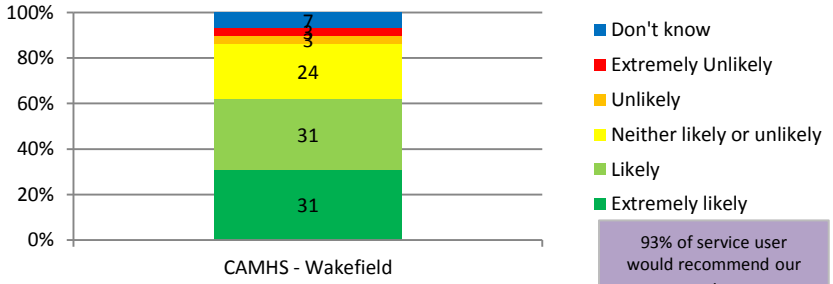
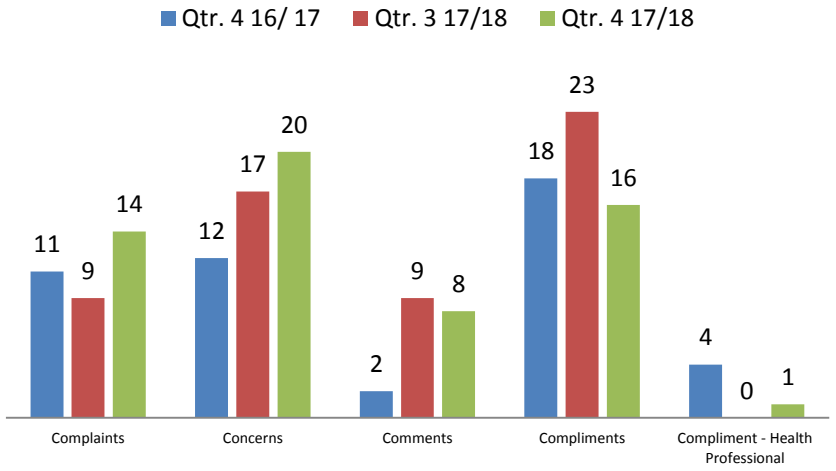


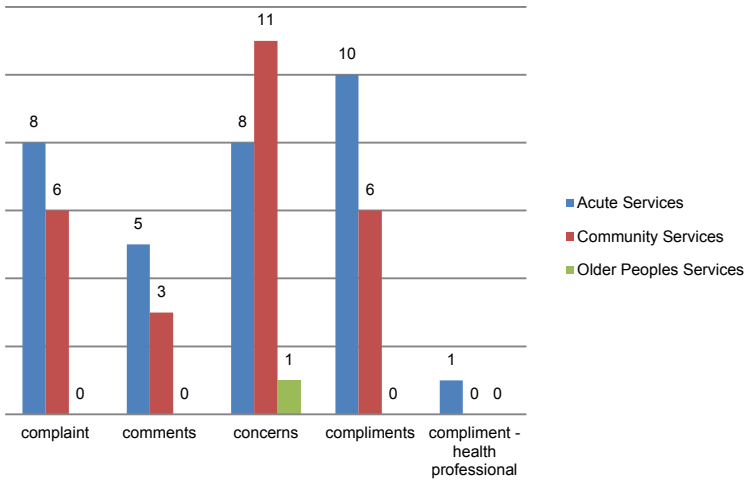

93% of service user would recommend our services.

# Wakefield Business Delivery Unit

## Number of Issues




## Issues by service line




## Learning:

- Service apologised for the lack of clear communication with relative and agreed that this should have been better . Even in the absence of consent from service user the service acknowledge that they could still listen to relatives concerns and provide general feedback **– Walton ward**
- All staff have been reminded of the importance of clearly explaining any information regarding diagnosis to service users, carers and their families and to check understanding of this **– Memory Services**

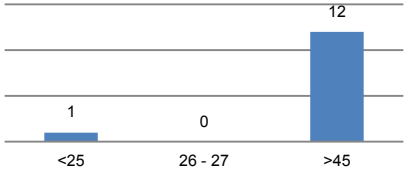
**Top Five Themes**

1. **Access to treatment and drugs**
2. **Communications**
3. **Clinical treatment**
4. **Admission and discharge**
5. **Values and behaviours**

The help and support we received from the service was second to none. We cannot thank them enough. I do not know how we would have coped without their kindness, professionalism and wholehearted support.
**Memory Service**

"You are all amazing and great people, thank you for everything"
**Priory ward**

## Response times

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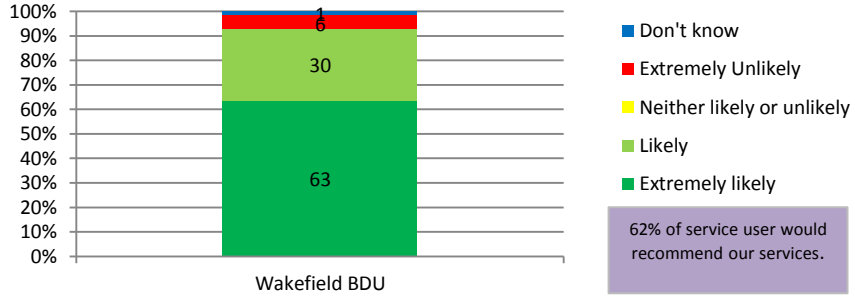


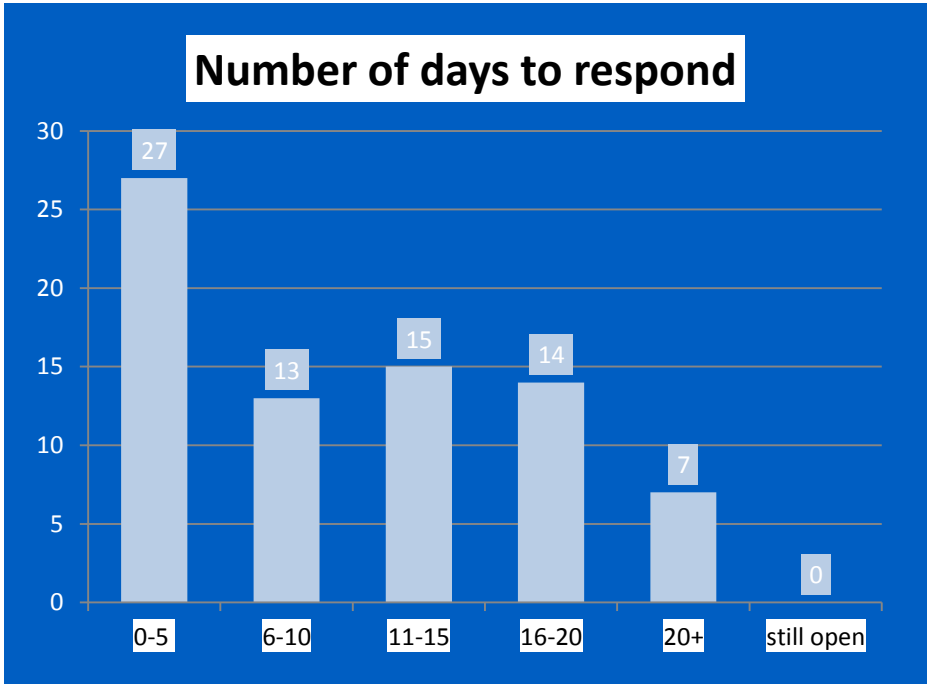

62% of service user would recommend our services.

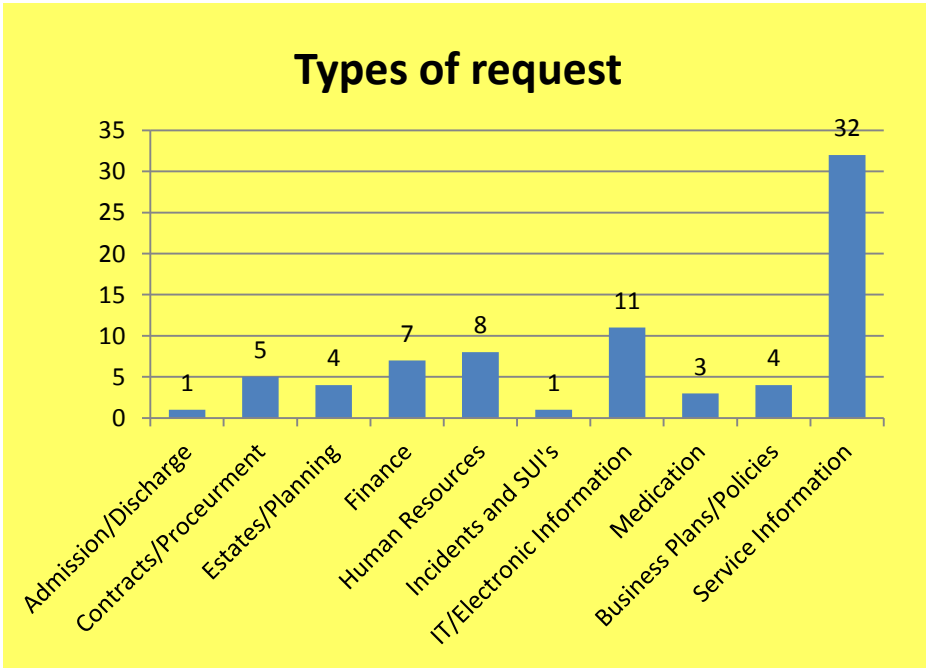
## Freedom of Information requests

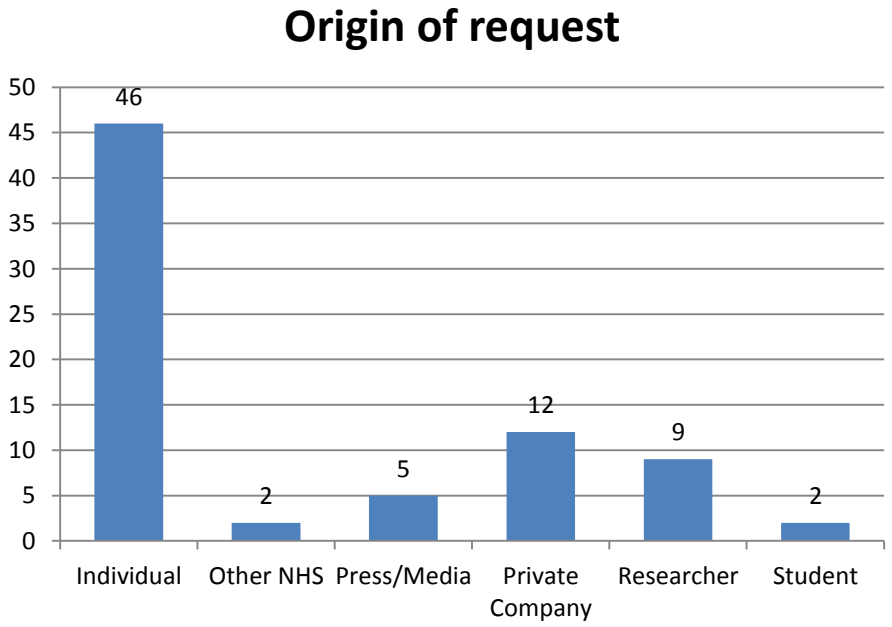
**76** requests to access information under the Freedom of Information Act were processed in Qtr. 4, a decrease on the previous quarter when 84 requests were processed. Most requests were detailed and complex in nature and required significant time to collate an appropriate response working with information owners across Trust services.

During the quarter the following exemptions were applied:

- 2 x The cost of complying would exceed the appropriate limit (Exemption 13(1) )
- 3 x Prejudice to commercial interest (Exemption 43)



South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 8.3

| | |
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| **Title:** | **Safer Staffing Report** |
| **Paper prepared by:** | Director of Nursing and Quality |
| **Purpose:** | This paper builds upon the previous six-monthly papers submitted since July 2014. It outlines the work being done to ensure ward areas provide staffing levels that are safe and effective. |
| **Mission/values:** | Honest, open and transparent, person first and in the centre, improve and be outstanding |
| **Any background papers/ previously considered by:** | Monthly safer staffing exception reports are submitted to the Trust Safer Staffing Group, Executive Management Team and Deputy District Directors. Business case August 2015 and updated paper May 2016 both presented to Executive Management Team. Presented 6 month report to Board 3 October 2017. |
| **Risk appetite** | Failing to maintain safer staffing within the clinical, operational and support services within the Trust is likely to result in risks to service users, staff and other stakeholders. There are also significant reputational risks. The Trust has invested in a safer staffing project to mitigate the risk to supplement existing environmental, procedural and relational solutions and policies and procedures. Capacity and demand are monitored closely and escalation processes in place to maintain safe staffing levels. |
| **Executive summary:** | The national commitment to safer staffing is ongoing and the Trust needs to maintain the progress already made in delivering safer staffing. At a national level, there continues to be key changes around the delivery of this agenda and despite the lead on Safer Staffing having changed to NHS Improvement there has been no definitive publication of Safer Staffing guidance for inpatient Mental Health/LD wards.<br><br>The Trust consistently meets its safer staffing requirement overall with staffing fill rates continuing to exceed 100%, although the planned levels of registered nursing staff are not always met. Safer staffing has been maintained through the high level of commitment from all clinical teams and the implementation of the professional guidance tool. This results in use of existing staff doing additional hours, bank and agency staff. Staff survey and Datix reports suggest concerns remain regarding safer staffing on wards but action throughout 2017 has resulted in increased staffing fill rates, successful recruitment of registered and non-registered staff, significant reduction in agency use and initiatives to respond quickly to areas of need.<br><br>In August 2017 NHS Improvement (NHSi) asked all trusts to complete an audit of care hours per patient day which was completed in October 2017. This will be reported on monthly from May 2018. This and current plans will |

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| | provide the platform from which to explore further workforce initiatives around the quality of care contact time, multi-professional approaches and use of non-registered staff.<br><br>Plans in place **include;**<br>➢ Building upon and improve data in exception reports including;<br>➢ Extending and maximise functionality within current e-rostering system as part of the centralisation programme for the trust staff bank<br>➢ Providing effective and efficient support to meet establishment templates<br>➢ Working closely with 'hotspot' wards where there is pressure on meeting staffing numbers<br>➢ Developing, managing and deploying the peripatetic workforce<br>➢ Working with Quality Leads to review safer staffing in the community and improve understanding and monitoring of direct care contact time<br>➢ Aligning Safer Staffing initiatives with new Trust Workforce Strategy<br>➢ Making effective use of the awarded agency master vendor contract for both Nursing and AHP<br><br>**New plans for Quarters 1 and 2 2018/19, include:**<br>➢ Involvement in the development of a National acuity and staffing resource, to ensure the trust is at the forefront of any developments<br>➢ Develop the Medical Bank capability<br>➢ Expanding the bank to support other areas including admin<br>➢ Interpret and act upon NHSi Care Hours Per Patient Day (CHPPD) statistics as they are reported monthly from May 2018<br>➢ Complete establishment review and share with operational services and OMG as the basis for workforce planning going forward.<br>➢ Ensure recruitment of overseas registered staff to support the ongoing recruitment issues<br>➢ Work with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners)<br><br>**The report was considered by the Clinical Governance & Clinical Safety Committee held on the 17 April 2018. The Committee commented as follows:-**<br>➢ The report provides a comprehensive review of activity relating to the Safer Staffing agenda.<br>➢ The positive work around staff retention through the workforce strategy has contributed to the current position.<br>➢ The increase in HCA vacancies and use of agency was noted. The Committee was assured that plans are in place to address these trends.<br>➢ The plan for enhanced reporting was welcomed and the improved reporting through the IPR during 17/18 was also noted.<br>➢ The regular system of exception reporting of planned vs actual fill rates remains an important part of the routine assurance. |

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| | ➢ The establishment reviews will be an important part of maintaining assurance and the outcome should be included in the next report.<br>➢ The report provided assurance that the Safer Staffing agenda is being addressed appropriately throughout the organisation. |
| **Recommendation:** | **Trust Board is asked to RECEIVE the report as assurance that the organisation is meeting safer staffing requirements.** |

South West Yorkshire Partnership NHS Foundation Trust

# Safer Staffing Report

## Scrutinised at Clinical Governance and Clinical Safety Committee 17 April 2018

Specialist Advisor for Safer Staffing
23 March 2018

Supported by
Deputy Director of Nursing and Quality
Assistant Director of Nursing and Quality

**PURPOSE OF THE PAPER**

This paper provides an update and overview of work undertaken by SWYPT in response to the safer staffing challenge. The paper outlines the work we have undertaken and what our future plans are to ensure that our clinical areas remain appropriately staffed so that they can run safely and effectively. This is an updated version of the safer staffing paper which went to our Trust Board in September 2017. This paper or an updated version of the paper, will be submitted to the April Trust Board, subject to CGCS committee review.

## 1.0 INTRODUCTION

At a national level, there continues to be some key changes around the delivery of this agenda. Interest in safer staffing arose from concerns nationally regarding acute inpatient staffing levels. The Trust is expected to publicly declare staffing fill rates for inpatient settings and the focus of much of the work to date has been on ensuring safer staffing levels on inpatient wards. However, there will continue to be an engagement process within community teams to scope what safer staffing means to them and what support can be provided following transformation processes.

National Health Service Improvement (NHSI) have begun work on providing Safe and Sustainable resource for Mental Health and Learning Disability services through the National Quality Board (NQB). One of the major conclusions is that there needs to be more research carried out in this area. They advise on what areas need to be looked at including the right staff at the right time and in the right place; however they do not provide a formula to calculate workforce or provide specific numbers.

Given this lack of progress in the area of mental health guidance, we continue to utilise our decision support tool adapted previously for our Trust, to look at establishments and rosters on our ward areas. This will also cross reference levels and trends of acuity, fill rates and anomalies such as bespoke care packages.

The Trust continues to maintain accurate and up-to-date information of "composite indicators" on the electronic staff record system (ESR) in relation to the proposed Safer Staffing Indicators as follows:

1. Staff sickness rate, taken from the ESR at the end of February2018;

- *Inpatient areas* –6.4% *compared to the Trust 5.2% (down from 5.9% in August 2017)*

2. The proportion of mandatory training completed at the end of February 2018;

- Inpatient areas: - 86.4% compared to the Trust figure of 86.8% (up from 84.1% in August 2017)

3. Completion of a appraisals at the end of February 2018;

- Inpatient areas – 98.4% compared to the Trust figure of 96.7%

- Staff views on staffing, taken from the 2016 National staff survey measure;

  *Key Finding 14. Staff satisfaction with resourcing and support shows a Trust score of 3.38 from 5 (very satisfied), which is above the national average for Trusts that are combined MH/LD and Community (3.33).*

Based on these indicators, positive findings are evident but we continue to be faced with some challenges. Within SWYPFT, significant financial investments have already been

made since 2014 to develop interventions around the Safer Staffing agenda including increasing some ward establishments following the production of a business case, establishing a peripatetic workforce and centralising the Trust staff bank.

The Trust has also made the decision to combine the function of the Trust staff bank manager with that of the Safer Staffing Project Lead to ensure a consistent and coordinated approach to Safer Staffing.

## 2.0 SUMMARY OF PREVIOUS REPORT AND ACTIONS

In previous safer staffing assurance reports, we identified a need for the following:

### 1. Continue to build upon and improve data in exception reports

Action: Monthly exception reports continue to highlight areas where staffing levels fall below 90% overall and below 80% for Registered-qualified staff. Ward Managers in areas that do not achieve targets are asked to provide updates to help improve our understanding of why we have shortfalls (see fill rates below). Monthly Exception Reports have allowed us to develop an enhanced picture of the inpatient ward areas regarding Safer Staffing. These reports now;

- Utilise the new dashboards for Datix incidents and reporting
- Triangulate DATIX, exception reporting and HR information
- Extend the narrative and analysis of the information
- Provide a trend analysis of fill rates

### 2. Extend and maximise functionality within current e-rostering system as part of the centralisation programme for the Trust staff bank

Action: This has led to the development of a report being sent weekly to the inpatient area Managers and General Managers providing an analysis of each ward's use of the e-roster system. This enables Managers to anticipate and plan for where they could make better use of their available resources and enables them to reflect on the previous week. This provides an understanding of areas which may require support and training to alleviate staffing issues, which can be influenced through the utilisation of current resources which will be expanded on.

### 3. Continue to provide effective and efficient support to meet establishment templates

Action: As well as having established a robust process to look at the appropriateness of the establishment resource for inpatient areas, there is an establishment review due to be completed by March 2018. This will look at Care Hours per Patient Day (CHPPD), fill rates and other indicators. This will inform on any establishment change and whether this template for the area needs to be changed.

This process is supported by the Nursing Directorate and Safer Staffing and follows a robust process including a Risk and Quality Impact Assessment.

### 4. Project Manager to work closely with 'hotspot' wards where there is pressure on meeting staffing numbers

Action: Where wards are experiencing staffing shortfalls for any reason, support is offered through the Project Manager. This has allowed for temporary contracts to be offered through the staff bank as well as the effective deployment of Peripatetic Workers (PWs). This has been particularly effective when dealing with short term anomalies or bespoke care

packages. There is an escalation plan available should areas require additional support to include clinicians in non-clinical roles supporting the area initially on a 9 – 5 basis.

**5. Involvement in the National Performance Advisory Group**

Action: Continued representation within the National Performance Advisory Group for Safer Temporary Staffing, which ensures we are kept abreast and involved in national developments around Safer Staffing. We have recently begun to collaborate with Northern NHS Trusts to get a consensus on reporting and managing safer staffing.

**6. Continue to develop, manage and deploy the peripatetic workforce**

Action: As well as maintaining a central resource which can be deployed across all areas of the trust when required, a significant proportion of these staff have been deployed to act as part of the over establishment strategy within the BDUs. This has had a positive effect on the agency spend within the last financial year.

**7. Support recruitment of Allied Health Professional's (AHP's) and assist in the development of links with Universities**

Action: Although a procurement process was completed which led to the appointment of a Master Vendor and subsequent contract for AHP's within the Trust, this has as yet not had the same positive impact as that of the nurse master vendor contract. This will be influenced from a central point of contact to assess how this is working and what effect this is having on support for the teams utilising this resource.

**8. Support the development of the Trust staff bank to enhance the support offered to all areas within the Trust and continue recruitment onto staff bank**

Action: There continues to be a coordinated recruitment drive within the trust staff bank which responds to the needs of the areas as they arise. This has included recruiting nurses as well as other disciplines. There continues to be ongoing, monthly recruitment of registered and non-registered staff and admin staff.

**9. Establish Safer Staffing Specialist Advisor post on a permanent basis**

Action: This role has now been filled and we will continue to develop this role. At present it includes the aforementioned roles as well as a lead for the centralised values based assessment centres for band 5s, engaging in developments from NHSI and the impact it has on our services as well as supporting the apprenticeship schemes

**10. Support establishment of a cohort of staff on annualised hours within BDUs**

Action: Offer advice and support to ensure that the cohort of annualised hour's staff is seen as part of the recruitment and retention programme within the trust. Establishing communications to ensure there is no unnecessary spend on bank and agency where members of this team are available.

**11. Monitor any NHS Improvement guidance for safer staffing and impact on the trust**

Action: As this guidance has been released, meetings and communication have taken place between the specialist areas identified and Safer Staffing Project Manager. This has resulted in the Trust being able to anticipate any impact this advice would have and respond accordingly. This will continue with the release of any new guidance

## 12. Align Safer Staffing initiatives with new Trust Workforce Strategy

Action: Close co-ordination with the workforce planning team has allowed the Trust to develop a strategy around the numbers of peripatetic staff needed in the Non-Registered workforce to support clinical acuity, which has resulted in a zero vacancy factor within inpatient areas. The projected number of bank staff needed to meet the demands of the inpatient areas is being assessed at present.

## 3.0 ANALYSIS OF FILL RATES September 2017 – January 2018

The Deputy District Directors and EMT receive monthly exception reports on fill rates (figures 1 and 2) within our inpatient areas with particular emphasis on areas where fill rate overall (Registered nurses and nursing support) is below 90%, and where Registered nurses on days or nights falls below 80%. Managers are asked to provide exception reports on why fill rates are not achieved, how it was managed and actions to prevent recurrence.

**Figure 1a.** **Registered Nurse Fill Rate Inpatient Areas per BDU Days**

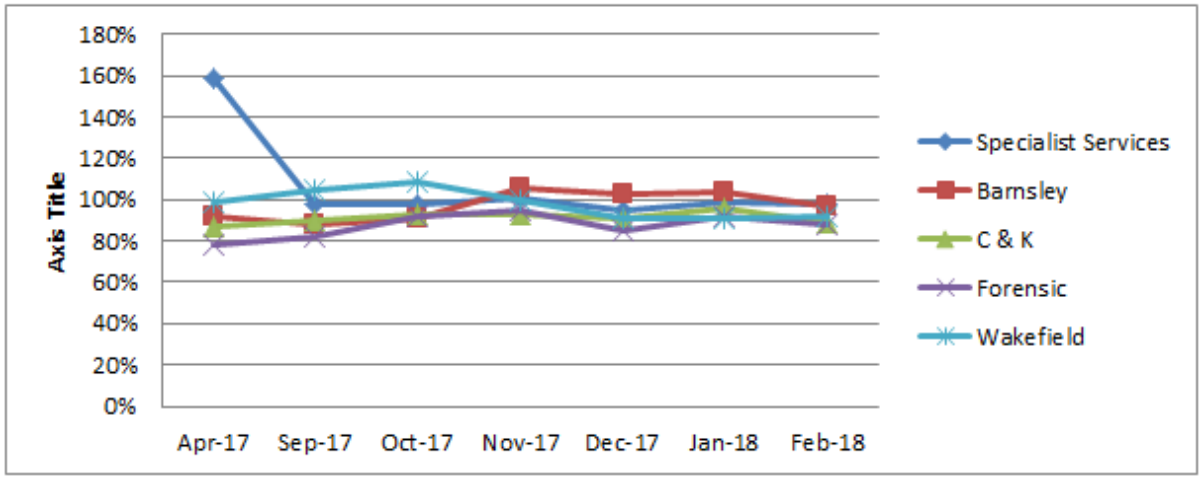



**Figure 1b.** **Registered Nurse Fill Rate Inpatient Areas per BDU Nights**

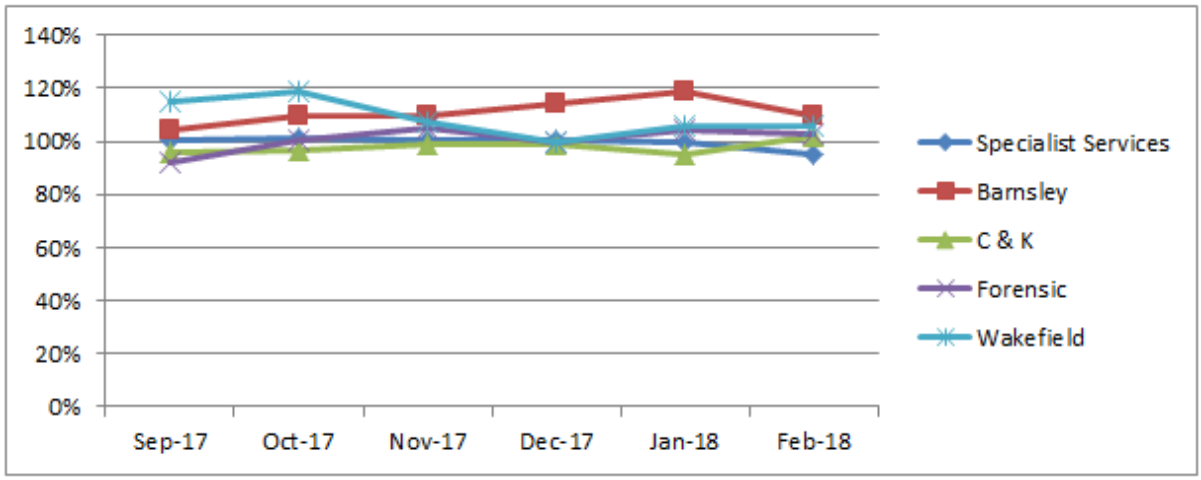
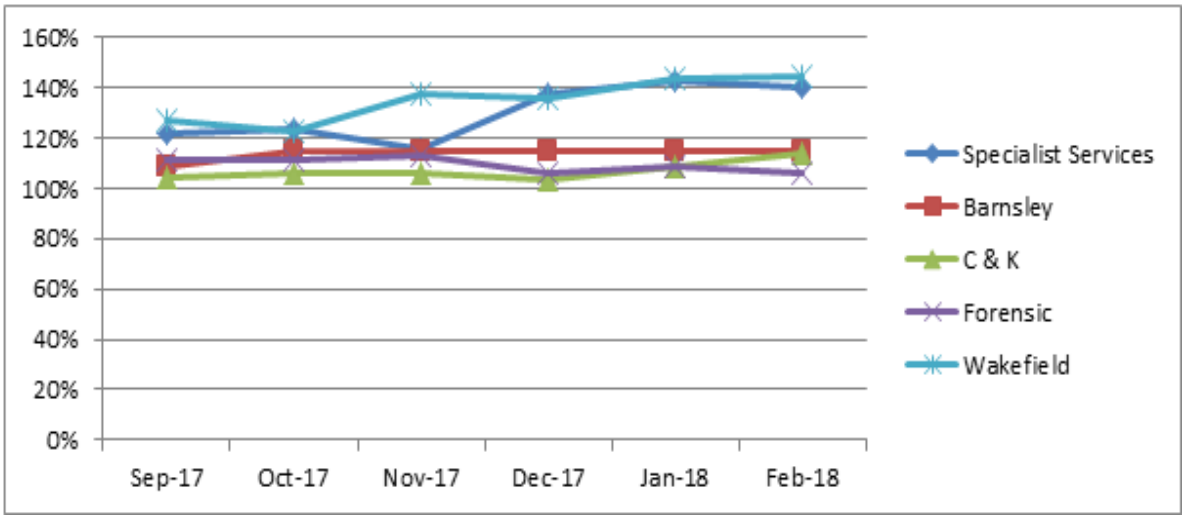


**Figure 2.** **Overall Nurse Fill Rate Inpatient Areas per BDU**




***Summary of fill rates***

Based on above graphs, overall combined fill rates remain above the 100% level and they have remained consistent for both registered and non-registered staff with September showing a slight increase which is in line with our recruitment timeline. They decreased in December which is to be expected due to increased annual leave, sickness and a general reluctance to fulfil bank shifts over the school holiday period. This trend shows a consistency in overall fill rate for registered nurses particularly, which is as a result of our centralised recruitment process where we recruited over 70 registered staff throughout the year. This process continues and has been extended to a centralised process of recruiting band 2's into our Trust.

The majority of wards are achieving the set targets in all three areas with only Chippendale not achieving the registered fill rate for days on a consistent basis. This has been due to a variety of reasons, including supporting other areas within their BDU where a clinical judgement was used to reduce the fill rate to support clinical acuity on other areas. There was also a consistent reduction in the number of filled beds.

To be able to provide a balanced understanding of why some wards are not achieving fill rates, we are looking at introducing the ability for ward areas to cancel a shift as opposed to showing it as an unfilled shift. This would only be an exceptional intervention based on the clinical needs of the ward (e.g. when number of inpatients reduces) and ensuring that there is no negative impact on the Service Users within that area.

Many of the areas continue to achieve the overall fill rate through the use of health care support workers to cover temporary vacancies. Again a strategy for filling the vacancies is being developed and supported constantly. There is also a pattern of a higher fill rate of registered nurses on nights in comparison to days and this is explained in the exception reports as being reflective of a sustained increase in acuity on nights and the need for covering a time span out with the working patterns of other disciplines and senior clinical staff.

***Acuity and additional duties***

There continues to be an upward trend in acuity, which is resulting in the need for more temporary staff. This has led to the bank resource being increased by 35 Registered Nurses as well as 126 Non-Registered Nurses in 2017.

Recent analysis of additional duties has shown a significant demand placed on wards over and above usual staffing establishments. These additional duties were for clinical reasons only and requested in response to increased clinical acuity and demands on staff. Additional duties included special observations of service users (e.g. staff: service user obs; 1-1, 2-1, 3-1), escorting inside and outside of ward, seclusion, special needs and enhanced care packages.

In summary, the review of additional duties found;

- The inpatient wards in SWYPT require 13% more staff than planned
- Inpatient areas are working above bed occupancy expectations by at least 3% overall
- Additional duties required during 2017 in response to clinical acuity equate to 78 HCAs and 10 registered nurses
- Additional duties costs nearly £3 million a year more than planned budget or an additional 12%

As part of our ongoing approach to ensuring that we are utilising our staffing resource optimally the trust has invested in the safe care acuity tool. This is an attachment to the allocate e-roster package which allows the inpatient areas to describe their acuity at multiple times during the day and dictates how many staff are needed to manage this at that given moment in time.

We were looking to introduce this in April/May time when IT capacity ready and with a set of indicators that would be developed by our clinicians utilising models that are currently in practice.

However, following a call with NHSi regarding the trust's CHPPD feedback, this will be placed on hold until the autumn as the trust will be involved in a table top exercise being facilitated by the NHSi. This is to test a set of indicators being developed in conjunction with staffing expert Keith Hurst, which they will then make available to NHS trusts in the autumn. This would allow for a true national acuity and staffing indicator tool.

## 4.0 ANALYSIS OF DATIX INCIDENTS RELATED TO STAFFING

In the 12 months leading up to the 28th February 2018, there were 325 Datix incident reports highlighting staffing issues. Although this is a decrease from the 351 incidents reported in the previous report and it continues to equate to less than one Datix incident per 31 shifts and none in the serious incidents category. This excludes all mid shifts. This decrease has been discussed at the safer staffing meetings and we continue to monitor and adapt the trend and reasoning behind reporting and, equally important, not reporting issues.

## 5.0 PERIPATETIC STAFFING PROJECT

The Safer Staffing Project Manager commenced in post in January 2016. As part of the development of a supplementary workforce, a peripatetic workforce (PW) was developed to enhance flexibility and sustainability of the workforce and giving more opportunities to cover the shortfalls as they arise.

In the interim it was felt that this resource should be locally managed and as a result all apart from a small cohort were transferred into the direct management of the BDUs. This has resulted in the individual wards being over established at times, which has allowed them to cover longer term vacancies in advance with staff that are familiar with the areas and the Service Users.

The centrally held peripatetic workforce remains available for deployment to areas within the trust that are experiencing staffing issues.

## 6.0 CQC INSPECTION AND REPORT ON SAFER STAFFING

The CQC published their re-inspection report in April 2017 following a comprehensive re-inspection of SWYPFT services between November 2016 and February 2017. In relation to safer staffing, the CQC identified that in working age adult and forensic mental health wards, we do not always meet our planned 'appropriate' staffing fill rates. However, they accepted that this was above a 'minimum' staffing fill rate. They also highlighted that the trust has taken significant steps in dealing with what is a national shortage of registered staff.

'The trust demonstrated a commitment to achieve its longer-term plans in relation to the safer staffing fill rate across the trust, the reduction of agency spend, and workforce development, through the implementation of a number of measures that had been further embedded since the last inspection.'

Although we are aware of the current challenges and are exploring every avenue to improve the recruitment and retention of staff, particularly registered staff, the CQC acknowledges that there is minimal impact on the delivery of care within the inpatient areas.

*'However, staff in the acute service continued to report there was insufficient staffing. Some patients on the acute wards and the forensic wards said that section 17 leave did not always take place or one to one meetings due to staffing levels, although there was good evidence, particularly in the forensic services that patients' section 17 leave and meaningful activities took place and was not affected adversely by insufficient staff on the wards'*

The issue of Agency staff having access to our RIO system is being robustly addressed and the majority of agency Registered staff now have access to our systems and Service Users notes. This program shall continue to include any further Registered Staff who are deployed regularly within our trust.

### 6.1 Recruitment since last CQC visit

The Trust has embarked on a centralised recruitment process for both registered and non-registered nursing staff within inpatient areas. Since September 2016 the Trust has held monthly assessment center's to recruit Band 5 nurses. There has been a continued program of recruitment of band 2 staff as well as registered and non-registered staff onto the staff bank. For 2017 the total figures are:

**Substantive Staff:**

| | |
|---|---|
| Registered band 5s | 77 |
| Non Registered band 2s | 34 |

*from April 2017 – February 2018

**Bank Staff:**

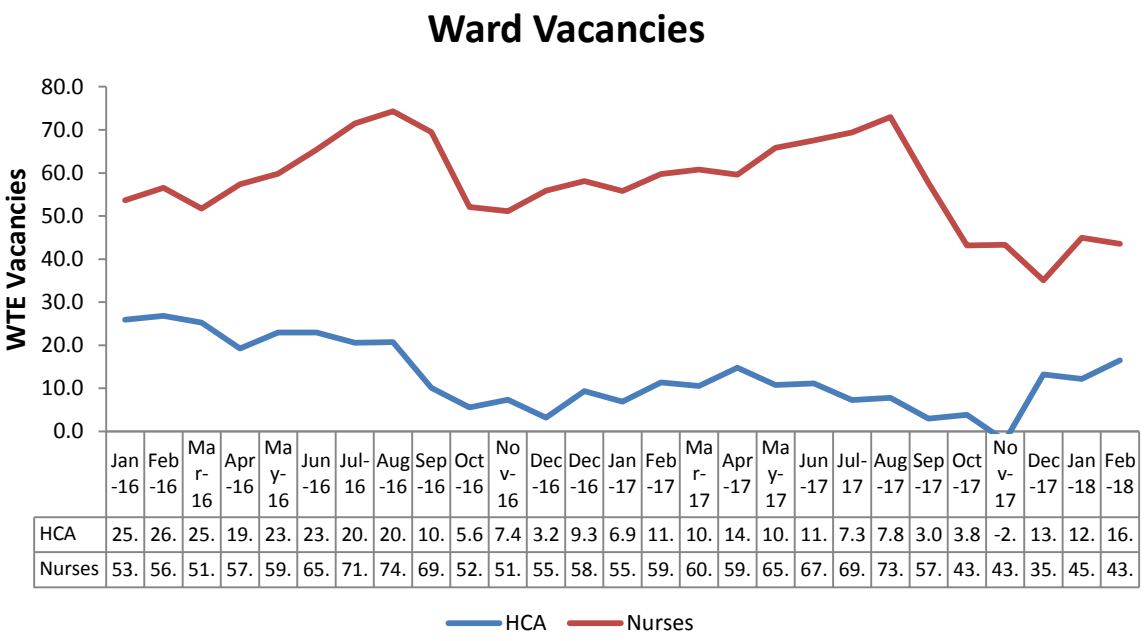
| | |
|---|---|
| Registered band 5s | 35 |
| Non Registered band 2s | 126 |

* For 2017

### 6.2 Retention strategy

As part of a new NHS Improvement initiative, SWYPT has developed a staff retention strategy aimed at improving retention of staff and reducing our turnover rate to 10% from 10.68% by April 2019. This has been shared with and commended by NHSi workforce team and will be shared at safer staffing meetings as part of implementation plan

**Figure 4 Inpatient vacancies**



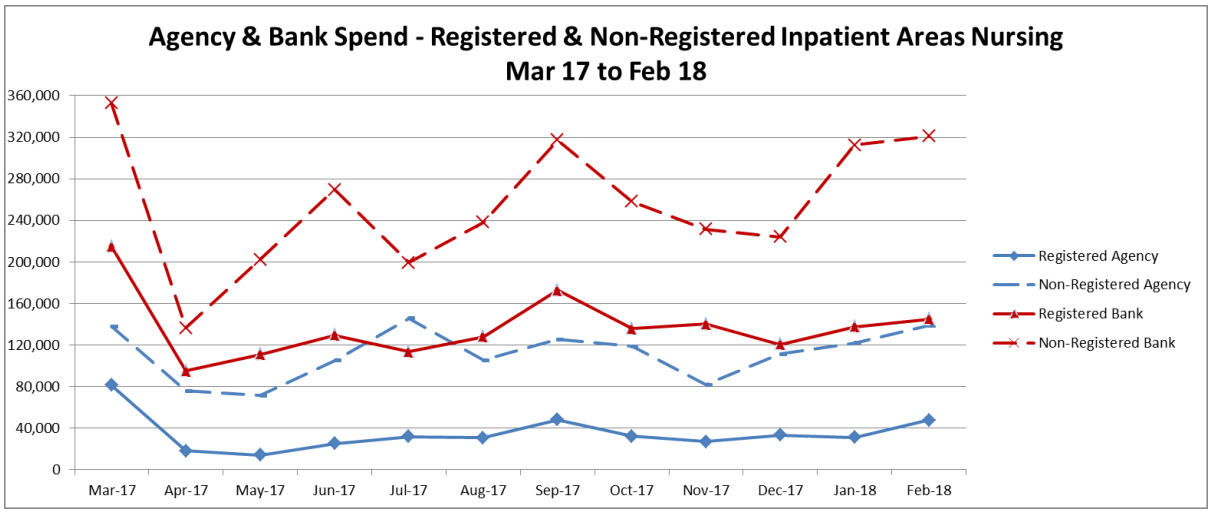

| | Jan -16 | Feb -16 | Mar-16 | Apr -16 | May-16 | Jun -16 | Jul-16 | Aug -16 | Sep -16 | Oct -16 | Nov-16 | Dec -16 | Dec -16 | Jan -17 | Feb -17 | Mar-17 | Apr -17 | May-17 | Jun -17 | Jul-17 | Aug -17 | Sep -17 | Oct -17 | Nov-17 | Dec -17 | Jan -18 | Feb -18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HCA | 25. | 26. | 25. | 19. | 23. | 23. | 20. | 20. | 10. | 5.6 | 7.4 | 3.2 | 9.3 | 6.9 | 11. | 10. | 14. | 10. | 11. | 7.3 | 7.8 | 3.0 | 3.8 | -2. | 13. | 12. | 16. |
| Nurses | 53. | 56. | 51. | 57. | 59. | 65. | 71. | 74. | 69. | 52. | 51. | 55. | 58. | 55. | 59. | 60. | 59. | 65. | 67. | 69. | 73. | 57. | 43. | 43. | 35. | 45. | 43. |

*This chart shows the difference between the budgeted establishment and staff on Health Roster at the end of each month. Staff on maternity leave and long-term sick are not excluded from the staff numbers but those on secondment (e.g. full-time nurse training) are.*

As with most mental health services and inpatient wards across the country, SWYPT experienced a sharp rise in registered nurse vacancies from June to August 2016 and again in 2017. This coincides with the timing of students qualifying and taking up post (Figure 4). There is however a positive downward trend in registered nurse vacancies from 59 in February 2017 to 43 in February 2018.

Figures 5 shows the positive impact that the recruitment drives, new agency vendor, the centralisation and expansion of the bank office and peripatetic workforce has had on the trust agency spend. However, due largely to ward acuity, the use of agency appears to be rising again after a sustained period of progress. Non-registered vacancies have also increased slightly.

**Figure 5 Inpatient Registered and Non-registered Agency Spend**



## 6.2 Safer Staffing in the community

Despite a focus on the inpatient areas there have been numerous discussions around safer staffing in community areas, mainly through transformation projects. There have been meetings between the Specialist Advisor for Safer Staffing and Community teams to initiate the development of an implementation plan and gain an understanding of the safer staffing needs and direction within the individual areas. This shows that the approach needs to be extremely flexible and adaptive to the individual areas.

## 7.0 SUMMARY AND NEXT STEPS

The national commitment to safer staffing is ongoing and SWYPFT need to maintain the progress already made in delivering safer staffing as well as being engaged in the national development of the mental health safer staffing tool and related initiatives.

The Trust currently meets its safer staffing requirement overall, although there is regularly a shortfall in registered nurses and in some areas difficulty in sustaining sufficient numbers in times of increased demands. This has resulted in the use of existing staff, bank and agency staff.

Agency use is down although in recent months there has been an increase, largely due to clinical acuity on the wards.

Planned inpatient staffing numbers rostered onto shifts meet or exceed the requirements for planned, appropriate staffing and measures are in place to manage demand and capacity to ensure our wards are safe.

Despite the achievement and surpassing of planned fill rates, high acuity has led to a significant demand for additional duties equating to 88 more wte staff than budgeted for. This will be reviewed as part of imminent establishment review.

The staff survey and Datix reports suggest concerns remain regarding safer staffing on wards and a more proactive, flexible and sustainable workforce is required to respond to fluctuations in need and demand. The concept of a more peripatetic workforce supported by an enhanced centralised bank staff management system is now established and likely to result in further financial savings whilst providing higher quality staffing and safer care for service users.

Registered nurse vacancies remain a concern but there is a downward trend in the last 12 months.

Two international registered nurses have been offered posts following interview, and more interviews planned.

Medical staffing bank established and due to be piloted form May 2018.

In September 2017 NHS Improvement (NHSi) received our trust's audit of care hours per patient day. This has formed an integral part of our establishment review and indeed we explored these figures for all inpatient areas for 12 months. Current plans will provide the platform from which to explore this and further workforce initiatives around the quality of care, contact time, multi-professional approaches and use of non-registered staff. Plans in place **to continue:**

- Building upon and improve data in exception reports including;
    a. Utilise the new dashboards for Datix incidents and reporting

    b. Triangulation of DATIX, exception reporting and HR information
    c. Extend the narrative and analysis of the information
    d. Weekly roster analysis including unfilled shifts, acuity and bed occupancy
    e. Understanding any significant increase in staffing fill rates
- Extending and maximise functionality within current e-rostering system as part of the centralisation programme for the trust staff bank
- Providing effective and efficient support to meet establishment templates
- Working closely with 'hotspot' wards where there is pressure on meeting staffing numbers
- Developing, managing and deploying the peripatetic workforce
- The Safer Staffing Group, and monitor the action plan and new initiatives
- Working with Quality Leads to review safer staffing in the community and improve understanding and monitoring of direct care contact time
- Recruitment onto staff bank
- Aligning Safer Staffing initiatives with new Trust Workforce Strategy
- Making effective use of the awarded agency master vendor contract for both Nursing and AHP

**New plans for Quarters 1 and 2 2018/19, include:**

- Involvement in the development of a National acuity and staffing resource, to ensure the trust is at the forefront of any developments
- Support establishment of cohorts of staff with annualised hours within BDUs
- Develop the Medical Bank capability
- Review staff bank policy
- Expanding the bank to support other areas including admin
- Interpret and act upon NHSi Care Hours Per Patient Day (CHPPD) statistics as they are reported monthly from May 2018
- Complete establishment review and share with operational services and OMG as the basis for workforce planning going forward.
- Ensure recruitment of overseas registered staff to support the ongoing recruitment issues
- Work with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners)
- Contribute to implementation of SWYPT Retention Strategy

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 9.1

| | |
|---|---|
| **Title:** | **Digital Strategy – Progress Update** |
| **Paper prepared by:** | Director of Finance and Resources<br>Director of Marketing, Communications and Engagement |
| **Purpose:** | To provide an update of the progress being made against the 2017/18 activities included in the Digital Strategy<br>To set out the key activities planned for 2018/19 as part of the delivery of the Digital Strategy. |
| **Mission/values:** | Supports all Trust objectives |
| **Any background papers/ previously considered by:** | Updated Digital strategy approved by the Trust Board in January 2018<br>Trust Board has been provided with regular updates of progress made against the previous separate IM&T and Digital strategies |
| **Executive summary:** | ➢ The Trust has previously operated with both a Digital strategy and a separate IM&T strategy. These have been combined into one effective from January 2018.<br>➢ Progress against the activities agreed for 2017/18 is identified in this report. Key achievements include:<br>  ➢ Refreshed Digital Strategy approved by the Trust Board<br>  ➢ Contract agreed to procure SystmOne for Mental Health services and set up of a dedicated project team<br>  ➢ Completion of the infrastructure modernisation activities as planned for 2017/18<br>  ➢ Rapid deployment of NHS Wifi across the eligible Trust sites during Q4 2017/18<br>  ➢ Clinical portal and integration developments<br>  ➢ The health records scanning bureau have scanned over 12,000 records, in excess of 2.2m pages, since April 2017<br>  ➢ Completion of the business intelligence solution releases 1 and 2<br>  ➢ Attainment of Information Governance Level 2 satisfactory compliance and achievement of the 95% Information Governance Toolkit training target by March 2018.<br>  ➢ £1.7m of capital investment made on the Digital Strategy during the year<br>  ➢ Plans for 2018/19 have been agreed and key activities have been identified in the report. These include:<br>  ➢ Implementation of SystmOne for Mental Health services<br>  ➢ Further work on infrastructure modernisation<br>  ➢ Replacement of existing N3 (NHS-wide national network)<br>  ➢ Actions to enhance cyber security |

| | |
|---|---|
| | ➢ Continue with the actions to support paper light<br>➢ Ensure organisational readiness for and compliance with General Data Protection Regulations (GDPR)<br>➢ Further roll-out of patient appointment reminder system<br>➢ Exploring opportunities from which to make information and services more accessible to our patients, service users and carers.<br><br>**Risk appetite**<br>This paper needs to be considered in line with the Trust risk appetite statement which aims for clinical risk of 1-6 (subject to Board approval). |
| **Recommendation:** | **The Trust Board is asked to NOTE and COMMENT on the update of progress made against the Trust's Digital Strategy.** |
| **Private session:** | Not applicable. |

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# Digital Strategy

## Progress Report

**Head of IT Services & Systems Development**

**April 2018**

With **all of us** in mind.

www.southwestyorkshire.nhs.uk

**Purpose of Report**
The purpose of this report is to inform the Board of the progress and developments made during the last 6 months in respect of the Trust Digital Strategy.

**Summary**
This refreshed Digital Strategy (approved by the Trust Board in January 2018) combines the previous Trust Digital and IM&T strategies into a single document. This is the first update report produced since these strategies were combined. Further work will take place over the course of the first quarter to ensure greater integration and a joint approach to managing the implementation of the strategy

To support the delivery of the Digital Strategy, a milestone delivery plan has been developed which includes 8 cross-cutting domains. These domains map to the 6 key aims of the digital strategy. The cross-cutting delivery domains are: -

1. ***Fit for Purpose IM&T Infrastructure***
   To ensure that the Trust has a strategically aligned, resilient and robust IT infrastructure (network/end user computing hardware and software) which enhances business continuity, disaster recovery capabilities and potential cyber security safeguards for wider organisational assurance.

2. ***Integrated Electronic Care Record System***
   Use technology and information innovatively to make the most effective and efficient use of resources and as an enabler in redesigning services which supports making better use of clinical information systems and integration capabilities.

3. ***Digitisation & Information Sharing with our Partners***
   Successfully work in partnership to deliver an integrated approach to the delivery and sharing of information and technology across the local health community to improve patient care. This also supports wider systems and business process integration so as to remove the requirement for paper records, enabling the Trust to drive forward in becoming paper free by 2020.

4. ***Business Intelligence Systems***
   The use of business intelligence tools to deliver information in a more standardised, user-friendly way via dashboards etc. Such developments aim to increase the use of forecasting, benchmarking and statistical techniques to deliver information rather than data. Sharing information supports the delivery of care, improves data quality and information accuracy and ensures relevant information is shared in a timely and automated way.

5. ***A Skilled & Digitally Enabled Workforce***
   Improve skills within services with all staff having access to or being provided with the appropriate skills to use current and future technologies to meet the changing demands of the organisation and the services we provide.

6. ***Engaging and Learning from Digital Best Practice***
   Sharing and spreading our own digital best practice, learning from what others do nationally and internationally, working with our partners and adopting digital tools that have been tried and tested elsewhere.

7. ***Championing Digital Inclusion for People Accessing our Services***
   Through setting up peer-to-peer projects to help people learn digital skills, putting in place WiFi access for service users, rolling out text message appointment reminders and using digital channels to engage with people more effectively.

8. ***Embedding Digital in our Culture***
   Through hosting digital events, launching a digital challenge on iHub to gather ideas, adopting a digital-by-design approach to service re-design and tenders and piloting the use of digital innovations e.g. apps in clinical practice.

Detailed within this report is a summary of the activities and progress to date over the last six months in respect of the agreed 2017/18 milestones. Below is a summary of the main achievements/work completed during this time period.

- Refreshed Digital Strategy approved by the Trust Board
- Completion of the infrastructure modernisation activities as planned for 2017/18
- Rapid deployment of NHS Wi-Fi across the eligible Trust sites during Q4 2017/18
- Clinical portal and integration developments
- The health records scanning bureau have scanned over 12,000 records, in excess of 2.2m pages, since April 2017
- Completion of the business intelligence solution releases 1 and 2
- Attainment of Information Governance Level 2 satisfactory compliance and achievement of the 95% Information Governance Toolkit training target by March 2018.
- Contract agreed to procure SystmOne for Mental Health services and set up of a dedicated project team

**Financial Investment**

In order to meet the priorities outlined in this report, capital investment of £1.2m was made during 2017/18 and £1.5m has been allocated in 2018/19. The table below provides a summary of the associated expenditure for 2017/18 and the planned capital allocation for 2018/19.

| Scheme | 17/18 (£k) | | 18/19 (£k) |
|---|---|---|---|
| | Allocation | Expenditure | Allocation |
| Mental Health Clinical Records System | 500 | 398 | 828 |
| Pharmacy System | 75 | 70 | 0 |
| Data Centre/Disaster Recovery | 400 | 370 | 400 |
| Infrastructure/WAN | 250 | 240 | 250 |
| Server Hardware Refresh | | | 200 |
| Network Switch Upgrades | | | 250 |
| Business Intelligence Solution | | | 180 |
| Paperlight/Paperless NHS | | | 100 |
| Integration & Portals | 100 | 95 | 0 |
| Inter-operability (Partnership Working) | 100 | 17 | 0 |
| NHS Wi-Fi* | | 372 | 0 |
| Other | 96 | 119 | 170 |
| **Overall Capital Total** | **1,521** | **1,681** | **2,378** |

***NHS WiFi – achieved via National funding allocated in Q4 2017/18**

## *COMPLETED MILESTONES FOR 2017/18 SCHEMES (April 2018 position):*

***Key:***

| | |
|---|---|
| ● | ***Completed activities within the schemes listed against the delivery domains*** |

| ***Domain 1: Fit for Purpose IM&T Infrastructure*** | ***Supports Digital Strategy Aims:***<br>***1. To enhance quality of care and patient safety***<br>***4. To develop an effective and digitally empowered workforce***<br>***5. To maximise efficiency and sustainability*** |
|---|---|

**Trust Issued Smartphones**

| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|---|---|---|---|
| ● | **Purpose:** Continued issuance and support for the wider deployment of Trust smartphones where requested and approved operationally. This further supports the digital agenda and follows on from the completed replacement of 600+ BlackBerry devices previously reported.<br><br>**Key Activities:**<br>➢ The number of Trust-issued smartphones has grown significantly since the completion of the initial rollout, where in excess of 600 devices were replaced. As at March 2018, there are now 775 Trust-issued smartphones in use. It is anticipated that demand is likely to grow further over the next 12 months as more business/clinical focused apps become available and new solutions come to market offering potential cost savings elsewhere, for example smartphone based lone worker solution and alternatives to traditional Pagers. The issue of smartphones is now conducted under business as usual operations.<br><br>**Outcomes Achieved:**<br>➢ Allows staff to utilise apps approved for use by the Trust in support of the digital agenda. | ***Q3-Q4 2017/18*** | ***Q4 2017/18*** |

| Infrastructure Modernisation Programme - Phase 3: Data Centre Improvements (Year 1) | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** This is year 1 of a 3-year programme of work that focuses on the review and modernisation of the Trust's core IT infrastructure and the two existing data centres located at Fieldhead and Kendray. The purpose is to provide a strategic, robust and secure IT environment, removing single points of failure, which therefore provides the Trust with the necessary assurances, business resilience and disaster recovery capabilities to support the digital future. The business case for this programme was approved by the Trust in July 2017.<br><br>**Key Activities:**<br>➢ Completion of the year 1 capital investments for data centre/disaster recovery and infrastructure/wide area network (WAN) capital schemes. All works and activities were completed by 31 March 2018 as planned.<br><br>**Outcomes Achieved:**<br>➢ There is no requirement for short term investment in the event of a disaster as partial measures have been put in place. Network equipment remains to be fully configured during 18/19 to further improve resilience coverage and disaster recovery capabilities.<br>➢ Improving resilience of core IT infrastructure.<br>➢ Improving end user experience. | **Q2-Q4 2017/18** | **Q4 2017/18** |

| Microsoft Licensing Agreement Usage Review | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** To conduct a review of the Trust's requirements for Microsoft products based on usage with a view to reducing/rationalising existing Trust license volumes where possible. This review will also explore the most appropriate and cost effective way forward for continued provision and access to Microsoft products as used by the Trust. This follows on from the commencement of the Trust's 3-year Enterprise Wide Agreement (EWA) with Microsoft for software licenses established on 1 July 2017.<br><br>**Key Activities:**<br>➢ An annual review process has been established to review and rationalise the number of end user computing devices and associated licenses. Licence requirements have reduced by 400 compared to the base case.<br><br>➢ A mechanism for BDUs to fund any additional licensing requirements has been established, e.g. inclusion of licensing requirements within service tender bid opportunities.<br><br>**Outcomes Achieved:**<br>➢ Provided a migration path from which to move away from software versions approaching end of life support, thus reducing associated risks (cyber security threats etc.)<br>➢ Provided the Trust with secured pricing through to June 2020 and allows the Trust to increase or decrease quantities at annual anniversaries without impacting unit cost. | ***From Q2 2017/18***<br><br>***From Q3 2017/18*** | ***Q4 2017/18***<br><br>***Q3 2017/18*** |

| | | | |
|---|---|---|---|
| | ➢ Supports the infrastructure modernisation programme which will serve to add resilience and improve performance for end users. | | |

## Cyber Security & Threat Monitoring

| Status | Description | Milestone | Achieved |
|---|---|---|---|
| | **Purpose:** The potential threat of cyber-attack is on the increase as witnessed by the WannaCry incident in May 2017, where a number of public sector/NHS and private sector organisations' business operations were impacted. Although on this occasion we were not impacted by this cyber outbreak, the Trust continues to take such threats extremely seriously and has established a number of steps to safeguard against such threats. The controls and measures in place are summarised below: - | | |
| | **Key Activities:** | | |
| | ➢ Cyber threat monitoring has been incorporated into the monthly review meetings with Daisy IT Services. The Trust routinely reviews the actions taken or required to be taken to mitigate and establish safeguards against the threat of cyber-attacks. | ***From July 2017*** | ***Q4 2018*** |
| | ➢ The Trust has actively engaged in cyber awareness and collaboration opportunities with Daisy IT Services along with our partners across the wider sustainability and transformation partnership (STP) footprints and with NHS Digital. | ***Throughout 2017/18*** | ***Q4 2018*** |
| | ➢ The Trust IT Service in conjunction with Daisy has reviewed the current infrastructure, solutions, tools and processes in line with Cyber Essentials (recognised industry standard) developed by UK Government and industry in 2014. A number of workshops have been held between Daisy and Trust IT Services and the findings and recommendations will inform ongoing strategic IT infrastructure roadmap planning and the detailed IT programme of works for 2018/19. | ***Q4 2017/18*** | ***Q4 2018*** |
| | ➢ Cyber security survey was issued during September 2017 to Trust staff to gauge awareness and understanding. The findings did not highlight any general areas of concern or note for wider staff education. | ***September 2017*** | ***October 2017*** |
| | **Outcomes Achieved:**<br>➢ Continued vigilance and awareness of the threat of cyber-attack.<br>➢ Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats and adoption of industry standard best practices, as appropriate. | | |

## Email Mailbox Limits (5Gb)

| Status | Description | Milestone | Achieved |
|---|---|---|---|
| | **Purpose:** The Trust needs to introduce mailbox size limits to ensure overall performance of email accounts for users is within acceptable levels. The introduction of a 5GB limit is a starting point and it is expected that this be reduced further in the future. This work is a pre-cursor to the future review of the Trust email platform that is planned for 2019/20. | | |

| | | | |
|---|---|---|---|
| | **Activities:**<br>➢ Communications have been issued to staff and the email mailbox limits are being set to a maximum of 5GB.<br>➢ Clinics and focus sessions provided to enable staff to make the best use of available resources and to promote best practice recommendations.<br>➢ Further general and targeted communications published, including offering of training prior to mailbox limits being imposed.<br>➢ Targeted communications and lists of staff whose mailboxes exceed the 5GB limit have been supplied to the Executive Management Team (EMT) for awareness.<br><br>This project is now complete. Ongoing mailbox monitoring will be through business as usual activities.<br><br>**Outcomes Achieved:**<br>➢ Good practice and readiness for the future.<br>➢ Helps to ensure that end user experience and email performance is maintained within acceptable levels.<br>➢ Ensures that consideration of the future email platform and requirements is cost effective. | ***From Q2 2017/18***<br>***From Q3 2017/18***<br>***From Q3 2017/18***<br>***From Q4 2017/18*** | ***Q3 2017/18***<br>***Q4 2018***<br>***Q4 2018***<br>***Q4 2018*** |

| ***Domain 2: Integrated Electronic Care Record System*** | ***Supports Digital Strategy Aims:***<br>***1. To enhance quality of care and patient safety***<br>***3. To foster integration, partnership and working together***<br>***5. To maximise efficiency and sustainability***<br>***6. To support people and communities*** |
|---|---|

| **Clinical Portal Development** | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
| | **Purpose:** Enables the Trust to bring together information from different clinical information systems such as RiO and SystmOne into a single integrated record view, enhancing the care we provide through improved information accessibility and reducing the time staff spend locating the clinical information they need.<br><br>**Activities:**<br>➢ The Trust's clinical portal (named PORTIA) deployment by initial early adopter services (circa 50 staff) was completed in December 2017, with the target of 500 patient records having been viewed and the information contained within the viewed records verified. General feedback received from staff within early adopter services was that training requirements were relatively low. PORTIA went live on 1 January 2018. | ***Q2/Q3 2017/18*** | ***Q3 2017/18*** |

| | | | |
|---|---|---|---|
| | ➢ At present over 350 staff have access to PORTIA. Over 4,300 patient record searches have been conducted and deployment will continue during Q1-Q2 2018/19.<br><br>➢ Interface developments providing additional data sources to feed into and enrich the PORTIA record have been completed, namely: -<br>▪ Health records scanning system (Trust-wide).<br>▪ Community equipment system (Barnsley).<br>▪ Medical Interoperability Gateway (MIG).<br><br>**Outcomes Achieved:**<br>➢ Provision of a single integrated holistic patient record view.<br>➢ Sourcing data from Trust internal systems, reducing the need to access multiple systems and moving forward from partner systems.<br>➢ Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. | ***Q4 2017/18***<br><br>***Q4 2017/18*** | ***Q4 2017/18***<br><br>***Q4 2017/18*** |
| **eCorrespondence** | | | |
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
| | **Purpose:** Enables the Trust to reduce the reliance and flow of paper both internally and with our partners in respect of delivering patient care. This also supports the digitisation agenda and the drive towards a paperlight/paperless NHS by 2020.<br><br>**Activities:**<br>➢ eDischarge: The creation of electronic discharge summaries generated from RiO. These allow the Trust to send information to GP practices via secure electronic transfer of encrypted eDischarge summary messages (for inpatient ward areas only at this stage).<br>▪ The Trust went live during October 2017 with eDischarge messaging following extensive testing with nominated GP practices.<br>▪ Engagement and communications with CCGs has been undertaken to raise awareness and garner support.<br>▪ 151 eDischarge messages have been successfully sent to and received by GP practices as at 31 March 2018.<br><br>**Outcomes Achieved:**<br>➢ Supports the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs.<br>➢ Potential to improve ongoing client care through the provision of discharge information to GPs in a much improved timeframe.<br>➢ Ability to send discharge letters etc. electronically rather than traditional printing/posting channels. | ***Q3 2017/18*** | ***Q3 2017/18*** |
| **Clinical Systems for Community Services (SystmOne)** | | | |

| Status | Description | Milestone | Achieved |
|---|---|---|---|
| | **Purpose:** Development of SystmOne to support Community Services development priorities, service re-design and new models of care agendas.<br><br>**Activities:**<br>➢ Integrated Intermediate Care Service<br>▪ Completion of the 'lift and shift' of the transition wards from Mount Vernon Hospital to Barnsley Hospital on 4 September 2017 as planned.<br>▪ Completion of the transfer of the transition ward from SWYPFT to BHNFT responsibility on 1 December 2017 as planned.<br><br>➢ Mental Health Navigators (Wakefield)<br>▪ The Mental Health Primary Care Navigators went live on SystmOne in December 2017 as part of a new model of care to support integrated working across Wakefield.<br><br>➢ Musculoskeletal Service (Barnsley)<br>▪ The revised service specification introduced a new service model which commenced from 1 April 2018. A mobilisation group was established to co-ordinate the service changes completed.<br><br>➢ Diabetes Service (Barnsley – BHNFT)<br>▪ The transfer of the clinical information system used by the service (SystmOne). This transfer will take place on 13 April 2018 and interim arrangements will allow system access to remain in place to ensure continuity of service and minimise any risks to patients.<br><br>**Outcomes Achieved:**<br>➢ To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information.<br>➢ To support the development of new integrated models of care. | ***Q2 2017/18***<br>***Q3 2017/18***<br><br>***Q3 2017/18***<br><br>***Q4 2017/18***<br><br>***Q4 2017/18*** | ***Q2 2017/18***<br>***Q3 2017/18***<br><br>***Q3 2017/18***<br><br>***Q4 2017/18***<br><br>***Q4 2017/18*** |

## Mental Health Clinical Records System Procurement/Commercial (SystmOne)

| Status | Description | Milestone | Achieved |
|---|---|---|---|
| | **Purpose:** To conclude the procurement and contractual activities to enable the Trust to progress the work to oversee the planning and implementation of the new mental health system (SystmOne). This is a major change initiative and an identified priority for both 2017/18 and 2018/19.<br><br>**Activities:**<br>➢ The formal contractual negotiations with the preferred supplier (TPP) were completed to enable the implementation activities to commence in support of the move from RiO to SystmOne.<br><br>➢ The Trust has invoked the optional additional 12 month contract extension for continued provision and | ***Q3 2017/18***<br><br>***Q4*** | ***Q3 2017/18***<br><br>***Q4*** |

| | | | |
|---|---|---|---|
| | support of RiO covering 1 April 2018 to 31 March 2019.<br><br>➢ Data extract requirements agreed with RiO supplier Servelec.<br><br>➢ Detailed and protracted discussions between the Trust and TPP concluded in support of data migration activities. Initial data extract activities have commenced (w/c 2/4/2018).<br><br>**Outcomes Achieved:**<br>➢ To ensure that the Trust has appropriate contractual arrangements in place to support both the implementation of SystmOne and also the continued support/maintenance of RiO during 2018/19. | ***2017/18***<br><br>***Q4 2017/18***<br>***Q4 2017/18*** | ***2017/18***<br><br>***Q4 2017/18***<br>***Q4 2017/18*** |

| **Legacy Systems Data Repatriation** | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
| | **Purpose:** Data repatriation of historic iPM and SAP system data previously held by NHS Digital/National Programme. This forms part of the decommissioning activities of the former Connecting for Health programme and data from systems that were deployed previously by NHS Barnsley and where SWYPFT was the incumbent data controller organisation. This work has been completed. | ***Q3 2017/18*** | ***Q4 2017/18*** |

| ***Domain 3: Digitisation & Information Sharing with our Partners*** | ***Supports Digital Strategy Aims:***<br>***1. To enhance quality of care and patient safety***<br>***2. To enable prevention, wellbeing and recovery***<br>***3. To foster integration, partnership and working together***<br>***4. To develop an effective and digitally empowered workforce***<br>***5. To maximise efficiency and sustainability***<br>***6. To support people and communities*** |
|---|---|

| **Digital Maturity Index Refresh** | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
| | **Purpose:** The Digital Maturity Self-Assessment was developed in 2015 to support the identification of key strengths and gaps in providers' digital capabilities. Since publishing the first round of results in April 2016, NHS England and NHS Improvement have worked with a range of stakeholders to update the self-assessment and have requested a refresh to capture progress made over the last 18 months.<br><br>**Activities:**<br>➢ A refresh of the Trust Digital Maturity Index self-assessment was completed and submitted prior to the 20 | ***October*** | ***October*** |

| | | | |
|---|---|---|---|
| | October 2017 deadline. This update was reported to EMT prior to formal submission.<br><br>**Outcomes Achieved:**<br>• Refreshed Trust Digital Maturity Index self-assessment completed. | ***2017*** | ***2017*** |

| **Records Management (Scanning – Archive/Paper Records)** | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** To develop the onsite scanning bureau and work towards meeting the 2020 paper free target.<br><br>**Activities:**<br>➢ During 2017/18 over 12,000 records have been scanned, consisting of 2.2m pages.<br><br>➢ Establishment of a test and training environment has been completed.<br><br>➢ Integration work between the Trust clinical portal (PORTIA) and the records scanning solution has concluded. This will be rolled out as part of the PORTIA deployment activities during Q1 2018/19.<br><br>**Outcomes Achieved:**<br>➢ Reduced reliance on off-site storage (avoidance of increased costs).<br>➢ Improved electronic access to all records related to a Trust client, supporting digital and paperless NHS agendas. | ***Q1-Q4 2017/18***<br>***Q2 2017/18***<br>***Q4 2017/18*** | ***Q4 2017/18***<br>***Q2 2017/18***<br>***Q4 2017/18*** |

| ***Domain 4: Business Intelligence Systems*** | ***Supports Digital Strategy Aims:***<br>***3. To foster integration, partnership and working together***<br>***5. To maximise efficiency and sustainability*** |
|---|---|

| **Business Intelligence / Data warehouse (information hub & dashboards)** | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** The development of a business intelligence/data warehouse that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service improvements and delivery.<br><br>**Activities:**<br>➢ Business Intelligence Release 1: Operational (whiteboard) and analytic (trend/summary) reports are now available for intensive home based treatment teams and working age adult acute wards. | ***Q1 2017/18*** | ***Q4 2017/18*** |

| | | | |
|---|---|---|---|
| | ➢ Business Intelligence Release 2 – Datix-based release: Mortality reporting developed bringing together data from Rio, SystmOne and Datix to support patient safety team in learning from deaths.<br><br>➢ New S.W.I.F.T site (South West Information for Teams) launched via Trust intranet, providing single portal for all business intelligence reporting.<br><br>➢ Engagement activities taking place to increase awareness and usage of business intelligence reporting.<br><br>**Outcomes Achieved:**<br>➢ Continue to improve and make available the use of real time information to support operational services and transformation agendas. | ***Q2 2017/18***<br><br>***Q3 2017/18***<br><br>***Q1-Q4 2017/18*** | ***Q2 2017/18***<br><br>***Q3 2017/18***<br><br>***Q4 2017/18*** |
| **Information Governance** | | | |
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** To ensure that the Trust achieves compliance with its Information Governance (IG) responsibilities and statutory obligations. General Data Protection Regulations (GDPR) is the new legal framework in the EU that will take effect from 25 May 2018. The regulations enhance data subjects' rights, introducing new rules that govern how data is collected, processed, shared and retained. Organisations will have significantly more legal liability if they are responsible for a breach with fines increased substantially compared to those currently in operation.<br><br>**Activities:**<br>➢ Information Governance Training: NHS Digital released the new e-learning solution for information governance training at the end of July 2017 which is available via ESR. Classroom based IG training was provided for staff groups who do not have ready access to a computer. The 95% target was achieved by 6 March 2018.<br><br>➢ Information Governance Toolkit: The 2017/18 toolkit was released in mid-July 2017.<br>▪ An interim submission was completed in October 2017 within required timescales.<br>▪ The toolkit audit was completed in March 2018 with the outcome being significant assurance opinion received. The final submission obtaining level 2 satisfactory compliance was achieved.<br><br>➢ GDPR: A project plan is in place to ensure the Trust meets the requirements of GDPR.<br><br>**Outcomes Achieved:**<br>➢ Mandatory Information Governance Training target is achieved.<br>➢ Information Governance Toolkit target of level 2 compliance is maintained.<br>➢ Preparedness for the GDPR is assured and processes established to ensure compliance. | ***Q2-Q4 2017/18***<br><br>***October 2017 March 2018***<br><br>***Q4 20-17/18*** | ***Q4 2017/18***<br><br>***October 2017 March 2018***<br><br>***Q4 2017/18*** |

| Domain 5: A Skilled & Digitally Enabled Workforce | Supports Digital Strategy Aims:<br>4. To develop an effective and digitally empowered workforce |
|---|---|

## Clinical Information Systems Training (Business as Usual/Operational)

| Status | Description | Milestone | Achieved |
|---|---|---|---|
|  | **Purpose:** Provision of role-based clinical information systems training programme/schedule in relation to RiO and SystmOne.<br><br>**Activities:**<br>➢ To address how training can be provided to junior doctors, discussions were held with the Medical Staffing Team and an approach agreed.<br><br>➢ A schedule of operational clinical information systems training for RiO and SystmOne.<br><br>**Outcomes Achieved:**<br>➢ Customer focused training provided to staff.<br>➢ Improved availability of training across each locality making it easier for staff to access or attend training sessions.<br>➢ A more responsive approach to meeting front-line services training needs.<br>➢ Ability to record training attendance/completion the Trust's eLearning system which enables training histories to be recorded against the staff record. | ***Q1 2017/18***<br><br>***Q1-Q4 2017/18*** | ***Q1 2017/18***<br><br>***Q4 2017/18*** |

## Intranet Development

| Status | Description | Milestone | Achieved |
|---|---|---|---|
|  | **Purpose:** To ensure that the Trust corporate Intranet is developed, maintained and services/information is accessible across the workforce.<br><br>**Key Activities:**<br>➢ A number of intranet maintenance and operational issues have been resolved during recent months.<br><br>**Outcomes Achieved:**<br>➢ To improve access to corporate systems and information in a timely and responsive manner. | ***Q3-Q4 2017/18*** | ***Q4 2017/18*** |

| Domain 6: Engaging and Learning from Digital Best Practice | *Supports Digital Strategy Aims:*<br>*1. To enhance quality of care and patient safety*<br>*2. To enable prevention, wellbeing and recovery*<br>*3. To foster integration, partnership and working together*<br>*4. To develop an effective and digitally empowered workforce*<br>*5. To maximise efficiency and sustainability*<br>*6. To support people and communities* |
|---|---|

| **Public Sector Wi-Fi Access (Govroam)** | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** The govroam service solution is now being actively implemented by public sector organisations. This solution provides SWYPFT network connectivity for staff when working out of non-Trust sites e.g. local authority/NHS sites where Wi-Fi is not currently available.<br><br>**Key Activities:**<br>➢ The implementation of Govroam was completed on Trust sites during December 2017 with additional testing activities completed during Q4 2017/18 to ensure that the solution works at other partner locations (e.g. Mid-Yorks sites) for SWYPFT staff.<br><br>**Outcomes Achieved:**<br>➢ Improved ability for agile and remote working that allows staff to access the Trust network and corporate systems when working in partner organisation sites. This further supports the Local Digital Roadmap (LDR) plans and aspirations of STPs, demonstrating our commitment to joint working and in meeting commissioner intentions. | ***Q3-Q4 2017/18*** | ***Q4 2017/18*** |

| **Service User Internet Access (Forensic Unit Pilot)** | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** To showcase the outcomes and finding of the Trust pilot deployment of service user internet access within the Forensics Service at the end of 2016/17. This initiative was a pre-cursor for the wider deployment of patient/service user Wi-Fi access, under the NHS Wi-Fi scheme.<br><br>**Activities:**<br>➢ Work undertaken with NHS Digital to produce a video that showcases the Trust deployment of service user Wi-Fi access within the pilot Forensics unit, as a NHS Digital good practice case study re digital inclusion.<br><br>**Outcomes Achieved:**<br>➢ Improves the overall patient experience.<br>➢ Demonstrates good practice.<br>➢ Promotes digital inclusion. | ***Q4 2017/18*** | ***Q4 2017/18*** |

| ***Domain 7: Championing Digital Inclusion for People Accessing our Services*** | ***Supports Digital Strategy Aims:***<br>***1. To enhance quality of care and patient safety***<br>***2. To enable prevention, wellbeing and recovery***<br>***3. To foster integration, partnership and working together***<br>***4. To develop an effective and digitally empowered workforce***<br>***5. To maximise efficiency and sustainability***<br>***6. To support people and communities*** |
|---|---|

| **Trust Wide Service User Internet Access (NHS WiFi)** | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** To implement the NHS Wi-Fi capability across the Trust providing patients/service users and the public, with access to the internet etc. The deployment of NHS Wi-Fi provides access in all Trust locations that has frequent patient contact. This builds on the initial pilot deployment completed within the Forensic unit at the end of 2016/17.<br><br>**Activities:**<br>➢ The Trust was successful in gaining fast follower status for the deployment of NHS WiFi across the Trust estate which was confirmed in January 2018. The fast follower status came with extremely tight timescales which caveated the completion of the work and call down/spend of centrally allocated monies by 31 March 2018. The Trust was categorised as a large organisation so was allocated the maximum one-off capital allocation of £350k during 2017/18.<br>▪ The solution has been installed at 58 Trust sites that were deemed in scope locations. As at 31 March 2018, 44 sites are live and the remaining 14 sites have minor residual work to be completed by mid-April 2018.<br>▪ The full one-off capital allocation of £350k was called down and spent prior to 31 March 2018.<br><br>**Outcomes Achieved:**<br>➢ Improves the overall patient experience.<br>➢ Addresses CQC recommendations.<br>➢ Supports the Local Digital Roadmap (LDR) plans and aspirations of STPs.<br>➢ Demonstrated the Trust capability to rapidly mobilise and complete activities against national/external stipulations. | ***Q4 2017/18*** | ***Q4 2017/18*** |

| Domain 8: Embedding Digital in our Culture | *Supports Digital Strategy Aims:*<br>*1. To enhance quality of care and patient safety*<br>*2. To enable prevention, wellbeing and recovery*<br>*3. To foster integration, partnership and working together*<br>*4. To develop an effective and digitally empowered workforce*<br>*5. To maximise efficiency and sustainability*<br>*6. To support people and communities* |
|---|---|

| IM&T Drop-in Clinics (User Engagement) | | | |
|---|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** | ***Achieved*** |
|  | **Purpose:** IM&T drop-in clinics were established during 2016/17 as a follow on response to feedback received from a staff survey issued regarding IM&T services and how services would like to be engaged and communicated with.<br><br>➢ IM&T operational drop-in clinics held across various BDU sites throughout 2017/18.<br>➢ Dates of clinics communicated via 'The Headlines' and key staff notified via email in advance of clinics run in their area (General Managers, Practice Governance Coaches, Admin Leads, Support Services). An Intranet page has also been created listing scheduled clinics. http://nww.swyt.nhs.uk/it/Pages/IT-clinics.aspx<br>➢ IM&T clinics will continue during 2018/19. This is now classed as an operational activity so marked as completed.<br><br>**Outcomes Achieved:**<br>➢ Improved communication and links with operational services.<br>➢ Ability to address issues and investigate options for developments with services in a timelier manner.<br>➢ Improved user and service experience of IM&T and technology.<br>➢ Approximately 80% of issues have been resolved during clinic attendance. | ***Throughout 2017/18*** | ***Q4 2017/18*** |

## *ONGOING MILESTONES FOR 2018/19 & BEYOND (April 2018 position):*

***Key outlining progress against the schemes listed within the IM&T Domains***

| | | | | | |
|---|---|---|---|---|---|
| ● | ***Completed*** | ● | ***On Track*** | O | ***Future Planning*** |
| ● | ***Off Track but in Control*** | ● | ***Off Track requires attention*** | | |

For any initiatives that continue in 2018/19 from 2017/18 only the key activities are shown in the summaries below so as to avoid duplication with the previous section of the report.

| ***Domain 1: Fit for Purpose IM&T Infrastructure*** | ***Supports Digital Strategy Aims***<br><br>***1. To enhance quality of care and patient safety***<br>***4. To develop an effective and digitally empowered workforce***<br>***5. To maximise efficiency and sustainability*** |
|---|---|

| **Infrastructure Modernisation Programme - Phase 3: Data Centre Improvements (Year 2)** | | |
|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** See previous section<br><br>**Key Activities:** | |
| ● | ➢ An end of period review report is being prepared that provides an update on what progress has been made to date and what this work has achieved/delivered in line with the business case previously approved. | **May 2018** |
| ● | ➢ The detailed technical schedule of works for 2018/19 is currently being drawn up and finalised, with technical plans being established for required activities throughout 2018/19. | **May 2018** |
| ● | ➢ This programme for year 2 activities is to be funded from the capital allocation for 2018/19 and will focus on the following capital schemes: -<br>▪ Data Centre/Disaster Recovery.<br>▪ Infrastructure/WAN.<br>▪ Server hardware refresh. | **March 2019** |

| | | |
|---|---|---|
| | ▪ Network switch upgrades.<br><br>**Expected Outcomes:**<br>➢ Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g. from Fieldhead to Kendray).<br>➢ No requirement for short term investment in event of a disaster.<br>➢ Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licensing (potentially reducing costs).<br>➢ Proven disaster recovery position with confirmed recovery points and associated timelines.<br>➢ Enhanced cyber security position would bring about improved resilience and greatly reduce the risk from cyber-attack, malicious or otherwise. | |
| **Microsoft Licensing Agreement Usage Review** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
| <br><br><br>● <br><br>● <br><br>● | **Purpose:** See previous section<br><br>**Key Activities:**<br>➢ Continue to explore further avenues and opportunities to facilitate additional reductions and Microsoft product usage across the Trust. This reduction will form part of the license review ahead of the start of year 2 of the agreement from July 2018.<br><br>➢ Monitor and consider the outcomes of the NHS England negotiations with Microsoft over a potential centralised NHS-wide agreement for Windows 10 software licensing via the Chief Information Officer (CIO) advisory group.<br><br>➢ Continue to work with Marketing, Communications and Engagement colleagues to inform and advise staff that the Trust will constantly review license usage across the organisation throughout the term of this agreement.<br><br>**Expected Outcomes:**<br>➢ Supports the infrastructure modernisation programme which will add resilience, improve performance for end users, and build in contingency in the event of network failure.<br>➢ Potential for a NHS-wide agreement for Windows 10 software licensing to reduce Trust direct annual costs associated with Microsoft licensing arrangements. | <br><br>***June 2018***<br><br>***Q1 2018/19***<br><br>***Throughout 2018/19*** |
| **N3 Replacement (Wide Area Network)** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
| <br><br>● | **Purpose:** Focuses on the replacement of the existing N3 (NHS-wide national network) with the new Health & Social Care Network (HSCN). Central funding allocations will be passed down to fund annual support costs locally.<br><br>**Key Activities:**<br>➢ The Trust has reviewed both current and future requirements in preparation for the replacement of the N3 connections | <br><br><br>***Q4*** |

| | | |
|---|---|---|
| | with the new HSCN and has contributed to the tendering activities to procure HSCN network provision on behalf of public sector organisations via the (Yorkshire & Humber Public Sector Network YH PSN). **Completed.** | ***2017/18*** |
| | ➢ NHS Digital has provided confirmation that the Trust will receive an allocation of £116k central funding to fund the annual support costs locally. **Completed.** | ***Q4 2017/18*** |
| | ➢ The Trust is awaiting the outcome of the tender process which is expected to be completed by the end of April 2018. This will enable the N3 replacement and HSCN circuit installation/implementation activities to be planned with NHS Digital. | ***April 2018*** |
| | ➢ The replacement of N3 and implementation of HSCN circuits is anticipated to take approximately 2 years to complete commencing from the start of 2018/19. At this stage the installation costs have not been determined and as yet NHS Digital has not confirmed funding arrangements. | ***Throughout 2018/19 & 2019/20*** |
| | **Expected Outcomes:**<br>• Continuity of wide area network (WAN) connections that essentially provide inter-connectivity between Trust sites and the wider NHS/Social Care infrastructure.<br>• Improved resilience of core IT infrastructure. | |

## Cyber Security & Threat Monitoring

| *Status* | *Description* | *Milestone* |
|---|---|---|
| | **Purpose:** see previous section | |
| | **Key Activities:** | |
| | ➢ Cyber threat monitoring continues to be an integral item of business for monthly service performance and review meetings with Daisy IT Services. The Trust routinely reviews the actions taken or required to be taken to mitigate and establish safeguards against the threat of cyber-attacks. | ***Ongoing 2018/19*** |
| | ➢ The Trust is also actively engaged in cyber awareness and collaboration opportunities with Daisy IT Services along with our partners across the wider STP footprints. | ***Ongoing 2018/19*** |
| | ➢ The findings from the cyber essentials review conducted during 2017/18 and the associated recommendations to inform ongoing strategic IT infrastructure roadmap planning will determine the detailed IT programme of works for 2018/19. This aims to incorporate additional cyber capabilities through enhanced threat protection and detection which provides more proactive technologies and safeguards. | ***Q1-Q2 2018/19*** |
| | ➢ The Trust has signed up to be an early adopter for the simulated phishing training tool being developed by NHS Digital. | ***Q1 2018/19*** |
| | ➢ The Trust has registered to take part in an NHS Digital assured cyber assessment that is being offered to a number of Trusts across the country. The scheduling of this assessment is in progress. | ***Q1-Q2 2018/19*** |
| | ➢ Staff vigilance remains an integral defence, Regular communications are issued to staff and staff are advised to raise any | ***Ongoing*** |

| | | |
|---|---|---|
| | questions or concerns with the IT service desk in the first instance at the earliest opportunity. | ***2018/19*** |
| ● | ➢ Conduct another annual cyber security survey following the one issued in September 2017, to further gauge staff awareness and understanding and identify if this is improving. | ***September 2018*** |
| ● | ➢ Provide quarterly highlight reports summarising cyber activities and responses to NHS Digital CareCert notifications issued detailing the measures, controls and remedial actions being taken to safeguard the Trust against potential cyber threats as part of ongoing assurance mechanisms.<br><br>**Expected Outcomes:**<br>➢ See previous section. | ***July 2018***<br>***Oct 2018***<br>***Jan 2019*** |

## Migration to Microsoft Windows 10

| *Status* | *Description* | *Milestone* |
|---|---|---|
| | **Purpose:** To initiate a programme of work during 2018/19 to bring about the upgrade/migration of the Trust's end user computing estate (desktops and laptops) from the existing Microsoft Windows 7 platform to Microsoft Windows 10 operating system ahead of the March 2020 deadline. This work will also include the planned end user computing replacement programme across the Trust as part of this work.<br><br>**Activities:** | |
| O | ➢ Implementation of the Trust approved end user computing replacement programme. | ***Q1 2018/19*** |
| O | ➢ Detailed plans and activities to be established subject to Trust approval of the proposal to initiate the migration from Windows 7 to Windows 10 from 2018/19.<br><br>**Expected Outcomes:**<br>➢ Enables the Trust to provision new and replacement end user computing devices in a strategic and planned manner, making better use of available resources.<br>➢ Centralised control of all end user computing assets, therefore optimising use across the Trust.<br>➢ Improves end user experience.<br>➢ Provides greater assurance and controls from which to minimise the risk of cyber threats through continuous availability to software security updates. | ***Q1/Q2 2018/19*** |

## Email Platform Review

| *Status* | *Description* | *Milestone* |
|---|---|---|
| | **Purpose:** To conduct a review of the options open to the Trust for the future provision of its corporate email platform (NHS Mail v Microsoft Exchange/Outlook) so as to inform the development of a business case for consideration and approval<br><br>**Activities:** | |

| | | |
|---|---|---|
| O | ➢ Consideration of an enforced mailbox limit that does not allow end users to send/receive emails once the limit has been reached. Subject to future EMT and Trust Board approvals. | ***Q3 2018/19*** |
| O | ➢ Conduct an options appraisal of future strategic corporate email platforms (NHS Mail v Microsoft Office365/Exchange) to inform a business case for consideration at the outset of 2019/20. | ***Q4 2018/19*** |
| O | ➢ Detailed plans and activities to be established following Trust approval of the proposed recommendations detailed within the business case.<br><br>**Expected Outcomes:**<br>➢ Ensures the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources.<br>➢ Potential for wider STP region standardisation of email platforms and closer partnership/collaborative working opportunities. | ***Q1 2019/20*** |

| ***Domain 2: Integrated Electronic Care Record System*** | ***Supports Digital Strategy Aims***<br><br>***1. To enhance quality of care and patient safety***<br>***3. To foster integration, partnership and working together***<br>***5. To maximise efficiency and sustainability***<br>***6. To support people and communities*** |
|---|---|

| **Mental Health Clinical Record System Implementation (SystmOne)** | | |
|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** Support for the planning and implementation of the new Mental Health Clinical Record System (SystmOne). This is a major change initiative being driven by staff from all areas of the organisation.<br><br>**Activities:** | |
| ● | ➢ Programme milestones base-lined and signed off by Programme Steering Group (supported by a detailed schedule). | ***Milestones & deliverables on-going throughout 2018/19*** |
| ● | ➢ Finalised 2 of the 8 work stream terms of reference, detailing key deliverables and milestones. | |
| ● | ➢ Submitted initial unit configuration to TPP (system supplier). | |
| ● | ➢ Significant service engagement in readiness for the change and 'SystmOne needs you' communications commenced. | |

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| | ➢ SystmOne reference groups set up in CAMHS and Learning Disabilities.<br><br>➢ Co-design Workshops<br>▪ Completed: Forensics and Specialist Services BDUs (37.5% of all Service Lines).<br>▪ In progress: Calderdale & Kirklees Acute, Barnsley Acute, Calderdale & Kirklees Community Adults, Calderdale & Kirklees Community Older peoples and inpatients (25% of all service lines).<br>▪ Still to commence: Barnsley Community, Barnsley Mental Health Specialist, Calderdale & Kirklees Rehab & Recovery, Wakefield Community, Wakefield Acute, Corporate/Support Services (37.5% of all Service Lines).<br><br>➢ Production of platinum and test patients as required by TPP.<br><br>➢ Rio training provided to programme team to familiarise them with the current system.<br><br>➢ Training proposal developed in conjunction with our learning and development colleagues has been shared with Trust deputy directors for consultation. After consultation the final approach will be agreed with operational management group and the programme steering group.<br><br>➢ Specifications complete for 25% of the Trust's highest priority reports.<br><br>**Expected Outcomes:**<br>➢ Transition services from RiO to SystmOne for mental health, by successfully moving the electronic clinical records and providing adequate training to colleagues for go-live.<br>➢ Work with clinical and administrative colleagues to co-produce a system that suits the Trust's needs. This includes key clinical documentation e.g. care plans to make the system fit for purpose.<br>➢ Deliver a new system that gives the Trust the opportunity to improve how we work now and in the future e.g.: -<br>▪ to better support the development of new integrated models of care<br>▪ the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs, further demonstrating our commitment in meeting commissioner intentions<br>▪ improve service user care through more timely receipt and management of referral to services via electronic capabilities | |

| **Clinical Systems for Community Services (SystmOne)** | | |
|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** Continued development of SystmOne to support Community Services priorities, service re-design and new models of care agendas.<br><br>**Activities:**<br>➢ Implementation of the agreed information systems architecture as part of the new integrated model of care and service transformation activities for Intermediate Care services, subject to agreement of funding. | ***Q2 2018/19*** |

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| | ➢ Clinical functionality deployment across all remaining community services (therapy services).<br><br>**Expected Outcomes:**<br>➢ To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information.<br>➢ To support the development of new integrated models of care.<br>➢ To ensure that all community services are fully optimised in their usage of SystmOne. | ***Q2 2018/19*** |
| **Clinical Portal Development (PORTIA)** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** see previous section.<br><br>**Activities:**<br>➢ Complete the interface development commissioned during March 2018 for the inclusion of IAPT data from the PC-MIS system used by Barnsley, Calderdale & Kirklees IAPT Services.<br><br>➢ Present a briefing paper summarising the progress of this project and the associated developments up to 31 March 2018.<br><br>➢ Continued wider deployment of PORTIA across the Trust and to promote its usage.<br><br>**Expected Outcomes:**<br>➢ See previous section. | ***Q1 2018/19***<br><br>***Q1 2018/19***<br>***Q1/Q2 2018/19*** |
| **eCorrespondence** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** Enables the Trust to reduce the reliance and flow of paper both internally and with our partners in respect of delivering patient care. This also supports the digital agenda and the drive towards a paperlight/paperless NHS by 2020.<br><br>**Activities:**<br>➢ eDischarge: The wider deployment of this new capability is being rolled out across inpatient services across the inpatient areas only at this stage.<br><br>**Expected Outcomes:**<br>➢ See previous section. | ***Q1 2018/19*** |

| Clinical Systems for Mental Health Services (RiO Version 7) | | |
|---|---|---|
| ***Status*** | ***Description*** | ***Milestone*** |
|  <br>  | **Purpose:** Continued development of RiO to support Mental Health operations, service priorities, service re-design and new models of care agendas. Progress will be subject to the implications on the impending migration to SystmOne.<br><br>**Activities:**<br>➢ Focused work is ongoing to migrate allergy information to the dedicated allergies section available on RiO. This is in support of the data migration activities that have commenced as part of the move to SystmOne for Mental Health Services.<br><br>➢ It is planned that the 15-minute refresh of RiO data for the business intelligence solution be scaled back to once within a 24-hour period.<br><br>**Expected Outcomes :**<br>➢ To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information.<br>➢ To support the development of new integrated models of care. | ***Q2 2018/19***<br><br>***May 2018*** |

| ***Domain 3: Digitisation & Information Sharing with our Partners*** | ***Supports Digital Strategy Aims***<br><br>***1. To enhance quality of care and patient safety***<br>***2. To enable prevention, wellbeing and recovery***<br>***3. To foster integration, partnership and working together***<br>***4. To develop an effective and digitally empowered workforce***<br>***5. To maximise efficiency and sustainability***<br>***6. To support people and communities*** |
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| STP Digital Work streams | | |
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| ***Status*** | ***Description*** | ***Milestone*** |
|  | **Purpose:** Across the STP regions in which SWYPFT is a key stakeholder, work has been progressing on a variety of digital interventions through the work of the place-based Local Digital Roadmaps(LDRs) and STP initiatives in support of wider digital maturity.<br><br>**Activities:**<br>➢ Trust participation a number of external groups/forums in support of the STP digital work stream initiatives in collaboration | ***on-going*** |

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| | with health and social care partners. | |
| ● | ➢ Trust participation in the local health and care integrated records exemplar (LHCRE) initiative. | ***on-going*** |
| ● | ➢ Further updates to the SWYPFT component of the LDRs will be scheduled as deadlines for revision become available. | ***on-going*** |
| | **Expected Outcomes:**<br>➢ The vision will lead to an integrated digital infrastructure across STP regions, making more effective use of the technical expertise available and allowing our collective digital capabilities to develop in parallel with technological advancement.<br>➢ Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve.<br>➢ Local systems will be supported to deliver and evaluate digital pilots within their respective areas and the scaling up of successful interventions will be coordinated by digital work streams and the supporting key interventions. | |
| **Records Management (Scanning – Archive/Paper Records)** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** Continue to develop the onsite scanning bureau and work towards meeting the 2020 paper free target.<br><br>**Activities:** | |
| ● | ➢ Continuation of records scanning, building on the good work and progress made during 2017/18. | ***Q4 2018/19*** |
| ● | ➢ Development of the Key Performance Indicators (KPIs). | ***Q1 2018/19*** |
| ● | ➢ BS10008 accreditation – final audit scheduled for April 2018, after which approval will be sought from EMT to destroy paper records. | ***Q1 2018/19*** |
| ● | ➢ Deployment of the access to scanned records via the Trust's clinical portal solution (PORTIA). | ***Q1-Q2 2018/19*** |
| ● | ➢ Calderdale &Kirklees Paperlight - Calderdale clinics are working towards becoming paper free and scanning of paper records from record libraries underway. Work on Kirklees clinics becoming paper free will commence once Calderdale activities have been completed. | ***Q2 2018/19*** |
| | **Expected Outcomes:**<br>➢ Reduced reliance on off-site storage (avoidance of increased costs).<br>➢ Improved governance through having easy, electronic access to all records related to a Trust client, supporting the digitisation and paperless NHS agendas. | |

| Centralised Mailing | | |
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| ***Status*** | ***Description*** | ***Milestone*** |
| O | **Purpose:** To explore ways to reduce IG incidents relating to service user information being mailed to incorrect correspondence addresses.<br><br>**Activities:**<br>➢ Review options for centralised mailing and explore opportunities to reduce IG related incidents resulting from misdirected mail.<br><br>**Expected Outcomes:**<br>➢ Reduced mailing costs and potential to reduce IG incidents related to clients being mailed to incorrect address.<br>➢ Alignment with eCorrespondence to consider opportunities for electronic transfer and messaging, communications in line with the drive towards a paperless NHS by 2020. | ***Not Started 2018/19*** |
| **Paperlight / Paperless NHS** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
| O | **Purpose:** Paperlight forms part of the wider care record digitisation agenda and aims for all clinical services (predominantly those services that currently use RiO or SystmOne as their main clinical information system) to work towards achieving paperlight accreditation.<br><br>**Activities:**<br>➢ This is under review as part of the clinical records system implementation and business change activities.<br><br>**Expected Outcomes:**<br>➢ Reduce/remove the creation of paper records/case files for new service users.<br>➢ Reduce the demand for paper records storage and space in the future.<br>➢ Support the Trust's drive towards achieving paperless services by 2020 as part of the wider national paperless agenda. | ***On-going*** |
| **eConsultation** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
| O | **Purpose:** eConsultations are electronic means of establishing consultative communications between clinician-to-clinician at a provider-to-provider level or in collaboration with patients/service users/carers via an electronic health record (EHR) or web-based platform. eConsultations offer the potential to improve access to specialty expertise for patients and providers without the need for a face-to-face visit.<br><br>**Activities:**<br>➢ In response to growing interest, a meeting took place in December 2017 to consider and explore the opportunities for use of Microsoft Skype for Business in support of eConsultation capabilities (clinician to clinician and/or clinician to patient | ***Throughout 2018/19*** |

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| | tele-conferencing). Further opportunities to explore this potential are to be determined during 2018/19.<br><br>**Expected Outcomes:**<br>➢ Improve the patient experience.<br>➢ Improve access to services, supportive information users and further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs. | |

| ***Domain 4: Business Intelligence Systems*** | ***Supports Digital Strategy Aims***<br><br>***3. To foster integration, partnership and working together***<br>***5. To maximise efficiency and sustainability*** |
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| **Business Intelligence / Data warehouse (information hub & dashboards)** | | |
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| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** see previous section.<br><br>**Activities:** | |
| 🟡 | ➢ Business Intelligence Release 3 – Integration of Community SystmOne into the data warehouse: Community SystmOne data for the Barnsley neighbourhood nursing service has been incorporated into the data warehouse and is in the final stage of testing with associated reports currently in development for the service. | ***April 2018*** |
| 🟢 | ➢ Engagement activities taking place to increase awareness and usage of business intelligence reporting. | ***Throughout 2018/19*** |
| | **Expected Outcomes:**<br>➢ Continue to improve and make available the use of real time information to support operational services and transformation agendas. | |

| **Information Governance** | | |
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| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations.<br><br>General Data Protection Regulations (GDPR) is the new legal framework in the EU that will take effect from 25 May 2018, irrespective of the UK's decision to leave the EU. The regulations enhance data subjects' rights, introducing new rules that govern how data is collected, processed, shared and retained. Organisations will have significantly more legal liability if they are responsible for a breach with fines increased substantially compared to those currently in operation. | |

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| | Activities:<br>➢ General Data Protection Regulations (GDPR): Ensure the organisational readiness and action plan activities are completed in preparation for the GDPR framework coming into force from 25 May 2018. | ***May 2018*** |
| | ➢ Information Governance Training: Ensure that the mandated annual information governance training update is maintained and that classroom based IG training continues to be rolled out for staff groups who do not have ready access to a computer. | ***Throughout 2018/19*** |
| | ➢ Data Protection & Security Toolkit (IG Toolkit): Gather evidence and ensure compliance against the 2018/19 toolkit: - | ***March 2019*** |
| | **Expected Outcomes:**<br>➢ Mandatory IG training target is achieved.<br>➢ IG toolkit target of level 2 compliance is maintained.<br>➢ Preparedness for the GDPR is assured and processes established to ensure compliance. | |

| ***Domain 5: A Skilled & Digitally Enabled Workforce*** | ***Supports Digital Strategy Aims***<br><br>***4. To develop an effective and digitally empowered workforce*** |
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| **Succession & Workforce Planning (IM&T Staff)** | | |
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| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** To ensure that the IM&T Service has a suitability skilled workforce, including the required skills-mix balance and the requisite resources from which to deliver effective and efficient services to the organisation. This includes meeting both current and future needs of the organisation and will establish foundations for a robust succession plan which informs and supports wider staff development opportunities<br><br>**Activities:** | |
| | ➢ Conduct a workforce review and develop succession plans. | ***Throughout 2018/19*** |
| | ➢ Explore staff development/leadership & management development opportunities. | ***Throughout 2018/19*** |
| | ➢ Collaborative working with Learning & Development to consider opportunities for wider eLearning training provision. | ***Throughout 2018/19*** |
| | ➢ Schedule focused workshops and timeouts to support service development and re-design. | ***Throughout 2018/19*** |

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| | **Expected Outcomes:**<br>➢ Improve staff retention.<br>➢ Improve access and availability of training and development opportunities in support of identified needs.<br>➢ Improves service resilience and delivery.<br>➢ Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience and capabilities. | |
| **Intranet Development** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
|  <br>  | **Purpose:** See previous section.<br><br>**Activities:**<br>➢ Define and scope out requirements for the re-design/re-development of the Trust intranet to inform the production of a business case for Trust approval.<br><br>➢ Initiate procurement activities, subject to Trust approval, for the re-provisioning of the Trust intranet based on the agreed requirements.<br><br>**Expected Outcomes:**<br>➢ See previous section. | ***Throughout 2018/19***<br><br>***From Q1 2019/20*** |
| **Social Media Access for Staff** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
|  | **Purpose:** To enable more staff to access information online and join online networks/discussions forums.<br><br>**Activities:**<br>➢ To unblock and improve access to social media sites across the Trust corporate network infrastructure.<br><br>**Expected Outcomes:**<br>➢ Improve staff access to social media to enhance digital capabilities. | ***Q1 2018/19*** |
| **Development of Staff Training (IT & Digital Skills)** | | |
| ***Status*** | ***Description*** | ***Milestone*** |
|  | **Purpose:** To explore opportunities from which to support staff development (capacity/capability) in the use of IT/Digital technologies and solutions in the workplace. Needs will be based on employee capability on using new systems as well as general IT/Digital skills in using applications such as Microsoft Office etc.<br><br>**Activities:**<br>➢ Discussions are ongoing between Learning & Development and IM&T regarding opportunities for the provision of IT/Digital training across the Trust. | ***On-going*** |

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| | **Expected Outcomes:**<br>➢ Improve staff retention.<br>➢ Improve access and availability of training and development opportunities in support of identified needs.<br>➢ Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience and capabilities. | |

| ***Domain 6: Engaging and Learning from Digital Best Practice*** | ***Supports Digital Strategy Aims:***<br>***1. To enhance quality of care and patient safety***<br>***2. To enable prevention, wellbeing and recovery***<br>***3. To foster integration, partnership and working together***<br>***4. To develop an effective and digitally empowered workforce***<br>***5. To maximise efficiency and sustainability***<br>***6. To support people and communities*** |
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| **NHS Test Bed Wave 2 sites (roll out and further development of ORCHA app platform)** | | |
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| ***Status*** | ***Description*** | ***Milestone*** |
|  | **Purpose:** The Test Beds programme provides funding and support to NHS organisations and industry to test combinations of technology and pathway innovation to tackle some of the biggest challenges facing the NHS. Up to £4.5 million will be available from the Office for Life Sciences for the second wave of Test Beds, with individual projects receiving between £500k and £1.5m. Projects must tackle health and care challenges (system or clinical) aligned with national and local priorities. Each Test Bed must be led by an NHS provider organisation and should be a partnership between NHS organisations and businesses working together to solve a specific and focused health and care challenges through a combination of digital products and pathway development, which will be evaluated during the programme.<br><br>**Activities:**<br>➢ The Trust has submitted an expression of interest to further develop and roll out the ORCHA app platform. This follows a pilot within Calderdale and Kirklees CAMHS. The expression of interest was successful and the Trust has been invited to participate in the bidding stage, with representatives attending an event on 23rd April 2018.<br><br>**Expected Outcomes:**<br>➢ The first wave of the Test Beds programme was unprecedented in scale: it leveraged £15m from industry, included 40 innovators, 51 digital products, and five voluntary sector organisations. Wave 2 is expected to be equally ambitious. | ***On-going*** |

| ***Domain 7: Championing Digital Inclusion for People Accessing our Services*** | ***Supports Digital Strategy Aims:***<br>***1. To enhance quality of care and patient safety***<br>***2. To enable prevention, wellbeing and recovery***<br>***3. To foster integration, partnership and working together***<br>***4. To develop an effective and digitally empowered workforce***<br>***5. To maximise efficiency and sustainability***<br>***6. To support people and communities*** |
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| **Patient Reminder System** | | |
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| ***Status*** | ***Description*** | ***Milestone*** |
|  | **Purpose:** We have a patient appointment reminder system in operation which aims to reduce did not attend (DNA) levels across the Trust services.<br><br>**Activities:**<br>➢ The further roll-out the patient reminder text system is underway following successful implementations in the pilot teams<br><br>**Expected Outcomes:**<br>➢ Reduce DNAs, increase re-use of appointment slots ('fast-track' patients in need of urgent appointment) and in turn reduce costs and waiting times. The pilot teams have been able to demonstrate a 30% reduction in DNA rates<br>➢ Improve efficiency of services.<br>➢ Improve quality of services.<br>➢ Improve patient experience. | ***Q1-Q2 2018/19*** |

| Domain 8: Embedding Digital in our Culture | *Supports Digital Strategy Aims:*<br>***1. To enhance quality of care and patient safety***<br>***2. To enable prevention, wellbeing and recovery***<br>***3. To foster integration, partnership and working together***<br>***4. To develop an effective and digitally empowered workforce***<br>***5. To maximise efficiency and sustainability***<br>***6. To support people and communities*** |
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| Apps for Service Users and Carers | | |
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| ***Status*** | ***Description*** | ***Milestone*** |
| | **Purpose:** As part of the wider digitisation agenda, the Trust is exploring opportunities from which to make information and services more accessible to our patients, service users and carers.<br><br>**Activities:** | |
| ● | ➢ The Trust is currently engaged with ORCHA regarding a micro-site for the Trust and associated economy. Focus to date has centred on CAMHs and the assuring of the quality of apps for service users and carers. A trial is currently in progress and the outcomes will inform future opportunities. | ***Q1-Q2 2018/19*** |
| ● | ➢ The Trust is also engaged with NHS Digital who are collaborating with ORCHA and other potential suppliers in a review of their offerings for an agreed framework that requires suppliers to comply with NHS Digital defined standards. | ***Q3 2018/19*** |
| | **Expected Outcomes:**<br>➢ Improves the overall patient experience.<br>➢ Improves access to services, supportive information users and is part of the wider digitisation of the NHS, further supporting the LDR plans and aspirations of STPs. | |

**Summary and Risks**

The priorities set out in 2018/19 as summarised in this report will continue to reduce the likelihood of risk of system failure. This includes the work activities focused on: -

- The main priority area and focus for Digital Strategy progression during 2018/19 will be the comprehensive engagement and participation (co-design/co-production) across the Trust in supporting the implementation of SystmOne to replace RiO within Mental Health services and ensuring a safe transition.
- Continuation of the infrastructure modernisation programme covering both the data centre enhancement and improvements to disaster recovery so as to improve resilience. This programme of work also incorporates cyber security enhancements to establish further controls and measures to reduce the risk and likelihood associated with the threat of cyber-attacks.

Ability to deliver on all of the 2018/19 priorities in line with the timescales identified is very much dependent on availability of suitable resources and balancing competing priorities. There are two particular points to note.

1) The implementation of SystmOne across Mental Health services will require significant input, collaboration and participation from both clinical services and corporate support service. This requires careful consideration in balancing other organisational priorities and ensuring sufficient skilled and experienced staff are in place to deliver. A separate project team has been put into place to support this and this team will draw on the considerable expertise in place across the Trust.

2) The growing demands on digital technologies, solutions and available resources will lead to expectations for staff and these expectations need to be carefully managed. Horizon scanning and exploring opportunities to source and secure other avenues for external funding will be key to supporting wider organisational aspirations in line with digital strategy objectives.

The provision of digitally enabled services is vital in enabling Trust staff to deliver safe care. As such risk appetite is considered low with a target score of 1-3. Historically IM&T schemes have been managed and governed separately from other digital schemes. During the first quarter governance processes will be re-assessed so as to ensure there is a joined up and consistent approach to the management and delivery of all aspects of the Digital Strategy.

**Summary**
The information included in this update report clearly articulates the breadth and scale of the Digital Strategy work programme completed during 2017/18 and which is underway or set to commence during 2018/19. A considerable amount of time has been afforded in the planning of activities to support progression of the Digital Strategy, which has also been accounted for in the annual planning processes. This has meant timescales for delivery of the initiatives in this document are realistic and achievable, subject to allocated/available resources. Any associated risks being managed with mitigating actions put in place where required.

It is recognised and understood that effective progression of the Mental Health Clinical Record System implementation is a key priority will require the focus of both clinical services and corporate support services to complete the necessary activities to support effective delivery. This in turn may impact on the ability to progress other digital priorities. However, this will be subject to continual close scrutiny, management and governance.

The Board is asked to note the achievements made in respect of the delivering against the 2017/18 milestones and to recognise the initiatives taking place in 2018/19. The Board will continue to be updated in respect of progress being made against the Digital Strategy twice a year. In addition, the Executive Management Team will receive updates every two months.

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 10.1

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| **Title:** | **Annual report on Safe Working Hours Doctors in Training (February – December 2017)** |
| **Paper prepared by:** | Guardian of Safe Working |
| **Purpose:** | To provide assurance to the Board that we are meeting our responsibilities in relation to the monitoring of safe working hours within the new Doctors in Training contract. Trust Board is asked to note the report. |
| **Mission/values:** | The Trust is meeting its duties and requirement to have a Guardian of Safe Working. Caring for the wellbeing of our staff and provision of safe clinical care is essential to support the Trust's mission in helping people to reach their potential and live well in their communities. The training of the next generation of substantive psychiatrists is of strategic importance for not only the Trust's succession planning but to ensure provision of a highly trained medical workforce within the wider mental health system. |
| **Any background papers/ previously considered by:** | Briefing paper presented to Trust Board on 25 April 2017<br>Quarterly report presented to Trust Board 27 June 2017 (covering February – March 2017)<br>Quarterly report presented to Trust Board 31 October 2017 (covering April - June 2017)<br>Quarterly report presented to Trust Board 30 January 2017 (covering July - September 2017)Quarterly report within the Integrated Performance Report presented to the Trust Board 24 April 2018 |
| **Executive summary:** | 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. In order to ensure that concerns raised during the negotiation process about the potential for unsafe working practices to be introduced, a specific role has been developed in order to oversee Doctors in Training contracts and, in particular, their working hours.<br>The Trust appointed Dr Richard Marriott as the Guardian of Safe Working and the 2017 Annual Report highlights the following:<br>➢ The number of exception reports has been low during 2017, which is in line with the majority of mental health trusts. However concerns about work pressure continue to be raised in other fora by Calderdale trainees.<br>➢ How the role of the Guardian of Safe Working is communicated to the trainees has been improved throughout the year.<br>➢ Processes for addressing concerns raised by trainees have been |

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| | developed.<br>➢ Although there continues to be a major concern around the number of vacancies on the on-call rotas, improvements have been made around the consistency across the Trust as to how the gaps are managed.<br>➢ The development of the Trust Medical Bank appears to be assisting in reducing the number of shifts needing to be covered by agency staff.<br>➢ Work to develop a system for monitoring the impact of vacancies from a financial point of view is on-going. |
| **Recommendation:** | **Trust Board is asked to RECEIVE, REVIEW and CONFIRM their assurance that the Trust has met its statutory duties.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

**GUARDIAN OF SAFE WORKING**
**ANNUAL REPORT ON SAFE WORKING HOURS:**
**DOCTORS IN TRAINING (Feb-Dec 2017)**

## Introduction

The 2016 junior doctors' contract has 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 will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The Guardian is independent of Trust management and the Guardian's main roles are to:

- Champion adherence to safe working hours
- Oversee safety-related exception reports and monitor compliance with the system
- Escalate issues for action where not addressed locally
- Request work schedule reviews to be undertaken where necessary
- Intervene as required to mitigate safety risks
- Intervene where issues are not being resolved satisfactorily
- Provide assurances on safe working and compliance with TCS
- Submit a quarterly and an annual report to the Trust Board on the functioning of the contract and exception reporting.

This report outlines:

- Challenges
- The Junior Doctors' Forum
- The number and distribution of doctors in training across the Trust
- A summary of exception reports (ERs) submitted by doctors in training
- Fines
- Work schedule reviews
- Rota gaps and cover arrangements
- Locum Work carried out by Trainees
- Medical Bank
- Qualitative information / Survey of Trainees
- Issues arising
- Actions taken
- Summary.

## High level data

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| Number of doctors in training (total): | 47 |
| Amount of time available in job plan for Guardian to do the role: | 1 Programmed Activity (PA) |
| Admin support provided to the Guardian: | Ad hoc |
| Amount of job-planned time for educational supervisors: | 0.125 PAs per Trainee |

The post holder will agree objectives with the Medical Director, who will also appraise or contribute to the appraisal for the post holder.

## Challenges

1) **IT System**: The Trust has used the IT system; Doctors Rostering System (DRS) to both develop the rota patterns for junior doctors and manage Exception Reports (ERs). A decision has been made to change to an alternative system provided by Allocate, who already work with the Trust with their e-Rostering system. The cost for the basic module of this system, which is equivalent to the DRS system, is similar. Allocate also has additional modules which might be worth considering in future. Whilst increasing the cost, these additional modules might make managing rotas easier and reduce the amount of administration time required. It is expected that the new system will be in place before the end of the financial year when the contract with DRS ends.

2) **Cost/Salary Implications**: The contract has been largely cost neutral but has resulted in considerable changes in salary for different grades of doctor which may have implications for recruitment in the future. Higher trainees without pay protection will be particularly worse off.

3) **Trainee and Clinical Supervisor Engagement**: The contract remains new to all doctors, many of whom have expressed confusion regarding its implications. To introduce the Guardian role and Exception Reporting System, presentations have been undertaken at the Induction Programme for each cohort of new junior doctors, the Medical Leaders Advisory Group and the Medical Staff Committee. The Guardian attends the Junior Doctors' Forum, and the Medical Education Trust Action Group, which has oversight of all issues to do with Medical Education within the Trust.

4) **Trainee concerns**: Trainees have been reluctant to complete ERs and have expressed anxiety about the exception reporting process.

5) **Interaction with other Trusts**: a number of the Trust's trainees are employed by partner organisations, one of whom has delayed introduction of the new contract, and a number have different systems for Exception Reporting. All trainees have been asked to use the SWYPFT reporting system whilst in a SWYPFT post.

## Junior Doctors' Forum

The setting up of a Junior Doctors' Forum is a key requirement of the new contract. The forum meets quarterly. The role of the forum is to advise the Guardian in all aspects of the role. At most meetings, the focus has been concerns raised by Calderdale trainees.

All junior doctors within the Trust are invited to the forum but particular efforts have been made to ensure that representatives of all the BDUs and rotas are able to attend. The other key attendees are the AMD for Postgraduate Medical Education, LNC Chair or representative and the HR Business Partner. The local BMA representative was also invited to attend.

## Distribution of Trainee Doctors within SWYPFT

The Trust covers a wide geographical area and receives trainees from a number of different rotational training schemes (Foundation Programme, General Practice Vocational Training Schemes, Psychiatry Core Training Schemes and Psychiatry Higher Training Schemes). Approximately half of the trainees are employed by the Trust, with the remainder employed by other organisations.

Each locality (Barnsley, Calderdale, Kirklees and Wakefield) has a 1st on-call rota staffed by junior doctors. These are trainees from the local Core Psychiatry Scheme, the Foundation Year 2 Scheme or GP Vocational Training Scheme, although Barnsley's 1st on-call rota also includes non-training Specialty Doctors. The 2nd on-call rotas for each locality are staffed partly by Higher trainees and partly by non-training Specialty Doctors, the latter whose contracts are subject to different terms and conditions.

Tables shown in the appendices demonstrate the breakdown of the different grades of trainees in each locality, also noting the areas where there are vacancies. Recruitment to the Foundation and GP training programmes has been good and almost all posts have been filled. Poor recruitment to core training posts in Psychiatry has led to a number of gaps with 2 out of the 7 Wakefield posts vacant, 5 out of 10 posts on the Calderdale and Kirklees Core Training Scheme and 1 of the 4 posts in Barnsley.

## Exception reports (with regard to working hours)

The Exception Reporting (ER) system is the main safeguard in the new junior contract that ensures junior doctors are not being forced to work excessive hours and are able to meet the training requirements of their contract. The hours and rest rules are complicated and a helpful factsheet covering the key features can be found at: http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20for%20guardians%20August%202016%20v2.pdf.

Each trainee receives a work schedule prior to commencement of their post, which outlines the rota pattern, hours and pay arrangements for that post. If a trainee is required to work beyond those hours, or if work commitments prevent them from

attending required training, the trainee is encouraged to complete an ER. This details the circumstances of the 'exception'. The report goes to the trainee's clinical supervisor. If the clinical supervisor agrees the ER, the options are for the trainee to be given time off in lieu or to be paid for the extra time.

There have only been a few ERs completed in SWYPFT since the introduction of the new contract. This is to some extent reassuring. However, there were anecdotal reports of problems that were not reflected in exception reports. A survey of all trainees by the Guardian was conducted to try to establish the reasons for non-reporting. Of the 20 trainees who responded that they had not completed an exception report, 75% stated that this was because there had been nothing for them to report. However, the remainder cited various concerns; these included uncertainty as to how to complete the report or what would constitute an exception. Others were concerned that exception reporting would not achieve anything and might lead to them being seen as causing trouble.

| Exception reports by area | | | | |
|---|---|---|---|---|
| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| Barnsley | 0 | 1 | 1 | 0 |
| Calderdale | 0 | 6* | 6* | 0 |
| Kirklees | 0 | 0 | 0 | 0 |
| Wakefield | 0 | 1 | 1 | 0 |
| Forensic | 0 | 0 | 0 | 0 |
| Total | 0 | 8* | 8* | 0 |

| Exception reports by grade | | | | |
|---|---|---|---|---|
| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| F1 | 0 | 0 | 0 | 0 |
| F2 | 0 | 1 | 1 | 0 |
| GPVTS | 0 | 1 | 1 | 0 |
| CT1-3 | 0 | 5* | 5* | 0 |
| ST4-6 | 0 | 1 | 1 | 0 |
| Total | 0 | 8* | 8* | 0 |

| Exception reports (response time) | | | | |
|---|---|---|---|---|
| | Addressed within 48 hours | Addressed within 7 days | Addressed in longer than 7 days | Still open |
| F1 | 0 | 0 | 0 | 0 |
| F2 | 0 | 1 | 0 | 0 |
| GPVTS | 0 | 1 | 0 | 0 |

| | | | | |
|---|---|---|---|---|
| CT1-3 | 0 | 0 | 5* | 0 |
| ST4-6 | 0 | 1 | 0 | 0 |
| Total | 0 | 3 | 5* | 0 |

*Due to a problem with the IT system, whereby it was not clear to trainees if the exception report had been logged by the system, 2 incidents led to multiple exception reports being logged. After liaising with staff at DRS, one trainee's duplicate exception reports was removed. The supervisor working with the other trainee signed off 4 reports relating to one incident. The figures above show the number of separate exceptions but viewing the DRS system, it would appear that there were 8 exception reports completed by CT trainees in Calderdale.

For the exceptions noted in the tables above, the actions were:

1) Extra payment was made for 1 exception when a higher trainee was asked to act down to cover a gap in the junior trainee rota.
2) Time off in lieu was granted for 4 exceptions.
3) No specific action was required for 3 exceptions. However, information from 2 of these led to an improvement in rostering to reduce the likelihood of trainees being on-call when they should be attending required teaching sessions.

There were issues with response time, partly due to consultant annual leave and lack of familiarity with the IT system used. Also, it appears that notifications from DRS were being caught by the Trust spam-filter. This has hopefully been resolved after liaison with the Trust's IT department to allow Skills For Health emails. All clinical supervisors have addressed the ERs once prompted.
There are still a number of doctors that remain on the old 2002 junior doctors' contract. Historically, the response rate for rota monitoring exercises under the old contract has been poor. It has therefore been decided not to attempt to monitor these doctors' working hours separately. They have all been given access to the DRS system and have been encouraged to complete ERs if they have concerns about their working patterns or hours, although they would not be eligible for payments in the same way as trainees on the new contract.

## Fines

Should certain of the hours and rest rules under the new contract be broken, a fine will be incurred, with a penalty hourly rate paid to the doctor and the remainder of the fine paid to the Guardian to use to improve training within the Trust. None of the ERs received so far have resulted in a fine.

## Work schedule reviews

The new contract requires that generic work schedules detailing work patterns and pay be sent to trainees prior to commencement of the post and this was achieved. Following commencement of the post, the generic work schedule should be used to develop a personalised work schedule according to the doctor's learning needs and training opportunities within the post.

The Work Schedule Review is the process whereby concerns about a doctor's working hours or access to training are reviewed. There were no work schedule reviews required during this period. However, as mentioned above, the whole of the

Calderdale and Kirklees rotas are under review due to concerns raised both informally and in previous exception reports.

## Rota gaps and cover arrangements

There continue to be a number of trainee vacancies across the Trust which in turn places greater pressure on those in post. As a result of these vacancies there are numerous gaps on the rota and the lack of staff means that the remaining trainees cannot be expected to do all the extra shifts. The following table details rota gaps by area and how these have been covered. As discussed, the areas with the most vacancies have the most gaps. Due to the number of gaps, it has been necessary to use agency or external staff on a number of occasions. In addition, there were 18 shifts where it was not possible to obtain junior doctor cover. Some of those earlier in the year did include weekend or overnight shifts. More recently, all of these were between 5-9.15pm and some were for a shorter period of time whilst the covering doctor travelled to the site (total 27.5 hours).

| Gaps by Rota February to December 2017 | | | | | |
|---|---|---|---|---|---|
| Rota | Number (%) of rota gaps | Number (%) covered by Trainees | Number (%) covered by agency / external | Number (%) covered by other Trust staff / Medical Bank | Number (%) vacant |
| Barnsley 1st | 44 (7%) | 12 (27%) | 6 (14%) | 26 (59%) | 0 |
| Calderdale 1st | 199 (30%) | 63 (32%) | 82 (41%) | 35 (18%) | 14 (7%) |
| Kirklees 1st | 47 (14%) | 42 (89%) | 0 | 5 (11%) | 0 |
| Wakefield 1st | 85 (13%) | 34 (40%) | 22 (26%) | 25 (29%) | 4 (5%) |
| Total 1st | 375 (14%) | 151 (40%) | 110 (29%) | 91 (24%) | 18 (5%) |
| Wakefield 2nd | 49 (15%) | 19 (39%) | 6 (12%) | 24 (49%) | 0 |

Postgraduate Administration have been able to capture some information about the financial cost to the Trust of covering rota gaps.

| Costs of Rota Cover November/December 2017 | | | | | | |
|---|---|---|---|---|---|---|
| 1st On-Call Rotas | Shifts (Hours) Covered by Trainees | Cost of Shifts Covered by Trainees | Shifts (Hours) Covered by Bank | Cost of Shifts Covered by Bank | Shifts (Hours) Covered by Agency | Cost of Shifts Covered by Agency |
| Barnsley | 2 (16)* | £560* | 0 | 0 | 0 | 0 |
| Calderdale | 8 (26.5) | £1277.50 | 10 (122.5) | £4287.50 | 14(138.75) | £6988.68 |
| Kirklees | 11 (184) | £5040 | 2 (40) | £1400 | 0 | 0 |
| Wakefield | 3 (28.75) | £1496.25 | 5 (61.25) | £2143.75 | 1 (12.25) | £528.83 |
| Total | 24 (255.25) | £8373.75 | 17 (223.75) | £7831.25 | 15 (151) | £7047.51 |

*The majority of shifts in Barnsley (13) were covered by Specialty Doctors who were paid according to their individual terms and conditions.

## Locum work carried out by Trainees

The Trust is largely reliant on the current trainees to do locum shifts to fill the gaps on the rota. However, the number of gaps that have been required to be filled has left staff stretched. Agency staff have been used in Calderdale and to a lesser extent, Wakefield and Barnsley, to fill gaps. Junior doctors were concerned that locum pay rates offered under the new TCS were unattractive, especially compared to other Trusts. It has been agreed that all locum shifts will be paid at £35/hour for junior doctors, although it is of note that the same rate is paid regardless of the rota pattern or how busy the rota is.
Postgraduate administrators and the Medical Bank staff ensure that trainees doing locum shifts sign the European Working Time Directive (EWTD) waiver. This allows trainees to work up to an average of 56 hours a week instead of the usual 48 hours a week. Postgraduate administrators then monitor to ensure that individual doctors are not taking on excessive additional hours / shifts.

## Medical Bank

A Trust Bank that all trainees are able to join on commencement of work with the Trust is now up and running. It does appear that following this, a greater number of shifts have been covered without the need to employ agency / external staff (22 shifts in Oct-Dec versus 43, Jul-Sept). This should be safer for patients as well as being slightly cheaper for the Trust, given the higher hourly rate charged by agencies.

There have been discussions at Health Education England (HEE) and with the other mental health Trusts in West Yorkshire aimed at setting up a county wide bank, to increase the pool of doctors that can cover vacant shifts but this is not likely to be available in the near future.

## Qualitative information

Following the recent concerns raised by Calderdale trainees regarding the pressures placed on them by the lack of medical staff, the Trust has employed locums to help deal with the workload. Trainees appear to be happier with the current situation and Health Education England have been reassured by the Trust response. It remains a concern that trainees have not completed ERs to reflect these issues. The new Allocate system should be easier for trainees to access and ERs can be completed quickly on a Smart phone.

## Issues arising

There are a number of issues that arise out of the implementation of the new junior doctors' contract:

1) **Recruitment:** The biggest current challenge and one that is largely out of the hands of the Trust, is recruitment to training posts, particularly core training posts in Psychiatry. Given that the situation is unlikely to improve significantly in the near future, staff managing the rotas need to be creative as to how we maintain a safe service to our patients while ensuring high quality training and safe working patterns for our trainees. In particular, the Calderdale rota remains a concern. Initiatives such as the Royal College MTI scheme (Medical Training Initiative – specific to Psychiatrists) and HEE's WAST scheme (Widening Access to Specialty Training – offering 6 months on Psychiatry and 6 months in General Practice), both attracting doctors from overseas, may go some way to reducing the number of gaps.

2) **Management of Rota Gaps:** The process for managing rota gaps appears to be improving. The Medical Bank appears to have started to have an impact on this. Also, new administrators are developing experience and getting used to processes to manage gaps. However, the Trust is likely to need to continue to need support from agency locums in the short to medium term.

3) **Education and Support**: Clinical Supervisors are still getting to grips with their role in the new contract both in relation to development of personalised work schedules and exception reporting. They are likely to require on-going support to ensure that they fulfill the requirements of the new contract. I will work closely with the new AMD for Postgraduate Medical Education to develop a more robust system to support clinical supervisors and monitor the educational aspects of the new contract.

4) **IT System Issues:** A decision has been made to move from the DRS system to Allocate. The Trust already has a good relationship with this company from use of e-Rostering and it is expected that this will be easier to use for administrative staff and trainees.

## Actions taken to resolve issues

**1)** Review of the Calderdale rota. In the short term the main action has been to employ locum doctors to cover gaps. Options to change the rota were presented to junior staff but there were great concerns that there may be impacts on patient safety. There has been a monitoring exercise looking at the type of work junior doctors are being asked to carry out, especially overnight. Managers are considering the possibility of extending the roles of nursing staff on the ward to carry out certain tasks that would otherwise fall to the doctor on-call such as phlebotomy and ECG recording. However there are concerns about the capacity of nurses to be able to undertake such tasks. A further meeting to look at progress on the developments is being arranged.

**2)** Close working with the Postgraduate Medical Education Coordinator is being undertaken to develop systems to support all the clinical leads and rota administrators to understand the contract more fully and record important information to allow us to ensure that rotas and especially cover of gaps, is managed appropriately. Also, rotas are being created, taking individual trainee's course dates in to account.

**3)** From 1st September a new Associate Medical Director for Postgraduate Medical Education was appointed. The post holder has taken over the line management responsibility for the three College Tutors across the Trust and will work closely with them and the Guardian to work to address the issues identified around education and support as highlighted in the previous section of this report.

**4)** The Guardian of Safe working has now a longer session at induction with the new trainees to explain the Exception Reporting (ER) system and assure them that ERs are encouraged within the Trust to help us ensure patient safety and a positive experience for trainees. A detailed information leaflet will be sent to all trainees.

## Summary

There is confidence that all generic work schedules include rota patterns that are compliant with the terms and conditions of the new junior doctors' contract.

The Postgraduate Medical Education Coordinator has implemented processes trust-wide to ensure that trainees doing extra shifts have signed the EWTD waiver and that the number of shifts they do remains within safe limits. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experiences for our junior medical staff.

The main concerns continue to arise out of vacancies and the management of gaps on the rota. There have been improvements in the consistency across the Trust as to how gaps on the on-call rotas are managed. The development of the Trust Medical Bank already appears to be improving this with a reduction in the number of shifts covered by agency staff.

There remains no central system to monitor the impact of vacancies from a financial point of view i.e. the cost to the Trust of covering vacant posts. However, the Postgraduate Medical Education Coordinator has now started to access some data regarding pay for locum cover.

As described above, there have been very few ERs generated in the first year of the new contract. This is not unusual compared to other Mental Health Trusts. However, Calderdale trainees have continued to voice concerns in various fora regarding the pressures placed on them by the lack of medical staff. These concerns have gone to Training Programme Directors of both Foundation doctors and Core Psychiatry trainees. Health Education England has been reassured by the response of the Trust to employ locums to relieve the pressure. It is unlikely that there will be any additional trainees from February and the most pressing need is to develop a solution to manage the workload issues. Without other solutions, employment of locum doctors is likely to be required for some time.

There remain concerns about work pressures, mainly caused by vacancies, especially in Calderdale. The Trust has signed up to national initiatives to offer trainees posts to doctors from overseas, which may go some way to fill some of the vacancies. Any unresolved issues will be included in the next quarterly report.

## Recommendations

Trust Board is asked to RECEIVE, REVIEW and CONFIRM their assurance that the Trust has met its statutory duties.

## Appendix

### Distribution of Trainees by Locality

**Barnsley**

| Grade of Trainee | Number Expected | Number in post (WTE) | Employer |
|---|---|---|---|
| ST4-6 | 3 | 2 | South West Yorkshire Partnership NHS FT |
| GP Trainee | 1 | 1 | South West Yorkshire Partnership NHS FT |
| CT1-3 | 4 | 3 | Sheffield Health and Social Care Trust |
| FY2<br><br>FY1 | 1<br><br>1 | 1<br><br>1 | Barnsley Hospital NHS Foundation Trust |

**Calderdale**

| Grade of Trainee | Number Expected | Number in Post (WTE) | Employer |
|---|---|---|---|
| ST4-6 | 1 | 1 | South West Yorkshire Partnership NHS FT |
| GP Trainee | 2 | 2 | South West Yorkshire Partnership NHS FT |
| CT1-3 | 4 | 2.8 | South West Yorkshire Partnership NHS FT |
| LAS (covering Training gaps) | N/A | 1 | South West Yorkshire Partnership NHS FT |
| FY2<br>FY1 | 3<br>1 | 2<br>1 | Calderdale and Huddersfield NHS FT<br>Calderdale and Huddersfield NHS FT |

**Kirklees**

| Grade of Trainee | Number Expected | Number in post (WTE) | Employer |
|---|---|---|---|
| ST4-6 | 1 | 0 | South West Yorkshire Partnership NHS FT |
| GP Trainee | 3 | 2.6 | South West Yorkshire Partnership NHS FT |
| CT1-3 | 6 | 2 | South West Yorkshire Partnership NHS FT |
| LAS (covering Training gaps) | N/A | 2 | South West Yorkshire Partnership NHS FT |
| FY2<br>FY1 | 1<br>1 | 1<br>1 | Calderdale and Huddersfield NHS FT<br>Calderdale and Huddersfield NHS FT |

**Wakefield**

| Grade of Trainee | Number Expected | Number in post (WTE) | Employer |
|---|---|---|---|
| ST4-6 | 4 | 4.6 | South West Yorkshire Partnership NHS FT |
| GP Trainee | 4 | 4 | Leeds and York Partnership NHS FT |
| CT1-3 | 7 | 5 | Leeds and York Partnership NHS FT |
| LAS (covering training gaps) | N/A | 0 | South West Yorkshire Partnership NHS FT |
| FY2<br>FY1 | 2<br>3 | 2<br>3 | Mid Yorkshire NHS Trust<br>Mid Yorkshire NHS Trust |

**Newton Lodge**

| Grade of Trainee | Number | Employer |
|---|---|---|
| ST4-6 | 3 | South West Yorkshire Partnership NHS FT |
| ST4-6 | 1 | Sheffield Health and Social Trust |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 10.2

| | |
|---|---|
| **Title:** | **Equality and Inclusion Forum Annual Report 2017/18** |
| **Paper prepared by:** | Chair of Equality and Inclusion Forum<br>Director of Nursing and Quality |
| **Purpose:** | The purpose of the paper is to provide assurance to Trust Board that the Forum operates effectively and meets the requirements of their Terms of Reference. |
| **Mission/values:** | A strong and effective Board, committee and forum structure enables the Trust to achieve its vision and goals, and maintain a sustainable and viable organisation. |
| **Any background papers/ previously considered by:** | Minutes of meetings of the Forum in 2017/18. |
| **Executive summary:** | The Forum is required under its Terms of Reference to formally report annually to the Trust Board. The updated Forum Terms of Reference are provided for the final approval of Trust Board along with a work programme for 2018 for noting. |
| **Recommendation:** | **Trust Board is asked to:**<br>➢ **RECEIVE the annual report from the Equality and Inclusion Forum against the requirements of their Terms of Reference; and**<br>➢ **APPROVE the update to the Equality and Inclusion Forum Terms of Reference.** |
| **Private session:** | Not applicable. |

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**Trust Board 24 April 2018**

**Equality and Inclusion Forum Annual Report 2017/18**

## 1. Purpose of report

The purpose of the report is to provide a summary of the Forum's activities during the financial year 2017/18 to provide assurance and evidence to Trust Board of its effectiveness and impact through compliance with its Terms of Reference.

## 2. Background

The Equality and Inclusion Forum was set up by Trust Board in May 2015 for a twelve-month period, subject to review. The Forum is a committee of the Board and has no executive powers other than those specifically delegated in the terms of reference and, as appropriate, by the Trust Board.

The Forum's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through promoting the values of inclusivity and treating people with respect and dignity. The Forum was established to develop and oversee a strategy, including an approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities.

The duties of the Forum are:

- To promote the values of inclusivity, mainstreaming equality, diversity and inclusion across the Trust.
- To ensure a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers and staff and Members' Council.
- To ensure that the Trust embeds diversity and inclusion in all its activities and functions.
- To agree an annual work plan/schedule of priorities that link to the Trust's strategic direction, workforce plan and the wider transformation of services and to monitor progress.
- To ensure that as a consequence of promoting the values of inclusivity the Trust's services comply with legal and national guidance, including Equality Delivery System 2 (EDS2) and the Workforce Race Equality Standard (WRES).

Changes to Forum Terms of Reference

In 2018, the Forum reviewed and made some minor changes to its Terms of Reference, including membership and Trust branding, which were approved by the Forum on 6 March 2018. These are presented to the Trust Board for formal approval.

Reporting to Trust Board

Under its Terms of Reference, the Forum is required to produce a brief annual report on its activities, which is presented formally to Trust Board. The Forum's Minutes will be presented to the Trust Board once ratified.

Membership

The Forum is made up of Non-Executive and executive Directors, and members from April 2017 to March 2018 were:

- Ian Black, Chair of the Trust (Committee Chair) - Chair to 30 November 2017
- Angela Monaghan, Chair of the Trust (Chair) - Chair from 1 December 2017
- Julie Fox, Deputy Chair of the Trust / Senior Independent Director - Member to 31 July 2017
- Charlotte Dyson, Deputy Chair of the Trust / Senior Independent Director - Member from 1 August 2017
- Chris Jones, Non-Executive Director - Member from 1 December 2017
- Rob Webster, Chief Executive
- Tim Breedon, Director of Nursing and Quality (clinical adviser) - Lead director from 1 October 2017
- Dawn Stephenson, Director of Corporate Development - Lead director to 30 September 2017
- Alan Davis, Director of Human Resources, Organisational Development and Estates
- Sean Rayner, District Director, Barnsley and Wakefield (operational adviser)
- Karen Taylor, District Director, Calderdale and Kirklees (operational adviser)

Technical support is provided by Human Resources Managers and Equality and Engagement Development Managers. The staff side representative with lead for equality and diversity is also invited to attend meetings. Governors are also welcome to attend meeting and other Directors, and relevant officers attend the Forum by invitation.

## 3. Review of Committee activities

The activities during 2017/18 have been cross-referenced to the purpose of the Committee as outlined in the Terms of Reference below:

| | **Progress** |
|---|---|
| To promote the values of inclusivity, mainstreaming equality, diversity and inclusion across the Trust. | The Forum has the following as standing items at each meeting:<br>- Trusts progress against the Accessible Information Standard (AIS).<br>- Trusts progress against the Equality Delivery System 2 (EDS2).<br>- Status of Equality Impact Assessments (EIA).<br>- Feedback from BAME staff network.<br>In 2017/18, the Forum received reports on the following:<br>- Barnsley pilot for service users into employment.<br>- initiatives to encourage engagement with young people.<br>- Dementia awareness.<br>- Wellbeing survey results. |
| To ensure a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers and staff and Members Council. | A publicly elected Governor from the Members' Council now attends Forum meetings.<br>The Forum receives updates on the Equality Delivery System 2 (EDS2), including work taking place with partners. |
| To ensure that the Trust embeds diversity and inclusion in all its activities and functions. | The Forum receives an update on Equality Impact Assessments (EIA) and feedback from the BAME staff network as standing items at all Forum meetings. |

| | Progress |
|---|---|
| To agree an annual work plan/schedule of priorities that link to the Trust's strategic direction, workforce plan and the wider transformation of services and to monitor progress. | The Forum received an update on the Equality Strategy action plan. The Strategy is next due for review in 2020. |
| To ensure that as a consequence of promoting the values of inclusivity the Trust's services comply with legal and national guidance, including Equality Delivery System (EDS2) and the Workforce Race Equality Standard (WRES). | The Forum receives an update against the Equality Delivery System 2 (EDS2) as a standing item at each meeting. A formal report on the Workforce Race Equality Standard (WRES) was received by the Forum for support prior to its approval by Trust Board.<br>The Forum received an update on the progress against the outcomes of the North Kirklees Mental Health Act Audit which supported the Trust's statutory duties relating to equality and diversity. |

## 4. Review of Forum administrative arrangements

The Forum met three times in 2017/18 and has been quorate at each meeting. The requirement to send papers out five working days has been met throughout the year. There have been some instances where individual papers have, with agreement, been sent out after the five-day requirement.

South West Yorkshire Partnership NHS Foundation Trust

# EQUALITY AND INCLUSION FORUM
## Terms of Reference
*To be approved by Trust Board 24 April 2018*

The Equality and Inclusion Forum was initially set up by Trust Board in May 2015 for a twelve-month period, subject to review, and is now a standing Forum. The Forum is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by the Trust Board.

## Purpose
The Equality and Inclusion Forum's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through promoting the values of inclusivity and treating people with respect and dignity. The Forum will develop and oversee a strategy, including an approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities.

## Membership
The Equality and Inclusion Forum is chaired by a Non-Executive Director. One other Non-Executive Director also sits on the Forum as well as relevant Directors of the Trust and a Governor.

*Membership as at 1 April 2018*
Chair - Chair of the Trust - Angela Monaghan;
Non-Executive Director - Chris Jones;
Chief Executive - Rob Webster;
Lead Director - Director of Nursing and Quality - Tim Breedon;
Director of Human Resources, Organisational Development and Estates - Alan Davis;
District Director, Barnsley and Wakefield - Sean Rayner;
Director of Delivery - Karen Taylor;
Governor - Nasim Hasnie (publicly elected Governor, Kirklees) (formerly in attendance - member from 24 April 2018).

## Attendance
Technical support is provided by Human Resources Managers and Equality and Engagement Development Managers. The staff side representative with lead for equality and diversity is also invited to attend meetings. Other Governors are also welcome to attend the meeting. Other Directors, and relevant officers attend the Forum by invitation. Administrative support is provided by the Corporate Governance team.

## Quorum

The quorum will be half of the membership which must include one Non-Executive Director and one Director; however, members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Forum will agree another Non-Executive Director to take the chair.

## Frequency of meetings

The Committee will meet a minimum of three times per year and be reviewed every twelve months.

## Duties

- To promote the values of inclusivity, mainstreaming equality, diversity and inclusion across the Trust.
- To ensure a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers and staff and Members Council.
- To ensure that the Trust embeds diversity and inclusion in all its activities and functions.
- To agree an annual work plan/schedule of priorities that link to the Trust's strategic direction, workforce plan and the wider transformation of services and to monitor progress.
- To ensure that as a consequence of promoting the values of inclusivity the Trust's services comply with legal and national guidance, including Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES), and the Disability Equality Standard (DES).

## Reporting to Trust Board

Trust Board will receive feedback from the Forum's meeting at the meeting following Forum meetings.

The Forum should report to the Board annually on its work.

All Trust Board Forums have a responsibility to ensure they foster and maintain relationships and links between the Forums/Committees and Trust Board. Each Forum also has a responsibility to ensure actions identified and agreed are placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

## Authority

The Forum is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Forum. The Forum is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

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# Equality & Inclusion Forum annual work programme 2018

| Agenda item/issue | Mar | Jun | Oct |
|---|---|---|---|
| **Standing items** | | | |
| Declarations of interest | X | X | X |
| Minutes of previous meeting | X | X | X |
| Consideration of items from the corporate/organisational risk register allocated to the Forum | X | X | X |
| Feedback from staff equality networks | X | X | X |
| Equality standard updates | X | X | X |
| Equality Impact Assessments (EIA) update | X | X | X |
| Equality Delivery System 2 (EDS2) update | X | X | X |
| Inclusive leadership and development programme updates | X | X | X |
| National issues and impact locally | X | X | X |
| Any other business | X | X | X |
| Items to bring to the attention of Trust Board | X | X | X |
| **Annual items** | | | |
| Forum annual report for Trust Board | X | | |
| Equality and diversity annual report for Trust Board | | X | |
| Disability Equality Standard (DES) for Trust Board | | | X |
| Workforce Race Equality Standard (WRES) for Trust Board | | | X |
| Agreement of Forum meeting dates and work programme for following year | | | X |
| **Other items** | | | |
| Equality Strategy<br>*(next due for review in 2020)* | | | |

NHS
South West Yorkshire Partnership
NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 10.3

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| **Title:** | **Audit Committee Annual Report 2017/18 including updated Terms of Reference for committees** |
| **Paper prepared by:** | Company Secretary on behalf of the Chair of Audit Committee |
| **Purpose:** | The purpose of this paper is:<br>➢ To provide assurance to Trust Board that its committees operate effectively and meet the requirements of their terms of reference.<br>➢ Make suggested improvement to Board and sub-committee arrangements.<br>➢ Support the Annual Governance Statement of the Trust. |
| **Mission/values:** | A strong and effective Board and committee structure enables the Trust to achieve its vision and goals, and maintain a sustainable and viable organisation. |
| **Any background papers/ previously considered by:** | The annual reports of each committee were considered at the following meetings:<br>➢ Audit Committee 10 April 2018<br>➢ Clinical Governance and Clinical Safety Committee 6 February 2018 and 17 April 2018<br>➢ Remuneration and Terms of Service Committee 26 March 2018<br>➢ Mental Health Act Committee 6 March 2018<br>The final annual reports of each committee were considered by the Audit Committee on 10 April 2018. |
| **Executive summary:** | The Audit Committee is required under its terms of reference to review other risk Committees' effectiveness and integration to provide assurance to Trust Board that:<br>➢ risk is effectively managed and mitigated within the organisation;<br>➢ Committees are fulfilling their terms of reference; and<br>➢ integration between Committees avoids duplication.<br>The Committee agreed to combine this process with the production of the Annual Governance Statement (AGS).<br>Trust Board committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. As part of this process of assurance to Trust Board and as part of development of the AGS annually, Trust Board committees are required to produce an annual report and an annual work programme, undertake an annual self-assessment, and review their terms of reference for relevance and |

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| | appropriateness.<br><br>The Audit Committee received the annual report, work programme, and updated Terms of Reference approved by each committee (Note, the Terms of Reference and work programme for the Clinical Governance and Clinical Safety Committee were reviewed and updated after the Audit Committee meeting). The reports were supported by each committee Chair and lead Director to provide assurance to in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other committees. A summary is contained within the Audit Committee annual report to Trust Board. Updated committee Terms of Reference are provided for the final approval of Trust Board. |
| **Recommendation:** | **Trust Board is asked to:**<br>➢ **RECEIVE the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:**<br>• **committees meeting the requirements of their Terms of Reference;**<br>• **committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and**<br>• **committees can demonstrate added value to the organisation.**<br>➢ **APPROVE the update to the:**<br>• **Audit Committee Terms of Reference;**<br>• **Mental Health Act Committee Terms of Reference;**<br>• **Workforce and Remuneration Committee (previously Remuneration and Terms of Service Committee) Terms of Reference; and**<br>• **Clinical Governance and Clinical Safety Committee Terms of Reference.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

**Trust Board 24 April 2018**

**Audit Committee Annual Report 2017/18**

## 1. Purpose of report

The purpose of the report is to provide a summary of the Audit Committee's activities during the financial year 2017/18 to provide assurance and evidence to Trust Board of its effectiveness and impact through compliance with its Terms of Reference.

## 2. Terms of Reference and Audit Committee duties

The Audit Committee is a formal Committee of Trust Board, which provides the Board with assurance that the Trust is discharging its responsibilities in relation to the following.

- The establishment and maintenance of effective systems and processes that provide internal control within the organisation, particularly, review of all risk and control related disclosure statements, such as the Annual Governance Statement and value for money audit opinion.
- The effectiveness of the governance arrangements that cover evidence of achievement of corporate objectives and the adequacy of the assurance framework.
- The effectiveness of policies and processes to ensure compliance with regulatory frameworks, including Monitor's (now NHS Improvement's) risk assessment framework.
- The effectiveness of systems of internal control for the management of risk including the risk strategy, risk management systems and the risk register.
- The effectiveness of policies and procedures to prevent and manage fraud and compliance with regulatory requirements monitored through the Counter Fraud and Security Management Service.
- Overview of the work of other Committees to provide Trust Board with assurance in relation to the overall effectiveness of governance arrangements through the committee structure.

Changes to Terms of Reference

In 2017, some minor updating was incorporated within the Committee Terms of Reference which were approved by the Committee on 24 January 2017. Further areas were incorporated to ensure consistency across the Committee's Terms of Reference and the addition of areas in relation to risk and internal meeting governance framework. Formal approval of the changes was given by Trust Board on 25 April 2017.

In 2018, some minor amendments have been made in relation to members of the Committee. Formal approval of the changes will be by Trust Board on 24 April 2018.

Reporting to Trust Board

Under its terms of reference, the Audit Committee is required to produce a brief annual report on its activities, which is presented formally to Trust Board. The Committee's minutes are presented to the Trust Board following each meeting.

Membership
The Committee is made up of Non-Executive Directors, members from April 2017 to March 2018 were:

- Laurence Campbell, Non-Executive Director (Chair of the Committee)
- Chris Jones, Non-Executive Director
- Julie Fox, Non-Executive Director (member to 31 July 2017)
- Rachel Court, Non-Executive Director (member from 1 August 2017)

## 3. Review of Audit Committee activities

The Audit Committee's activities during the year have been cross referenced to its Terms of Reference.

### 3.1 Governance, risk management and internal control

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation.

| | **Progress** |
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| Review all risk and control related disclosures, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances. | As part of its consideration of the annual report, accounts and Quality Accounts, the Committee received and recommended for approval the Chief Executive's Annual Governance Statement for 2016/17. The Committee also received the statement from external audit for those with responsibility for governance in relation to 2016/17 and the Head of Internal Audit opinion. |
| Review underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principle risks and the appropriateness of the disclosure statements (above), including the fitness for purpose of the assurance framework. | The Committee was presented with the external audit plan in October 2017. Significant audit risks were outlined as follows.<br>- Revenue recognition in respect of CQUIN Income and Barnsley Intermediate Care<br>- Management override of controls<br>- Property Valuations<br>- Provisions<br>These were noted by the Committee and the Trust's annual report will specifically outline the management action to address these risks, explaining the mitigating action in place to address the risks or, where appropriate, an explanation as to why the Trust does not consider these to be risks, and explaining its tolerance of any residual risk.<br>One area of potential risk was identified in relation to value for money in terms of the delivery of the CIP programme.<br>The Committee receives an annual report on the process to develop the Assurance Framework, which is presented quarterly to Trust Board. |
| Review policies and processes for ensuring compliance with relevant regulatory, legal or code of conduct requirements, including the Monitor risk assessment framework. | The Committee reviewed the Treasury Management Policy and Strategy in January 2018 and supported its approval by Trust Board.<br>The Committee last reviewed the Trust Constitution, Scheme of Delegation, and Risk Management Strategy in January 2017 and supported their approval by Trust Board. They will next be due for review in 2019. |

| | Progress |
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| Review the systems for internal control, including the risk management strategy, risk management systems and the risk register. | *Consideration and approval of the Trust's risk management strategy is a matter reserved for Trust Board and the organisational risk register is reviewed quarterly by Trust Board.*<br>The Committee receives a report at each meeting on the triangulation of risk, performance and governance, which provides assurance that all key strategic risks are captured by the risk management process, that risks are appropriately highlighted and managed through governance committees and operational meetings, and there is a clear link between risk management and identifying areas of poor performance by the cross-reference of performance reporting to the risk register. The Committee finds this report particularly helpful in supporting scrutiny of performance and risk through Trust Board. |
| Review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service. | See section 3.3. |
| Review the work of other Committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements. | See section 4.2. |
| Review the arrangements that allow Trust staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters. | *Updates in relation to 'whistleblowing' arrangements and Freedom to Speak Up Guardians are provided to the Clinical Governance and Clinical Safety Committee.* |

### 3.2 Internal Audit

The Committee shall consider the appointment of the internal auditor (for approval by Trust Board) and ensure that there is an effective internal audit function, established by management, that meets Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chair, Chief Executive and Trust Board.

| | Progress |
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| Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal. | The contract for KPMG as the Trust's internal auditors ended on 30 June 2017. Through a procurement framework and tender process, 360 Assurance was appointed as the Trust's internal auditor from 1 July 2017.<br>Under the Public Sector Internal Audit Standards, all internal audit service providers are required to develop an internal audit charter, which is a formal document that defines the activities, purpose, authority and responsibilities of internal audit at the Trust. It also ensures the internal audit service provided to the Trust meets the requirements of both Professional Internal Auditing Standards and 360Assurance's own Internal Audit Manual. |
| Review and approval of the Internal Audit strategy and programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework. | The Internal Audit Annual Plan for 2017/18 was presented to and approved by the Committee in May 2017. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the |

| | **Progress** |
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| | Trust's corporate objectives, priorities and areas identified for improvement.<br>Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by internal audit. Regular meetings are held with the Director of Finance to monitor progress against the work plan. |
| Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources. | The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. In 2017/18, 8 internal audit reports were presented to the Committee. Of these, there were:<br>- 6 'significant assurance reports;<br>- 2 'limited assurance reports (Preparedness for Implementation of GDPR, Additional Pay Spend (Agency / Bank / Overtime))<br>Management action has been agreed for all recommendations. These are reported to the Committee and, where appropriate, progressed by 360Assurance. In the main, there are no significant outstanding actions.<br>The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2016/17. This provided significant assurance with minor improvement opportunities. |
| Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation. | The ongoing adequacy of resources is assessed as part of the review of the internal audit plan and monitoring progress. No significant issues have been raised in-year. |
| An annual review of the effectiveness of internal audit. | Performance is reported to the Committee through the internal audit progress report at each meeting and a summary included in the internal audit annual report.<br>The Committee and other relevant staff have also completed an established internal audit questionnaire to obtain feedback on the performance of internal audit in 2016/17. This will be repeated in 2018/19. |

### 3.3 Counter Fraud

The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service. The Committee shall also review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Protect Standards for Providers and as required by NHS Protect.

| | **Progress** |
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| Consideration of the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal. | The contract for KPMG as the Trust's local counter fraud specialist ended on 30 June 2017. Through a procurement framework and tender process, Audit Yorkshire was appointed as the Trust's Local Counter Fraud Specialist from 1 July 2017. |

| | Progress |
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| Review the proposed work plan of the Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures. | Audit Yorkshire presented a programme of work to the Committee in May 2017, which was approved. The Committee receives a Counter Fraud update report at each meeting to identify progress and any significant issues for action. |
| Receive and review the annual report prepared by the Local Counter Fraud Specialist. | The Committee received an annual report for 2016/17 in May 2017. |
| Receive update reports on any investigations that are being undertaken. | These are included in the progress reports to the Committee. |

### 3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to their work.

| | Progress |
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| Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit. | Following a re-procurement exercise during 2015, the Members' Council approved a proposal to re-appoint Deloitte as the Trust's external auditor from 1 October 2015 for a period of three years. The Lead Governor for the Members' Council was involved in the tender process. |
| Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy. | The Audit Committee has received and approved the Annual Audit Plan in October 2017. Progress against the plan is monitored at each meeting. |
| Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee. | The fee for Deloitte was approved as part of the re-appointment process in 2015.<br>A formal audit plan was presented to and approved by the Committee in October 2017. This included an evaluation of risk, which is summarised under section 3.1 above. |
| Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses. | The Audit Committee received and approved:<br>- the statement for those with responsibility for governance in relation to 2016/17 accounts;<br>- final reports and recommendations as scheduled in the annual plan. |
| Develop and implement a policy on the provision of non-audit services by the External Auditor. | The Trust Board have agreed to a change in the terms of reference of the Audit Committee with respect to the provision of non-audit services to be formally approved. |

### 3.5 Financial reporting

| | Progress |
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| The Committee has responsibility for approving accounting policies. | The Committee considered and approved minor changes to accounting policies at its meeting in January 2018. These changes were supported by the Trust's external auditor. |
| The Committee has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and charitable Funds, and the Quality Accounts/Report and to make a recommendation to the Chair, Chief Executive and Director of Finance on the signing of the accounts and associated documents prior to submission. | The Committee recommended to the Trust Board for approval the annual report, accounts and Quality Accounts at its meeting in May 2017 prior to submission to NHS Improvement (Monitor). This included the Trust's charitable funds. The Committee also recommended for approval the stand-alone annual report and accounts for charitable funds in July 2017.<br>As part of the consideration of the auditor's |

| | **Progress** |
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| | report, the Committee received and reviewed the Use of Resources Assessment for 2016/17.<br>The Committee also reviewed the external audit report on the production of Quality Accounts for 2016/17. *(It should be noted that the scrutiny of the preparation, development and final content of the Quality Accounts is the responsibility of the Clinical Governance and Clinical Safety Committee.)* |
| The Committee also ensures that the systems for, and content of, financial reporting to Trust Board are subject to review so as to be assured of the completeness and accuracy of the information provided. | The internal audit programme includes routine testing of the Trust's financial reporting systems; however, financial reporting and scrutiny remains with Trust Board, including any review of the adequacy of reporting.<br>The Committee receives a regular report on treasury management and reviewed its Treasury Management Strategy and Policy in January 2018.<br>The Committee also receives a detailed report on procurement activity, which monitors non-pay spend and progress on tenders, and progress against the Procurement Strategy and associated cost improvement programme.<br>The Committee's agenda includes a standing item to review progress towards implementation of service line reporting and currency development. This has included assurance on operational implementation and use from BDU Directors.<br>The Committee is also required, on behalf of Trust Board, to approve the methodology for determining the Trust's reference cost submission.<br>The Committee received and reviewed the Use of Resources Assessment for 2016/17. |
| The Committee also:<br>- reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation;<br>- examines circumstances associated with each occasion Standing Orders are waived;<br>- reviews the schedules of losses and compensations on behalf of Trust Board. | Changes to the Trust's Standing Financial Instructions were approved by the Audit Committee and Trust Board in October 2016.<br>Changes to the Trust's Constitution (including the Standing Orders) and Scheme of Delegation were considered by the Committee in January 2017 and approved by the Trust Board in January 2017 and Members' Council in February 2017.<br>There were no occasions when Standing Orders were waived in 2017/18.<br>The losses and special payments report is received by the Committee at each meeting. |

## 4. Review of Audit Committee administrative arrangements

The Audit Committee meets the minimum requirement for the number of meetings in the year and has been quorate at each meeting. The requirement to send papers out six clear days in advance of the meeting has been met throughout the year. There have been some instances where individual papers have, with agreement, been sent out after this requirement.

## 5. Audit Committee self-assessment

In line with the Terms of Reference, the Audit Committee has an agreed self-assessment process. The proforma used is that recommended by the Audit Committee Handbook. The self-assessment has eight sections:

- composition, establishment and duties;
- compliance with the law and regulations governing the NHS;
- internal control and risk management;
- Internal Audit;
- External Audit;
- Annual Accounts;
- administrative arrangements
- other issues

The Committee reviewed the positive outcome of the self-assessment with all areas assessed as compliant at its meeting on 10 April 2018. No further actions were identified.

## 6. Governance assurance

### 6.1 Review of committee effectiveness

Each Committee has Terms of Reference and is required to produce an annual report outlining achievements against objectives and compliance with Terms of Reference. The annual reports, work programmes and updated terms of reference were provided to the Audit Committee to provide assurance to Trust Board.

### 6.2 Audit Committee review of the effectiveness of Trust Board committees

In April 2010, the Audit Committee agreed an approach and process to fulfilling its role to provide oversight and assurance to Trust Board on the effectiveness of the other sub-committees of the Board.

The committees assumed within scope of the Audit Committee review are:

- Clinical Governance and Clinical Safety Committee;
- Mental Health Act Committee; and
- Remuneration and Terms of Service Committee.

The draft annual report, annual work programme and the outcome of self-assessments for these committees will be provided to the Audit Committee on 10 April 2018 for 2017/18. The purpose of the review is for the Audit Committee to provide assurance to Trust Board that:

- each committee meets the requirements of its Terms of Reference;
- each committee's work programme is aligned to the risks and objectives of the organisation, which are in the scope of its remit;
- each committee can demonstrate added value to the organisation.

The review was undertaken as part of formal Audit Committee business with committee chairs and lead Directors invited to present to provide assurance to the Audit Committee on the assurance each committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other committees.

<u>Audit Committee</u>
Chair – Laurence Campbell; Lead Director – Mark Brooks
Key areas highlighted for 2017/18 are:

- The Committee met its Terms of Reference and developed a work programme to reflect the risks and objectives of the organisation.
- Small changes to the Committee's terms of reference were approved by Trust Board in April 2017.
- In his role as Audit Committee Chair, Laurence Campbell has attended meetings of all Committees prior to the approval of the annual governance statement to facilitate integration and to receive assurance.

Clinical Governance and Clinical Safety Committee
Chair – Charlotte Dyson; Lead Director – Tim Breedon

Key areas highlighted for 2017/18 are:

- Approval of updated Quality Strategy and new Learning from Deaths Policy.
- Ongoing scrutiny of Child and Adolescent Mental Health Services (CAMHS) improvement plan.
- Ongoing review of waiting list initiative.
- Improvements as a result of the new Patient Safety Strategy.
- Performance management of Care Quality Commission (CQC) action plan.
- Ongoing focus on Serious Incident reporting.

Mental Health Act Committee
Chair – Chris Jones*;* Lead Director – Dr Adrian Berry

The committee's agenda is informed by two main areas:

- The Act in practice ensures the Committee is aware of matters, mostly external, that impact on the Trust.
- Compliance and assurance provides a focus on the application of the Act within the Trust.

Key priority areas highlighted for 2018/19 are:

- Ongoing commitment to delivering mandatory training and development of Web based solutions to deliver refresher training for the Mental Health Act (MHA) and Mental Capacity Act (MCA).
- Review and implementation of government response to MCA legislation.
- Implementation of NICE guidance on assessment of capacity.
- Development and implementation of system one in relation to MHA and MCA.
- Performance management of MHA focused Care Quality Commission (CQC) action plans.
- Review and implementation of CQC MHA/MCA annual report.
- Implementation of internal audit recommendations.

Remuneration and Terms of Service Committee
Chair – Rachel Court; Lead Director – Alan Davis

Overall the review of the documents and presentation on the work of the committees was sufficient to enable the Chair of the Audit Committee to support an assurance to Trust Board that the integrated governance arrangements in the Trust were operating effectively and that committees:

- had met the requirements of their Terms of Reference;
- had followed a workplan aligned to the risks and objectives of the organisation, within the scope of each Committee's remit; and

- could demonstrate added value to the organisation.

### 4.3 Independent review of the Trust's governance arrangements

In 2014, Monitor (now NHS Improvement) stated its expectation that all foundation trust boards would carry out an external review of their governance arrangements every three years given that:

- good governance is essential in addressing the challenges the sector faces;
- oversight of the Trust's governance arrangements is the responsibility of Trust Board;
- governance issues are increasing across the sector; and
- regular reviews can provide assurance that governance arrangements are fit for purpose.

As a result, Monitor issued guidance to support Trusts in ensuring they are 'well-led'. The framework supports the NHS response to the Francis Report and is aligned with the assessment the Care Quality Commission (CQC) makes on whether a foundation trust is well-led as part of its revised inspection regime. The framework has four domains, ten high-level questions and a description of 'good practice' that can be used to assess governance. The four domains cover:

- strategy and planning – how well the Board sets the direction for the organisation;
- capability and culture – whether the Board takes steps to ensure it has the appropriate experience and ability, now and into the future, and whether it positively shapes the organisation's culture to deliver care in a safe and sustainable way;
- process and structures – whether reporting lines and accountabilities support the effective oversight of the organisation; and
- measurement – whether the Board receives appropriate, robust and timely information and that this supports the leadership of the Trust.

Following a decision by Trust Board to undertake an independent review of the Trust's governance arrangements in line with Monitor's well-led framework for governance reviews, Deloitte undertook the review in April 2015. Following a robust and thorough review and scrutiny of the Trust's governance arrangements, which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff, the review concluded with presentation of the key findings to Trust Board on 21 July 2015. This was followed by a workshop with the Members' Council on 21 September 2015. There were no 'material governance concerns' arising from the review. Out of the ten areas assessed, two areas were rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight as amber/green. There were a number of developmental areas where Deloitte has recommended further work and these formed the basis of an action plan with timescales. An update on the progress against the action plan was presented to Trust Board in April 2016 and internal audit undertook a review of implementation as part of its audit work for corporate governance arrangements in 2016. This audit received 'significant assurance'.

In 2017, NHS Improvement aligned its well-led review to the CQC well-led key lines of enquiry. In April 2018, the CQC is undertaking a well-led review of the Trust.

## 7. Conclusion

In summary, the Annual Report of the Audit Committee can evidence the Committee has discharged its responsibilities in relation to its statutory obligations and Terms of Reference. This includes providing the Board with assurance on the effectiveness of other Committees which is part of the Audit Committee role in supporting integrated Governance.

South West Yorkshire Partnership NHS Foundation Trust

# AUDIT COMMITTEE
## Terms of Reference
*To be approved by Trust Board 24 April 2018*

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Audit Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board.



## Purpose
The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Annual Governance Statement on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

## Membership
Taking guidance from Monitor and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors.

*Membership as at 1 April 2018*
Chair – Non-Executive Director - Laurence Campbell
Non-Executive Director - Chris Jones;
Non-Executive Director - Rachel Court.

## Attendance
The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Company Secretary also attends meetings. Representatives of internal and external audit are also invited and expected to attend. The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Audit Committee by invitation. Administrative support is provided by the Personal Assistant to the Director of Finance and Resources.

## Quorum

The quorum will be two Non-Executive Directors (including the Chair of the Committee). Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

## Frequency of meetings

The Committee will meet a minimum of four times per year to reflect best practice. The Chair of the Committee, External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary. There will also be an additional meeting to approve the annual report, accounts and Quality Accounts.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation, and to agree these with the Chair of the Committee.

## Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

## Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

## Duties

<u>Governance, risk management and internal control</u>

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by Trust Board;
- the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principal risks and the appropriateness of the above disclosure statements. This includes assessing the fitness for purpose of the assurance framework including risk appetite and providing assurance that action plans are in place to address significant control issues;
- the policies and processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements, including the Monitor risk assessment framework;
- the systems for internal control including the risk management strategy, risk management systems and the risk register;

- the polices and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service;
- the work of other committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.

In carrying out its work, the Committee will primarily utilise the work of Internal and External Audit; however, it will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. The Committee will use the Trust's Assurance Framework to guide its work and that of the audit and assurance functions reporting to it.

The Committee will also review arrangements that allow Trust staff (and other individuals where relevant) to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee will ensure that:

- arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action;
- ensure safeguards for those who raise concerns are in place and that these safeguards operate effectively;
- such processes enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure valid concerns are promptly addressed; and
- these processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

Internal Audit

The Committee shall consider the appointment of the Internal Auditor (for approval by Trust Board) and ensure there is an effective internal audit function established by management that meets Public Sector Internal Audit Standards that provides appropriate independent assurance to the Audit Committee, Chief Executive, Chair and Trust Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation or dismissal;
- review and approval of the Internal Audit approach, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between internal and external auditors to optimise audit resources;
- ensure the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of internal audit.

External audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to its work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit;

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure co-ordination, as appropriate, with other external auditors in the local health economy;
- discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
- review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses;
- Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.

The Committee will also advise the Members' Council with regard to the appointment and removal of the Trust's external auditors and, to inform this advice, carry out a market testing exercise for the appointment of the external auditor at least every five years.

Counter fraud

The Committee shall review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Protect Standards for Providers and as required by NHS Protect. In particular:

- consider the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal;
- review the proposed work plan of the Trust's Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures;
- receive and review the annual report prepared by the Local Counter Fraud Specialist;
- receive update reports on any investigations that are being undertaken.

Financial reporting

The Committee has responsibility for approving accounting policies. It also has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and for charitable funds, and the Quality Accounts/Report on its behalf and to make a recommendation to the Chair and Chief Executive on the signing of the accounts and associated documents prior to submission to Monitor, Trust Board and the Members' Council. In particular, the Committee shall focus on:

- changes in, and compliance with, accounting policies and practices;
- major judgemental areas; and
- significant adjustments arising from the annual audit.

The Committee also ensures that the systems for, and content of, financial reporting to Trust Board, including those of and for budgetary control, are subject to review so as be assured of the completeness and accuracy of the information provided to Trust Board.

The Committee also:

- reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before these are laid before Trust Board;
- examines the circumstances associated with each occasion Standing Orders are waived;
- reviews schedules of losses and compensations on behalf of Trust Board.

## Relationship with the Members' Council

To reflect best practice and Monitor's Code of Governance, Trust Board will consult with the Members' Council annually on the Audit Committee's terms of reference. At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

## Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

## Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

South West Yorkshire Partnership NHS Foundation Trust

# MENTAL HEALTH ACT COMMITTEE
## Terms of Reference
*To be approved by Trust Board 24 April 2018*

All Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. It is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.



## Purpose
The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

## Membership
The Mental Health Act Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors also sit on the Committee as well as relevant Directors of the Trust.

*Membership as at 1 December 2017*
Chair – Non-Executive Director - Chris Jones;
Non-Executive Director - Laurence Campbell;
Non-Executive Director - Kate Quail;
Lead Director - Medical Director - Dr Subha Thiyagesh;
Director of Nursing and Quality - Tim Breedon.

The Committee also has scope to co-opt external individuals either as permanent members of the Committee or on an ad-hoc basis where it is felt expertise or specialist advice is required.

## Attendance
Representatives of the four local authorities, a representative of the three acute trusts covering the Trust's geography, a representative from the District Directors, and one Associate Hospital Manager (as nominated by the Hospital Managers' Forum) are invited to attend meetings. The Assistant Director, Legal Services, is in attendance at meetings. The Chief Executive, other Directors, and relevant officers attend the Mental Health Act

Committee by invitation. Administrative support is provided by the Integrated Governance Manager.

## Quorum

The quorum will be two Non-Executive Directors (including the Chair of the Committee or his/her nominated deputy) and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

## Frequency of meetings

The Committee will meet a minimum of four times per year to reflect availability of quarterly reports.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

## Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

## Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groupsincluding but not limited to:

- Hospital Managers Forum

## Duties

1. To monitor the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983 and the Mental Capacity Act 2005, within the Trust taking into account best practice.
2. To consider the implication of any changes to legislation and regulations within a local context.
3. To receive reports from Associate 'Hospital Managers' in their role of hearing appeals and to scrutinise the processes for and outcome of appeals and tribunals.
4. To ensure there is an appropriate number of Hospital Managers in place with the appropriate skills and experience to fulfil their role.
5. To monitor trends in the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary.

6. To receive reports following Care Quality Commission visits for information and comment and ensure appropriate action is agreed and implemented within the organisation.
7. To scrutinise delivery against the Trust's action plan developed as a result of the Care Quality Commission's Annual Report as instructed by Trust Board.
8. To approve policies in relation to the Mental Health Act and Mental Capacity Act across the Trust and scrutinise the application of these policies throughout the Trust in relation to both Acts.
9. To address training issues in terms of delegation of responsibilities under the Mental Health Act 1983
10. To address quality issues in terms of delegation of responsibilities under the Mental Health Act 1983
11. To manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation.
12. To request specific reports relevant to the application of the Mental Health Act.
13. To undertake duties relevant to the Committee set out in the 'Duties of Hospital Managers' Policy.

## Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

## Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

# WORKFORCE AND REMUNERATION COMMITTEE
## Terms of Reference
*To be approved by Trust Board 24 April 2018*

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Workforce and Remuneration Committee (formerly known as Remuneration and Terms of Service Committee) was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board.



## Purpose
The Workforce and Remuneration Committee has delegated authority for developing and determining appropriate pay and reward packages for the Chief Executive and Executive Directors and a local pay framework for senior managers as appropriate that actively contribute to the achievement of the Trust's aims and objectives. The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors. Additionally, the Committee is responsible for ratifying Clinical Excellence Awards for Consultant Medical Staff.

The Committee also supports and monitors the strategic development of human resources and workforce development and considers issues and risks relating to the broader workforce strategy. On behalf of Trust Board, it reviews in detail key workforce performance issues, and takes ownership of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, and giving assurance to the Board around the management of such risks.

## Membership
Membership of the Committee is comprised of the Chair of the Trust, two Non-Executive Directors and the Chief Executive.

*Membership as at 1 December 2017*
Chair – Non-Executive Director - Rachel Court;
Non-Executive Director - Angela Monaghan (Chair of the Trust);
Non-Executive Director - Charlotte Dyson (Deputy Chair of the Trust / Senior Independent Director);
Chief Executive - Rob Webster (non-voting Committee member).

## Attendance

The Chief Executive is a non-voting member of the Committee and will take no part in or be present for any items relating to his/her own personal remuneration or conditions of service. The Director of Human Resources, Organisational Development and Estates is also in attendance at meetings as lead Director and provides advice and support to the Committee. Administrative support is provided by the Personal Assistant to the Director of Human Resources, Organisational Development and Estates.

## Quorum

The quorum will be two Non-Executive Directors (including the Chair of the Committee or their nominated deputy); members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

## Frequency of meetings

The Committee will meet no less than four times per year.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

## Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

## Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees including but not limited to:

- Clinical Excellence Awards Panel.

## Duties

1. To develop and determine appropriate pay and reward packages for the Chief Executive, Executive Directors and other designated senior managers and other locally determined pay arrangements that actively contribute to the achievement of the Trust's aims and objectives, are affordable and are in line with the Trust's financial strategy. Specifically to:
   a) determine the remuneration and terms of service for the Chief Executive;
   b) determine the remuneration arrangements for Executive Directors and to agree individual salary levels for Executive Directors;
   c) to determine any annual uplift, for example, cost of living, for the Chief Executive and Executive Directors;

d) to ratify remuneration arrangements for senior management posts;
e) to approve any annual uplifts in pay structures and any performance-related pay arrangements for senior posts;
f) to approve any termination payments to the Chief Executive and Executive Directors and ensure these are properly calculated and reasonable with regard to probity and value for money;
g) to receive a report from the Chief Executive of any proposed termination payments to be made to senior managers.

2. Under delegated authority from Trust Board as deemed appropriate for each circumstance, to agree and oversee the process for the appointment of the Chief Executive and Executive Directors of the Trust.
3. To approve recommendations of the Clinical Excellence Awards Panel for Clinical Excellence Awards to Consultant Medical Staff.
4. To support the strategic development of human resources and workforce development and consider issues and risks relating to the broader workforce strategy.
5. On behalf of Trust Board, to monitor progress of the Workforce Strategy and review in detail key workforce performance issues.
6. To have oversight of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.
7. To consider future national developments which could impact on the Trust's strategic workforce objectives.

## Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

## Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting. Confidential personnel matters will go to the Private Session of Trust Board, if appropriate, and the decisions of the Committee in relation to specific salary matters are reported to the Non-Executive Directors of the Trust only. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# CLINICAL GOVERNANCE AND CLINICAL SAFETY COMMITTEE
## Terms of Reference
*To be approved by Trust Board 24 April 2018*

All Trust Board Committees are responsible for scrutinising and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

## Purpose
The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. On behalf of the Trust Board, it will have an oversight of clinical risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

## Membership
The Clinical Governance and Clinical Safety Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors (NED) also sit on the Committee as well as relevant Directors of the Trust.

*Membership as at 19 April 2018*
Chair - Non-Executive Director - Charlotte Dyson (Deputy Chair / Senior Independent Director)
Non-Executive Director - Angela Monaghan (Chair of the Trust)
Non-Executive Director - Kate Quail
Lead Director - Director of Nursing and Quality – Tim Breedon
Medical Director - Dr Subha Thiyagesh
Director of Human Resources, Organisational Development and Estates - Alan Davis

## Attendance
District Directors and the Deputy Director of Nursing and Quality in attendance at each meeting. Clinical representatives and relevant Trust officers are invited to meetings as appropriate to ensure the remit of the Committee is adequately covered. The Chief Executive, other Directors, and relevant officers attend the Clinical Governance and Clinical Safety Committee by invitation. Administrative support is provided by the Integrated Governance Manager as Secretary to Trust Board.

## Quorum

The quorum will be two Non-Executive Directors (including the Chair of the Committee or nominated deputy) and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

## Frequency of meetings

The Committee will meet a minimum of six times per year.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

## Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

## Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees including but not limited to:

- Health and Safety;
- Drugs and Therapeutics (Medicines Management);
- Safeguarding (vulnerable adults and children);
- Infection Prevention and Control;
- Managing Aggression and Violence;
- Quality Network Improvement Group;
- Patient Safety Strategy Group.

## Duties

The Committee provides assurance to Trust Board on service quality, practice effectiveness and the application of controls assurance in relation to clinical services and ensures the Trust is discharging its responsibilities with regard to clinical governance and clinical safety.

<u>Strategy and policy</u>

1. To approve relevant strategies and policies on behalf of the Trust Board
2. To monitor implementation of strategic objectives relevant to clinical governance, care delivery and practice effectiveness, such as implementation of care management processes and clinical information management, providing assurance to Trust Board that these are appropriately managed and resourced.

Clinical governance

3. 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 discharge 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.
4. To provide assurance to Trust Board that the Trust is meeting national requirements for clinical governance and clinical safety.
5. To assure Trust Board that the Executive Management Team and Business Delivery Units have systems in place that encourage and foster greater awareness of clinical governance and clinical safety throughout the organisation, at all levels.

Compliance

6. To monitor, scrutinise and provide assurance to Trust Board on the Trust's compliance with national standards, including the Care Quality Commission, the quality elements relating to NHSI and NICE guidance.
7. To provide assurance to the Trust Board that the Trust is compliant with relevant legislation.
8. To provide assurance that the Trust has effective arrangements for the prevention and control of infection, safeguarding adults and children, information governance and records management, and the safety elements covered by the Health and Safety TAG.

Clinical safety management

9. To provide assurance to the Trust Board that environmental risks, including those identified as a result of PLACE inspections or environmental audit, are addressed and monitor appropriate action plans to mitigate these risks.
10. To provide assurance to the Trust Board that robust arrangements are in place for the proactive management of complaints, adverse events and incidents, including scrutiny of quarterly and annual reports on incidents and complaints and implementation of action plans.
11. To provide assurance to Trust Board that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.
12. As delegated by Trust Board, to monitor implementation of action plans relating to reviews of complaints by the Health Service Ombudsman and of action plans identified through independent inquiry reports relating to the Trust.

Public and service user experience

13. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users and carers, and clinicians to shape service delivery.

## Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

## Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting wherever practical. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 10.4

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|---|---|
| **Title:** | **Draft Annual Governance Statement 2017/18** |
| **Paper prepared by:** | Company Secretary on behalf of the Chief Executive |
| **Purpose:** | The purpose of the paper is to seek Trust Board support for the first draft of the Annual Governance Statement, which will be included in the Annual Report and accounts for 2017/18 and will be subject to independent audit by Deloitte as part of this process. |
| **Mission/values:** | A sound system of internal control supports the Trust's Mission. Effective governance arrangements are underpinned by openness, honesty, transparency and respect. |
| **Any background papers/ previously considered by:** | Guidance on completing the Annual Governance Statement is included in NHS Improvement's NHS Foundation Trust Annual Reporting Manual and is based on Treasury requirements. |
| **Executive summary:** | All NHS organisations are required to have risk management, control and review processes in place, appropriate to their circumstances and business. All Foundation Trusts have to produce an Annual Governance Statement (AGS), which is included in the organisation's Annual Report and accounts and is externally audited, covering:<br>➢ scope of responsibility;<br>➢ the purpose of the system of internal control;<br>➢ capacity to handle risk;<br>➢ the risk and control framework;<br>➢ review of economy, efficiency and effectiveness of the use of resources;<br>➢ annual Quality Report;<br>➢ review of effectiveness;<br>➢ conclusion.<br>Foundation Trusts are required to make disclosures or qualifications in the AGS about their risk management and review processes being in place for the full year, and gaps in assurance frameworks. The AGS must contain statements on compliance with and assessment against specified requirements and significant control issues for 2017/18.<br>Organisations should ensure that they have evidence which they deem sufficient to demonstrate that they have implemented processes appropriate to their circumstances under each of the high level elements to support their AGS for 2017/18.<br>The AGS has been produced in accordance with current guidance from NHS Improvement. |

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|---|---|
| | The document is working progress with some areas awaiting available information highlighted in red. The Trust is required to include the narrative highlighted in grey in the Statement as required by the guidance in NHS Improvement's NHS Foundation Trust Annual Reporting Manual.<br><br>**Risk appetite**<br><br>The AGS supports our view that the Board should take significant assurance from the governance arrangements, and in itself is managed within our Risk Appetite. |
| **Recommendation:** | **The Trust Board is asked to APPROVE the first draft of the Annual Governance Statement for 2017/18.** The Trust Board should note that the Statement will be subject to change following review by Deloitte as part of the audit of the Trust's Annual Report and accounts. |
| **Private session:** | Not applicable. |

# Annual Governance Statement 2017/18

## Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

This Annual Governance Statement reflects the challenging context within which I deliver my responsibilities and demonstrates the complexity and diversity of the services the Trust provides across a broad geographical area.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

**Our Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk.** This includes responsibility for standards of public behaviour and accountability for monitoring the organisation's performance against the Trust's strategy and objectives, ensuring corrective action is in place where necessary. The Trust Board's attitude to risk is based on appropriate tolerance to risk. The Board acknowledges that the services provided by the Trust cannot be without risk and ensures that, as far as is possible, risk is minimised and managed within a risk tolerance. This is set out in the Trust's Risk Strategy and Risk Appetite Statement.

**The Board is supported and governed by an involved and proactive Members' Council, a key part of the Trust's governance arrangements.** Since becoming a Foundation Trust in 2009, the Members' Council has matured, in its role of holding Non-Executive Directors to account for the performance of the Trust Board. The agendas for Members' Council meetings, produced in partnership with the Members' Council Co-ordination Group, focus on its statutory duties, areas of risk for the Trust and on the Trust's future strategy. Training and development ensures governors have the skills and experience required to fulfil their duties.

**The Board includes an Executive team with the day to day responsibility for managing risk.** Over the last year, we have had a largely stable Executive Director team. There has been a reduction in the number of Business Delivery Unit (BDU) directors of one, with that individual now fulfilling a Director of Delivery role to focus on operational excellence. The

Director of Corporate Development role ceased during the year with the associated responsibilities transferring to other directors. Executive director portfolios are continually reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust.

**The Members' Council, Board and Executive team are operating in an environment of change and system pressure where risk is constant and at a heightened level.**

**The Trust operates within a strategic framework that includes a Vision, Mission and Values, supported by three Strategic Objectives and a number of Priority Programmes.** This approach is agreed and set by the Board and provides an effective underpinning of the Chief Executive objectives and the objectives of the Executive team determined in line with director accountabilities. I review these objectives on an on-going basis with individual directors with progress, issues and risks reflected in the Board Assurance Framework and corporate/organisational risk register.

This approach reflects the Trust's framework that devolves responsibility and accountability throughout the organisation by having robust delivery arrangements. Capacity for delivery is assured through business planning processes and control is executed through an appropriate Scheme of Delegation and Standing Financial Instructions.

**The Trust works in partnership with health economies in Calderdale, Kirklees, Wakefield, Barnsley and the Sustainability and Transformation Partnerships of South Yorkshire and West Yorkshire.** We identify and manage risk at those levels as well as at Trust level, as reflected in the roles and responsibilities of the Board, of Executives and staff within the Trust. This is evident from the Board Assurance Framework and Trust risk registers.

The Trust strengthened its risk management arrangements during 2017/18 by creating a formal Risk Officer role and scheduling regular reviews of risk at Executive Management team meetings, and the Trust Board, alongside the forums of the Board and its sub-committees. This recognises the dynamic nature of the environment in which we operate and the need to constantly focus, assess and manage risk.

Risk management training for the Trust Board is undertaken bi-annually. The training needs of staff are assessed through a formal training needs analysis and staff receive training appropriate to their authority and duties. The role of individual staff in managing risk is supported by a framework of policies and procedures that promote learning from experience and sharing of good practice. The Risk Management Strategy was updated and approved by Trust Board on 31 January 2017.

Alongside this capacity, the Trust has effective Internal Audit arrangements, with a work plan that helps to manage strategic and business risk within the Trust.

## The risk and control framework

**The risk and control framework flows from the principles of good governance.** It uses effective Board and committee structures, supported by the Trust's Constitution (including Standing Orders) and Scheme of Delegation. The Risk Management Strategy describes in detail how risk is applied within this framework.

**The Audit Committee assures the Board and Members' Council of the effectiveness of the governance structures** through a cycle of audit, self-assessment and annual review. The latest annual review will be discussed by the Board on 24 April 2018.

**The Audit Committee assessment was supported by an internal audit that was undertaken on Risk Management and the Board Assurance Framework in October 2017 and provided 'significant assurance'. Furthermore, the new Trust internal auditors conducted a survey of Trust Board members in relation to risk management which again supports this assessment.**

The cycle of Trust Board meetings continues to ensure that the Trust Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Within each quarterly cycle, there is one monthly meeting with a forward-looking focus centred on business risk and future performance, one meeting focusing on performance and monitoring, and one strategic development session. Trust Board meetings are held in public and the Chair encourages governors to attend each meeting.

The Board has recognised the development of stronger partnerships across the geography in which we operate. Formal partnership Boards and committees have reports and Minutes received by the Board and are reflected in our risks.

**The Trust's Risk Management Strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk.** The Trust's Risk Appetite Statement was defined in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix. The Statement was approved by Trust Board in July 2016 for implementation from September 2016. The Risk Appetite Statement sets out the Board's strategic approach to risk-taking by defining its specific boundaries and risk tolerance thresholds under four categories (strategic, clinical, financial or commercial, and compliance risks), and supports delivery of the Trust's Risk Management Strategy and procedures. Risks that are significant are monitored by the appropriate committee. Over 2017/18, further work has been undertaken to review risk registers where organisational risks not considered significant (level 15 and above) fall outside the Risk Appetite.

During the year, improvements have been agreed with a risk exception report being developed to go to the relevant committee or forum of the Board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Work is also taking place to further develop risk tolerance following a discussion at a Board strategic meeting.

**The Board Assurance Framework (BAF) describes the strategic risks that will continue to be managed by the Trust.** The BAF is aligned to the three strategic objectives of the Trust. This ensures alignment between the business of the Trust and the risks we manage across the organisation and the system. The BAF is used to help shape the agenda of the Board and its sub-committees.

**As Chief Executive and the Accounting Officer, my accountabilities are secured through delegated executive responsibility to the Executive Directors of the Trust** for the delivery of the organisational objectives, ensuring there is a high standard of public accountability, probity and performance management. In 2017/18, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director.

**In support of the BAF, the Trust also has a corporate/organisational risk register in place** which outlines the key strategic risks for the organisation and action identified to mitigate these risks. This is reviewed on a monthly basis by the Executive Management Team and quarterly by Trust Board, providing leadership for the risk management process.

Risk registers are also developed at service delivery level within BDUs and within the corporate directorates. These are reviewed regularly at the Operational Management Group.

**The Trust's main risks at the end Quarter 4 2017/18, as set out in the organisational risk register, will be discussed by Board on 24 April 2018.**

**Given the strategic context within which we operate, the risks outlined above will continue into 2018/19 with mitigating actions in place.** The creation of Sustainability and Transformation Partnerships (STP) across West and South Yorkshire will provide a further mechanism for managing some risks across organisations. As the lead Chief Executive for the STP in West Yorkshire & Harrogate, I will be able to ensure we are closely engaged in the leadership and delivery of these plans. As an engaged member of the leadership team of the South Yorkshire & Bassetlaw, I will ensure that the risks inherent in the move to an Integrated Care System are understood and mitigated.

## Our Licence

**The Trust was awarded a Licence by Monitor on 1 April 2013 with no conditions. There are currently no risks to compliance with the Licence conditions that apply to the Trust, including NHS Foundation Trust condition 4, which applies to Foundation Trusts only.**

The Trust operates under the Single Oversight Framework issues by NHS Improvement which assists the Trust in compliance with the Monitor Licence. Our rating under this framework is 2 – targeted support

**The foundation trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).** The Trust continues to assess its compliance with CQC registration requirements through an internal regulatory compliance review process and by learning from a regular programme of unannounced visits. Following the CQC visit in March 2016, the Trust developed a new internal visit programme, which initially targeted those services rated as 'requires improvement'. Feedback reports are received and reviewed by BDU management trios, BDU deputy directors and team managers, who develop an action plan to address areas for improvement that are monitored through BDU governance functions. Feedback, lessons learned and good practice from the process are shared with the Clinical Governance and Clinical Safety Committee and used to inform changes to the next planned visit programme.

**The Trust is rated GOOD by the CQC. This includes Safety, Caring, Effectiveness and for being Well-Led.** We are still rated as 'requiring improvement' for Being Responsive and we will continue to address issues in this area.

**Our ratings chart shows that 90% of the ratings within our service lines were found to be 'Good' or 'Outstanding'.** The CQC found that, without exception, our staff were caring and compassionate as well as respectful and warm towards patients. This reflects a values based culture within the Trust.

**The Trust assesses itself annually against the NHS Constitution.** A report was presented to Trust Board in December 2017 which set out how the Trust meets the rights and pledges of the NHS Constitution.

**As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with**. This includes ensuring that deductions from salary,

employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

## Value Based Culture

**The Trust works hard to provide the highest standards of healthcare to all its service users.** The promotion of a culture of openness is a prerequisite to improving business resilience, patient safety and the quality of healthcare systems. Good governance and a risk aware culture is emphasised in the Values of the Trust and reinforced through values based recruitment, appraisal and induction.

**Learning from incidents and the impact on risk management is critical.** The Trust uses an e-based reporting system, DATIX, at directorate and service line level to capture incidents and risks, which can be input at source and data can be interrogated through ward, team and locality processes. This encourages local ownership and accountability for incident and risk management. Data is interrogated regularly to ensure that any risks are identified and escalated at the appropriate level. Staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes, ensuring risks are reduced. In 2017/18, TBC incidents were reported, of which TBC% resulted in low or no harm to patients and service users, recognising that the Trust has a risk based culture.

**The Trust works closely with safety teams in NHS Improvement and uses Root Cause Analysis (RCA) as a tool to undertake structured investigation into serious incidents.** Our aim is to identify the true cause of what happened, to identify the actions necessary to prevent recurrence and to ensure that the Trust takes every opportunity to learn and develop from an incident and mitigate future risk.

**The provision of mental health, learning disability and community services carries a significant inherent risk.** Unfortunately, serious incidents do occur which require robust and well governed organisational controls. During 2017/18, there were TBC serious incidents across the Trust compared to 65 in 2016/17. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

**Where harm has taken place, the Trust ensures that communication with staff, service users and families is open, honest and occurs as soon as possible following any patient safety event.** Our Duty of Candour is taken extremely seriously and staff understand their role in relation to Duty of Candour; they have the support required to comply with the duty and to raise concerns; the Duty of Candour is met through meaningful and sensitive engagement with relevant people; and all staff understand the consequences of non-compliance. This is monitored through the Executive Management Team and reported through the governance structures to Board.

**The Clinical Governance and Clinical Safety Committee has a leading role to play.** It scrutinises and monitors quarterly serious incident reports and bi-annual reports on how and where lessons have been learnt and practice improved and/or changed. The Committee also monitors implementation of recommendations arising from external reviews and reports. In the last year, this has included the Trust's action plan in response to the CQC in relation to waiting lists, a review of arrangements for Child and Adolescent Mental Health Services (CAMHS), and a report on improving the quality of the mortality review process. The Committee oversees all work until actions have been completed and closed and it is satisfied that risks have been moderated.

**The Clinical Risk Scan, chaired by the Director of Nursing and Quality, provides an organisational overview** of the incident review, action planning and learning processes to improve patient safety and provide assurance on the performance management of the review process, associated learning, and subsequent impact within the organisation.

**The key elements of the Trust's quality governance arrangements are as follows:**

- The Trust's approach to quality reinforces its commitment to quality care that is safe, person-centred, efficient and effective. The Quality Strategy outlines the responsibilities held by individuals, BDUs, the Executive Management Team and Trust Board. The Trust Board approved an updated Quality Strategy on 27 March 2018.
- The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance.
- This is supported by the Patient Safety Strategy to improve the safety culture throughout the organisation whilst supporting people on their recovery journey, to reduce the frequency and severity of harm resulting from patient safety incidents, to enhance the safety, effectiveness and positive experience of the services we provide, and to reduce the costs, both personal and financial, associated with patient safety incidents. The Trust has also signed up to the national 'Sign up to Safety' initiative and will deliver against a specific safety improvement plan over the next three years.
- Monthly compliance reporting against quality indicators within the Integrated Performance report. Trust Board also receives a quarterly report on complaints.
- CQC regulation leads, monitor performance against CQC regulations and the Trust undertakes regular self-assessments.
- External validation, accreditation, assessment and quality schemes support self-assessment for example, accreditation of electroconvulsive therapy (ECT), Psychiatric Intensive Care Unit (PICU) and Memory Services, CQC Mental Health Act Visits, national surveys (staff and service user).
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as Serious Incidents, Infection Prevention and Control, Information Governance, Management of Aggression and Violence, Drugs and Therapeutics and Practice Effectiveness.
- Quality Impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing approval required before a scheme can proceed.
- Measures are implemented and maintained to ensure practice and services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.
- The annual validation of the Trust's Corporate Governance Statements as required under NHS foundation trust conditions. The Board certified that it was satisfied with the risks and mitigating actions against each area of the required six areas within the statement.

**The Trust continues to build on its existing service user insight framework to enhance and increase understanding of the Trust's services, to demonstrate the quality of services and to show the actions taken in response to the feedback.** A number of initiatives have been established to strengthen customer insight arrangements, including the following:

- Systematising the collection of service user and carer feedback, with a consistent approach to action planning and communication of the responses, including assessment against the Department of Health's Friends and Family Test.

- Insight events for members and the public.
- Ongoing facilitated engagement events for service users and carers, staff and stakeholders in support of the Trust's transformation programme.
- Quantitative and qualitative local and national surveys undertaken on a regular basis and actions taken.
- The principle of co-production being embedded throughout the Trust, such as co-production of training in Recovery Colleges.
- Accreditation against the Cabinet Office's Customer Service Excellence award.

This approach has resulted in an increase in the number of issues raised and in the number of compliments received, which is a positive development in the context of the encouragement the Trust gives to people to offer feedback in all its forms.

**The Trust continues to lay the foundations for its ambitious vision to provide outstanding physical, mental and social care in a modern health and care system, developing service change programmes and associated structures to transform the way it delivers services**. The priority programmes are focused on ensuring the Trust continues to deliver services that meet local need, offer the best care and better outcomes, and provide value for money whilst ensuring the Trust remains sustainable and viable. The Trust has six priorities with a number of programmes that provide the framework for driving improvements. These include:

- Joined up care - working with our local system partners in each of the places that we provide services including the two integrated systems that we are part of across South Yorkshire & Bassetlaw and West Yorkshire & Harrogate.
- Quality counts, safety first - is a key priority that focuses on programmes to develop and deliver safe, effective and high quality services, including mental health services, learning disability services, general community services and forensic services.
- Operational excellence - focuses on improving productivity, making the best use of all our resources and ensuring that we reduce waste, duplication, unnecessary waste and variation in our care pathways and patient flows.
- Digital by default - ensures we embed the use of technology to improve clinical care and improve our productivity through agile working and the implementation of a new clinical record system.

This is underpinned by our values based culture and our approach to Leadership and a culture of improvement and inclusive change that is co-produced. Each programme has a Director sponsor and clinical lead, and is supported by robust project and change management arrangements through the integrated change team.

**The Trust continues to develop and create additional capacity in the community and different models of delivery and support for service users and carers.** This is through initiatives such as Creative Minds and the development of a recovery approach and recovery colleges across our districts, as well as continuing to host Altogether Better, a national initiative which supports development of community champions.

**The Trust continues its commitment towards carbon reduction.** South West Yorkshire Partnership NHS Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

## Equality and Diversity

**Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with and the value of diverse thinking and staffing is secured.** This is achieved through Trust policies, training and audit processes. Early in 2015, Trust Board established an Equality and Inclusion Forum to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does.

The Forum develops and oversees the Equality Strategy to improve access, experience and outcomes for people from all backgrounds and communities including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities. Staff survey results in 2016/17 suggested that the overall experience of British Black, Asian, Minority Ethnic (BAME) staff working in the Trust is positive, a number of scores being better than the national average and they were generally more positive than white staff. BAME staff who responded to the survey had a higher overall engagement score, a higher number recommending it as a place to work or receive treatment and a higher number feeling valued by the Trust and senior managers that white staff. Areas where BAME staff were less positive than white staff are harassment and bullying and opportunities for career progression. The Trust has been engaging with staff on developing a new approach to tackling harassment and bullying and a positive action development programme for BAME staff was launched in 2017/18. The BAME staff network was established to empower and support BAME staff to achieve their potential and maximise their contribution in delivering the Trust's Mission, Values and Strategic Objectives and had a celebration of their first year, which showcased some of their achievements, in October 2017. The Trust has looked to establish a disability staff equality network which is due to start operating in 2018. In 2017/18, the Forum received reports on the following:

- Barnsley pilot for service users into employment.
- initiatives to encourage engagement with young people.
- Dementia awareness.
- Wellbeing survey results.

During 2016/17, we worked with our Members' Council to develop our Membership Strategy which was approved by the Members' Council in April 2017. The key objectives of the strategy, underpinned by a detailed action plan, are:

1. We will build and maintain membership numbers to meet our annual plan targets, ensuring membership is representative of the population the Trust serves.
2. We will communicate effectively and engage with our public members and our staff members, maintaining a two-way dialogue and encouraging more active involvement.
3. We will develop an effective and inclusive approach to give our public members and our staff members a voice and opportunities to contribute to the organisation, our services, and plans for the future.

The Trust has adopted the National Equality Delivery System 2 (EDS2) Framework and focussed on improving the following areas, working closely with service users, public and commissioners:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well supported staff
4. Inclusive leadership at all levels

The Trust Board approved a Workforce Strategy in March 2017 which includes objectives, linked to the EDS2 Framework and the NHS Workforce Race Equality Standards (WRES), to support a representative workforce. The Trust has a joint EDS2 and WRES action plan which included action on increasing BAME representation in senior roles, including at Board level, career development programmes for BAME staff and a clinical network looking to address harassment and bullying by service users and carers which BAME reporting significantly higher levels than the average.

We ensure Equality Impact Assessments (EIA) are undertaken and published for all new and revised policies and services. This ensures that equality; diversity and human rights issues and service user involvement are systematically considered and delivered, through core Trust business.

## Review of economy, efficiency and effectiveness of the use of resources

The governance framework of the Trust is determined by the Trust Board. It is described in the Trust's annual report and includes information on the terms of reference, membership and attendance at Trust Board and its committees, including the Nominations Committee, which is a sub-group of the Members' Council. The Trust complies with Monitor's (now NHS Improvement) Code of Governance and further information is included in the Trust's annual report.

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, through Executive Management Team meetings, The Operational Management Group (OMG), BDU management teams and at various operational team meetings. The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used alongside reference cost and other benchmarking metrics to review specific areas of service in an attempt to target future efficiency savings. Work has continued with BDUs to implement and utilise service line reporting.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the Trust's strategic objectives and quality priorities whilst aligning Trust plans with commissioning intentions and local health and wellbeing plans. Increasingly we are ensuring that Sustainability and Transformation Plans (and their successors) inform our work. These annual plans detail the workforce and financial resources required to deliver service objectives and include the identification of cost savings. The achievement of the Trust's financial plan is dependent upon the delivery of these savings.

A robust process is undertaken to assess the impact on quality and risks associated with cost improvements both prior to inclusion in the annual plan and during the year to ensure circumstances have not changed. The process and its effectiveness are monitored by the Clinical Governance and Clinical Safety Committee. Quality Impact Assessments (QIA) take an objective view of the impact of cost improvements on the quality of services in relation to the CQC five domains of safe, caring, effective, responsive, and well led. The Assessments are led by the Director of Nursing and Quality and the Medical Director with BDU Directors and senior BDU staff, particularly clinicians.

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

The Trust delivered against its financial control total of £TBC million by achieving £TBC million. This entitled us to receive Sustainability and Transformation Funding (STF) of £TBC million. In total, £TBC million cost savings were delivered against a target of £TBC million (TBC% delivery). Of the £TBC million, £TBC million was delivered recurrently and a further £TBC million non-recurrently.

## Information Governance

**Information governance compliance is assured through a number of control measures to ensure that risks to data security are identified, managed and controlled.** The Trust has put an information risk management process in place led by the Trust Senior Information Risk Owner (SIRO). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust achieved the target of 95% of staff completing training on information governance by 31 March 2018.

**To strengthen its arrangements, the Trust's approach in 2017/18 has been** to review guidance and policies, take a targeted approach to providing advice and support to staff through proactive monitoring of incidents, providing awareness raising sessions at all levels in the organisation, including senior level through Extended Executive Management Team, and offering advice and increasing availability of training for staff.

Incidents and risks are reviewed by the Improving Clinical Information Group which informs policy changes and reminders to staff.

**In November 2016, the Information Commissioner's Office (ICO)** undertook a consensual data protection audit. The final report, which provided reasonable assurance, was issued to the Trust in February 2017 and the executive summary was published on the ICO's webpage and the Trust's website. At each meeting of the Audit Committee an update on the progress made on the actions identified is provided. An update of progress made was provided to the ICO in December 2017. The vast majority of actions have now been completed.

**The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioner's Office (ICO).** There have been 3 such incidents reported in 2017/18. This is a reduction compared to the nine reported incidents in 2016/17 and they are summarised below together with the actions taken:

- A letter including highly sensitive personal data was sent to a patient's home address despite their request that no correspondence be sent: the letter was opened by relatives who were previously unaware of the patient's diagnoses, causing significant distress to both the patient and their family – actions taken include ensuring outgoing post is checked by a clinician before release and the issue of a briefing paper to the team outlining the principles and practice for patient correspondence.
- A letter pertaining to one patient was left in the home of another by a community nurse after it had been collected from a standalone printer with a leaflet and stapled into the leaflet – actions taken include removing standalone printers from the premises and only using multi-functional devices and briefs at service and team

meetings outlining responsibility for checking printed information when collecting from devices and prior to handing over to patients.

- Two highly sensitive reports about children were sent to the other's intended recipients – actions taken include immediately implementing a two-person check of post items before sending and recruiting an additional member of administrative staff to reduce pressure on the team.

**Good information governance will continue to be a feature of the Trust in 2018/19.** The Information Toolkit was submitted at level 2 – satisfactory.

## Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*. We have fully compiled our Annual Report with the guidance issued, with our Quality Account being published alongside our Financial Accounts to ensure there is a balanced picture of the value delivered by the Trust. Our public and staff members are represented by the Members' Council Quality Group who are fully involved in agreeing the indicators within the Quality Account. Public facing and easy read versions of the Quality Report will be made available and the full report will be accessible on the Trust's website.

The following steps have been put in place to assure the Trust Board that the Quality Report presents a balanced view and that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

### Governance and leadership of quality reporting

- Quality metrics are reviewed monthly by Trust Board and the Executive Management Team, alongside the performance reviews undertaken by BDUs as part of their governance structures.
- The integrated performance report covers substantial quality information and is reported to the Board and Executive Management team. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints and patient experience.
- The Clinical Governance and Clinical Safety Committee oversees the development of the Quality Report and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance, supported by the Director of Nursing and Quality.
- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy and evidenced through the Trust's Information Assurance Framework.
- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- The Director of Nursing and Quality and Director of Finance co-chair the Trust-wide Improving Clinical Information and Information Governance Meeting. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.
- The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

**Role of policies and plans in ensuring quality of care provided**

- Good clinical record keeping is part of good clinical practice and provision of quality care to the people who use our services.
- There is comprehensive guidance for staff on data quality, collection, recording, analysis and reporting which meets the requirements of national standards, translating corporate commitment into consistent practice, through the Data Quality Policy and associated information management and technology policies.
- There are performance and information procedures for all internal and external reporting. Mechanisms are in place to ensure compliance through the Improving Clinical Information and Information Governance Meeting with reports to the Audit and Clinical Governance and Clinical Safety Committees on data quality.

**Systems and processes**

- There are systems and processes in place for the collection, recording, analysis and reporting of data which are accurate, valid, reliable, timely, relevant and complete through system documentation, guides, policies and training.
- Corporate security and recovery arrangements are in place with regular tests of business critical systems. These systems and processes are replicated Trust-wide.

**People and skills**

- Behaviours and skills are an essential part of good data quality, recording and reporting and compliance with policy.
- Roles and responsibilities in relation to data quality are clearly defined and documented.
- There is a clear training plan for Information Governance and the Trust's clinical information systems (RiO, SystmOne and a small number of additional systems) with the provision of targeted training and support to ensure responsible staff have the necessary capacity and skills.

**Data use and reporting**

- Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through Executive Management Team meeting and Trust Board, with key performance indicators set at both service and Board level. This includes identification of any issues in relation to data collection and reporting and focussed action to address such issues

The Trust is committed to a continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to meet its business needs. Regular reviews of the quality of the Trust's clinical data are undertaken by the Improving Clinical Information Group and, where data quality standards are identified as a risk factor, these are reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation.

The Trust's external auditor, Deloitte, provides external assurance on the Quality Report and the findings are presented to the Audit Committee, Clinical Governance and Clinical Safety Committee, Trust Board and the Members' Council. During 2017/18, an Internal Audit of data quality baseline assessment within the Trust found significant assurance.

## Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed

by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee and the Clinical Governance and Clinical Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework (BAF) provides evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The BAF is approved by Trust Board on an annual basis and reviewed and updated on a quarterly basis throughout the year. There were no significant gaps identified in the BAF.

Directors' appraisals are conducted by the Chief Executive with objectives reviewed on a quarterly basis and prioritised in line with the performance-related pay structure agreed by the Remuneration and Terms of Service Committee. This has provided a strong discipline and focus for Director performance. Non-Executive Director appraisals are undertaken by the Chair of the Trust.

The Trust has refined its values-based appraisal system for staff with a target for all staff in Bands 6 and above to have an appraisal in the first quarter of the year and the remainder of staff by the end of the second quarter. The Trust also uses values-based recruitment and selection.

All committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. The committees have met regularly throughout the year and their minutes and annual reports are received by the Board. Further information on Trust Board committees is contained in the annual report and in the Trust's Risk Management Strategy.

The Audit Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme. This was reported through its Annual Report to the Board. The Audit Committee was able to provide assurance that, in terms of the effectiveness and integration of risk committees, risk was effectively managed and mitigated. Assurance was provided that committees met the requirements of their Terms of Reference, that committee work programmes were aligned to the risks and objectives of the organisation, in the scope of their remit, and that Committees could demonstrate added value to the organisation.

The role of internal audit at the Trust is to provide an independent and objective opinion to the Trust, its managers and Trust Board on the system of control. It provides a Head of Internal Audit opinion each year. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The internal audit function within the Trust for 2017/18 was provided by 360Assurance.

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the Executive Management Team. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of

other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the Executive Management Team focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

From 1 April 2017 to 31 March 2018, 10 internal audit reviews were presented to the Audit Committee. Of these, there were eight 'significant assurance' opinions and two 'limited assurance' opinions in relation to General Data Protection Regulations and additional pay spend. There were no 'no assurance opinions'. These opinions and any resulting actions support the Trust in delivering an effective governance system.

The follow up review prior to submission of the Trust's Information Governance toolkit return resulted in a 'significant assurance' opinion.

The fieldwork for three remaining reports from the 2017/18 plan relating to Pharmacy procurement, IT Strategy, and staff engagement are in progress with the assurance rating subject to agreement with management.

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each 'limited' or 'no' assurance' report to attend to provide assurance on actions taken to implement recommendations. For all 'limited' and 'no' assurance' reports, a follow up audit is undertaken within twelve months.

The Draft Head of Internal Audit's overall opinion for 2017/18 is providing '**significant assurance**' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

## Conclusion

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust, its Board and members of the leadership and management structure are alert to their accountabilities in respect of internal control. Throughout the year, the Trust has had processes in place to identify and manage risk.

The review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. A small number of internal control issues outlined in this statement are not considered significant. I can confirm that those control issues have been or are being addressed.

Over the past year, the Trust has delivered its business in a context of significant change. During this time, the system of internal control has remained robust and enabled change and risk to be managed effectively.

Rob Webster
Chief Executive Date: TBC

NHS
South West Yorkshire Partnership
NHS Foundation Trust

# Trust Board 24 April 2018
# Agenda item 10.5

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|---|---|
| **Title:** | **Trust Board self-certification (G6/CoS7) – compliance with NHS provider licence conditions** |
| **Paper prepared by:** | Director of Finance<br>Company Secretary |
| **Purpose:** | To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider license. |
| **Mission/values:** | Good governance supports the Trust to deliver its mission and adhere to its values. |
| **Any background papers/ previously considered by:** | Trust Board received and approved the operational plan for 2017/18-2018/19 on 20 December 2016 and will approve an update on 24 April 2018. The Trust reviewed compliance with NHS Constitution on 20 December 2017. The attached document was reviewed by the Executive Management Team on 5 April 2018. A further self-certification will come to Trust Board on 26 June 2018. |
| **Executive summary:** | **Background**<br>NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.<br>As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations. Trust Board is required to make self-certifications (G6/CoS7) by 31 May 2018 in relation to:<br>➢ The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions); and<br>➢ If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions).<br>A further self-certification (FT4) is required by 30 June 2018 and will come to the Trust Board meeting on 26 June 2018:<br>➢ The provider has complied with required governance |

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|---|---|
| | arrangements (as required by condition FT4(8) of the NHS Provider Licence); and<br>➢ The training of Governors (as required by s151(5) of the Health and Social Care Act 2012).<br><br>**Self-certification - part one (G6/CoS7)**<br><u>Trust compliance with its Licence</u><br>The Licence is a requirement of the Health and Social Care Act 2012 and is the mechanism by which NHS Improvement/Monitor regulates providers of NHS services, both NHS and non-NHS. The provider licence is split into six sections, which apply to different types of providers. From 1 April 2013, all foundation trusts were automatically issued with a licence as the Health and Social Care Act 2012 specified that foundation trusts were to be treated as having met all the licence criteria.<br><br>In the main, the licence requires the Trust to adhere to (and provide evidence that it has done so) certain conditions, which it does as part of its existing governance and reporting arrangements. The attached paper (appendix 1) provides assurance to Trust Board that the Trust meets the conditions of its Licence and identifies potential areas of risk. From the assurance provided, Trust Board is asked to certify that "***the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution***".<br><br><u>Providing commissioner requested services (CRS)</u><br>CRS designation is not simply a standard contract with a commissioner to provide services. CRS are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:<br>➢ there is no alternative provider close enough<br>➢ removing the services would increase health inequalities<br>➢ removing the services would make other related services unviable.<br><br>The attached paper (appendix 1) sets out the way the Trust complies with the continuity of services conditions in the NHS provider licence. From the assurance provided, Trust Board is asked to certify that ***"the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking into account distributions which might reasonably be expected to be declared or paid for the period of 12 months"***. |

| | |
|---|---|
| **Recommendation:** | **Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to compliance with the conditions of its Licence.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018
# NHS provider licence

This paper is intended to provide assurance that the Trust complies with the terms of its Licence and sets out a broad outline of the licence conditions and any issues for Trust Board to note.

The provider licence is split into six sections, which apply to different types of providers.

1. General conditions (G) – general requirements applying to all licensed providers.
2. Obligations about pricing (F) – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.
3. Obligations around choice and competition (C) – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.
4. Obligations to enable integrated care (IC) – enables the provision of integrated services and applies to all licensed providers.
5. Conditions to support continuity of service (CoS) – allows NHS Improvement/Monitor to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services (CRS) only.
6. Governance licence conditions for Foundation Trusts (FT) – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.

| Condition | Provision | Comments |
|---|---|---|
| **General licence conditions (G)** | | |
| 1. Provision of information | Obligation to provide NHS Improvement/Monitor with any information it requires for its licensing functions. | The Trust is currently obliged to provide NHS Improvement/Monitor with any information it requires and, within reasonable parameters, to publish any information NHS Improvement/Monitor requires it to. We have systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust although the Conditions are so broad the obligation could become overly burdensome. |
| 2. Publication of information | Obligation to publish such information as NHS Improvement/Monitor may require. | |
| 3. Payment of fees to NHS Improvement/Monitor | Gives NHS Improvement/Monitor the ability to charge fees and for licence holders to pay them. | There are currently no plans to charge a fee to Licence holders. Trust Board should note that there is, currently, no provision in the budget for |

| Condition | Provision | Comments |
|---|---|---|
| | | additional fees and this would, therefore, become a cost pressure. |
| 4. Fit and proper persons | Prevents licences from allowing unfit persons to become or continue as governors or directors. | The Care Quality Commission (CQC) published the fit and proper person requirements to take effect from 1 October 2014. The Trust has included the requirement for members of Trust Board to make an annual declaration against the requirements on an annual basis and has robust arrangements in place for new appointments to the Board (whether non-executive or executive). |
| 5. NHS Improvement/Monitor guidance | Requires licensees to have regard to NHS Improvement/Monitor guidance. | The Trust responds to guidance issued by NHS Improvement/Monitor. Submissions and information provided to NHS Improvement/Monitor are approved through relevant and appropriate authorisation processes. |
| 6. Systems for compliance with licence conditions and related obligations | Requires providers to take reasonable precautions against risk of failure to comply with the licence. | The Trust has systems and processes in place to ensure it complies with its Licence and this is co-ordinated by the Director of Finance. |
| 7. Registration with the Care Quality Commission (CQC) | Requires providers to be registered with the CQC and to notify NHS Improvement/Monitor if their registration is cancelled. | The Trust is registered with the Care Quality Commission (CQC). |
| 8. Patient eligibility and selection criteria | Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner. | The Trust's website sets out the service directories for each Business Delivery Unit (BDU) and the relevant access criteria for the services. |
| 9. Application of section 5 (which relates to continuity of services) | Sets out the conditions under which a service will be designated as a CRS | Covers all services which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS)." See CoS1. |
| **Pricing conditions (P)** | | |
| 1. Recording of information | Obligation of licensees to record information, particularly about costs. | The Trust responds to guidance and requests from NHS Improvement/Monitor. Information provided is approved through the relevant and appropriate authorisation processes. |
| 2. Provision of information | Obligation to submit the above to NHS Improvement/Monitor. | |
| 3. Assurance report on submissions to NHS Improvement/Monitor | Obliges licensees to submit an assurance report confirming that the information provided is accurate. | |
| 4. Compliance with the national tariff | Obliges licensees to charge for NHS health care | All contracts are agreed annually and are in line |

| Condition | Provision | Comments |
|---|---|---|
| | services in line with national tariff. | with the national tariff. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance. |
| 5. Constructive engagement concerning local tariff modifications | Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to NHS Improvement/Monitor for a modification. | See P4. |
| **Choice and competition (C)** | | |
| 1. Patient choice | Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. | The Trust has in place a service directory setting out the services available. Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements. |
| 2. Competition oversight | Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. | Trust Board has reviewed its position and considers that it has no arrangements that could be perceived as having the effect of preventing, restricting or distorting competition in the provision of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board decide to consider any structural changes, such mergers or joint ventures. |
| **Integrated care condition (IC)** | | |
| 1. Provision of integrated care | Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services. | The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in several pilots aimed at developing new ways of working and new models of delivery. A number of services provided are done so through partnership working with other local stakeholders. |
| **Continuity of service (CoS)** | | |
| 1. Continuing provision of commissioner requested services (CRS) | Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners. | As part of contract negotiations, the Trust has agreed CRS with commissioners, with the exception of Barnsley, that all mental health services will be considered as CRS. Barnsley Clinical Commissioning Group has reviewed the |

| Condition | Provision | Comments |
|---|---|---|
| | | guidance and has determined that services provided under their contract will not be designated as Essential or CRS. |
| 2. Restriction on the disposal of assets | Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHS Improvement/Monitor's consent before disposing of these assets IF NHS Improvement/Monitor has concerns about the licensee continuing as a going concern. | As the majority of services the Trust provides are classed as CRS, all assets associated with these services are classed as restricted and these can be identified by the Trust. Any changes to estate and the asset base are discussed with commissioners in relation to the provision of services.<br>The Trust has an asset register in place.<br>The Trust is only required to seek NHS Improvement/Monitor's consent for disposal of assets if NHS Improvement/Monitor was concerned about its ability to continue as a going concern. |
| 3. NHS Improvement/Monitor risk rating (standards of corporate governance and financial management) | Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern. | The Trust has robust and comprehensive corporate and financial governance arrangements in place with significant assurance received from an internal audit in 2017/18. |
| 4. Undertaking from the ultimate controller | Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions. | Does not apply to the Trust. |
| 5. Risk pool levy | Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails). | Further guidance on this is awaited from NHS Improvement/Monitor. It could have the potential to bring significant further financial burden on providers. |
| 6. Co-operation in the event of financial stress | Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with NHS Improvement/Monitor. | The Trust is aware it would need to co-operate with NHS Improvement/Monitor in such circumstances. |
| 7. Availability of resources | Requires licenses to act in a way that secures resources to operate commissioner requested services (CRS). | The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver its services. |
| **Foundation Trust conditions (FT)** | | |
| 1. Information to update the register of NHS | Obliges foundation trusts to provide information to | See G1. The Trust is currently obliged to provide |

| Condition | Provision | Comments |
|---|---|---|
| foundation trusts | NHS Improvement/Monitor. | NHS Improvement/Monitor with any information it requires, including information to update its entry on the register of NHS foundation trusts and has processes in place to ensure it complies with such requirements |
| 2. Payment to NHS Improvement/Monitor in respect of registration and related costs | The Trust would be required to pay any fees set by NHS Improvement/Monitor. | NHS Improvement/Monitor has undertaken not to levy any registration fees on foundation trusts without further consultation. |
| 3. Provision of information to advisory panel | NHS Improvement/Monitor has established an independent advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel. | The independent advisory panel was established in April 2013 and the Trust provided a briefing on the Panel for the Members' Council. The Trust's governors understand the role and remit of the Panel and the seriousness of any reference to it, representing a breakdown of the existing communication channels between the Trust Board and the Members' Council. |
| 4. NHS Foundation Trust governance arrangements | Gives NHS Improvement/Monitor continued oversight of the governance of foundation trusts. | The Trust has sound corporate governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. This was also evidenced in the outcome of the well-led review of the Trust's governance arrangements in 2015/16 and by a CQC review in 2016/17 |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018

## Agenda item 11 – Receipt of public minutes of partnership boards

### Calderdale Health and Wellbeing Board

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|---|---|
| **Date** | 12 April 2018 |
| **Non-Voting Member** | Medical Director /<br>District Director – Forensic, Specialist, Calderdale and Kirklees |
| **Items discussed** | ➢ Single Plan for Calderdale – Calderdale Cares Update<br>➢ Pharmaceutical Needs Assessment<br>➢ Draft Health and Wellbeing Board Annual Report |
| **Minutes** | Papers and draft minutes (when available):<br>https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=26273 |

### Barnsley Health and Wellbeing Board

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|---|---|
| **Date** | 3 April 2018 |
| **Member** | Chief Executive /<br>District Director - Barnsley & Wakefield |
| **Items discussed** | ➢ Director of Public Health Annual Report<br>➢ Barnsley Respiratory Assessment and Therapy Service<br>➢ Excess Winter Deaths |
| **Minutes** | Papers and draft minutes (when available):<br>http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143 |

### Wakefield Health and Wellbeing Board

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|---|---|
| **Date** | 29 March 2018 |
| **Member** | Chief Executive /<br>District Director - Barnsley & Wakefield |
| **Items discussed** | ➢ West Yorkshire and Harrogate Health and Care Partnership - Next steps document<br>➢ Delivering the Five Year Forward View in Wakefield<br>➢ Collaborative Arrangements for Health and Care - Wakefield Wellbeing priority<br>➢ Carers Strategy<br>➢ Wakefield District Safeguarding Adults Board Annual Report<br>➢ Improvements to Children's Services<br>➢ Pharmaceutical Needs Assessment |
| **Minutes** | Papers and draft minutes are available at:<br>http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board |

## Kirklees Health and Wellbeing Board

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|---|---|
| **Date** | To be confirmed (last update from meeting 22 March 2018) |
| **Invited Observer** | Chief Executive /<br>District Director – Forensic, Specialist, Calderdale and Kirklees |
| **Items discussed** | ➢ To be confirmed. |
| **Minutes** | Papers and draft minutes (when available):<br>https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159 |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 24 April 2018

## Agenda item 12 – Assurance from Trust Board Committees

### Clinical Governance and Clinical Safety Committee

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|---|---|
| **Date** | 17 April 2018 |
| **Presented by** | Charlotte Dyson, Deputy Chair / Senior Independent Director (Chair of the Committee) |
| **Key items to raise at Trust Board** | ➢ Verbal update to be provided at the Trust Board meeting. |
| **Approved Minutes of previous meeting/s for receiving** | ➢ To follow. |

### Audit Committee

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|---|---|
| **Date** | 10 April 2018 |
| **Presented by** | Laurence Campbell, Non-Executive Director (Chair of the Committee) |
| **Key items to raise at Trust Board** | ➢ Delivering Service Change - Need to review some projects at points before BAU.<br>➢ SystmOne implementation - Committee currently not assured: risk levels, clarification of milestones and assurance at each point, design, conversion and full load risks.<br>➢ Risk Register - Growing/emergent risks.<br>➢ Agency internal audit - Limited assurance.<br>➢ Out of area bed risk.<br>➢ Risk appetite.<br>➢ General Data Protection Regulations (GDPR) progress.<br>➢ Internal Audit plan 2018/19.<br>➢ Draft Head of Internal Audit Opinion 2017/18. |
| **Approved Minutes of previous meeting/s for receiving** | ➢ Approved Minutes of the Committee meeting held on 9 January 2018 (attached). |

### Nominations Committee

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|---|---|
| **Date** | 10 April 2018 |
| **Presented by** | Angela Monaghan, Chair (Chair of the Committee) |
| **Key items to raise at Trust Board** | ➢ Non-Executive Director recruitment update<br>➢ Deputy Chair / Senior Independent Director re-appointment recommendation to Members' Council. |
| **Approved Minutes of previous meeting/s for receiving** | ➢ Approved Minutes of the Committee meeting held on 22 February 2018 (attached). |

South West Yorkshire Partnership NHS Foundation Trust

# Minutes of the Audit Committee held on 9 January 2018

| | | |
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| **Present:** | Laurence Campbell | Chair of the Committee |
| | Chris Jones | Non-Executive Director |
| **Apologies** | Members | |
| | Rachael Court | Non-Executive Director |
| | Other | |
| | Tony Cooper | Head of Procurement |
| **In attendance:** | Mark Brooks | Director of Finance (lead director) |
| | Rob Adamson | Deputy Director of Finance |
| | Tim Breedon | Director of Nursing & Quality (items 4.1 and 18) |
| | Leanne Hawkes | Deputy Director, 360 Assurance |
| | Paul Hewitson | Director, Deloitte |
| | Caroline Jamieson | Manager, Deloitte |
| | Emma Jones | Company Secretary |
| | Olivia Townend | Assistant Anti-Crime Manager, Audit Yorkshire |
| | Jane Wilson | PA to the Director of Finance (author) |

## AC/18/01 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Laurence Campbell (LC) welcomed everyone to the meeting. The apologies, as above, were noted. It was noted that a training session had been held prior to the meeting for Board members relating General Data Protection Regulation (GDPR). This training was provided by Deloitte.

## AC/18/02 Declaration of Interest (agenda item 2)

There were no declarations over and above those made in the annual return to Trust Board in March 2017 or subsequently. Staff also have a requirement to declare interests on an annual basis and more work will be done to ensure staff are aware of this before the end of the financial year.

## AC/18/03 Minutes from the meeting held on 10 October (agenda item 3)

**It was RESOLVED to APPROVE the minutes of the meeting held on 10 October 2017 as a true and accurate record with the amendment of a typographical error.**

## AC/18/04 Matters arising from the meeting held on 10 October and 18 July 2017

The following matters arising were discussed:

AC/17/63a Internal Audit (KPMG) progress report 2016/17 (Data Quality – Clinical Record Keeping

Tim Breedon (TB) reported the first data cut to take place by end of March 2018. TB explained that a suite of reports has been developed which are being reviewed at the next Improving Clinical Information Group (ICIG) and Operational Management Group (OMG). This provides

the base for a richer conversation and has been acknowledged as a positive step forward. TB also explained that data quality action plans have been refreshed and progress is being monitored through each Business Delivery Unit (BDU), OMG and EMT. This approach is helping with increasing awareness which contributes towards improved performance.

In terms of progress against the other recommendations made in the audit the awareness exercise has been completed and processes have been introduced in each BDU to ensure the metrics are regularly reviewed. It is recognised that the introduction of SystmOne for Mental Health needs to cover data quality.

Chris Jones (CJ) asked if there could be greater focus on providing metrics to demonstrate how performance is improving. He acknowledged that clearly a lot of processes had been put in place, but would like to see more data relating to record-keeping and to understand the impact of the dashboards. TB to identify suitable metrics for inclusion in future IPR reporting that will demonstrate data quality improvements.

**ACTION: Tim Breedon**

AC/17/64 Counterfraud progress report and Ant-Fraud Bribery and Corruption Policy
Mark Brooks (MB) presented update on raising concerns at work. It was suggested that raising concerns with a Non-Executive Director as an option should be made clear on the intranet leaflet. It was also suggested the intranet leaflet is updated to include freedom to speak up guardians. MB to speak with Alan Davis to update the intranet leaflet for these two items.

**ACTION: Mark Brooks**

## AC/18/05 Consideration of items from the organisational risk register relevant to the remit of the Audit Committee (agenda item 5)

Emma Jones (EJ) reported that the paper included risks from the Organisational/Corporate Risk Register that had been aligned with the Audit Committee, with a summary on any changes since the Audit Committee meeting on 10 October 2017.

EJ advised that all risks from the trust-wide corporate/level risk register (ORR) (graded 15 and above) were reported to the Trust Board on 31 October 2017. There were 4 potential risks that have been assessed as relevant to the work of the Audit Committee and are currently exceeding the risk appetite of the Trust. Two new risks had been added to the organisational risk register which are allocated to the Audit Committee. These are the risks relating to the implementation of SystmOne and implementation of GDPR.

It was acknowledged there have been a number of conversations in relation to risk appetite and that some further work will take place on this subject at the Board strategic session in February 2018.

It was noted that the risk relating to arson did not have an identified sub-committee. MB suggested that given it was a Health and Safety risk the Clinical Governance meeting was most appropriate. EJ to arrange for the risk register to be updated accordingly.

LC asked if there needs to be a risk in relation to the recent issue with Intel chips. MB to discuss this potential risk with the IT lead.

CJ asked if the consequences of ACO development could really be catastrophic. MB/EJ to review this risk scoring.

The recommendation to close the RiO 7 upgrade risk was agreed.

**ACTION: Mark Brooks/Emma Jones**

**It was RESOLVED to NOTE the current Trust-wide Corporate/Organisational level risks relevant to this Committee.**

## AC/18/06 Triangulation of risk, performance and governance (agenda item 6)

The report covering the triangulation of risk, performance and governance was recognised as being helpful.

**It was RESOLVED to RECEIVE the report as part of the evidence of assurance on the operation of risk processes within the Trust.**

## AC/18/07 Agreement of draft final accounts timetable and plans (agenda item 7)

Rob Adamson (RA) presented a draft plan and timetable for the 2017/18 financial year-end and associated review, approval and reporting requirements. The key submission dates have been taken from the draft FT Annual Reporting Manual and communications from NHS Improvement where these are available, however there are still a number of submission dates to be confirmed. The timetable will be updated on receipt of any further information.

The Audit Committee are required to review the annual accounts, annual report and quality accounts and make a recommendation to the Trust Board for approval of the accounts. This Audit Committee meeting is scheduled to take place on 22 May 2018. This will be followed by ratification at the Trust Board on 24 May 2018.

MB suggested that as with last year an informal meeting or two could be held with Audit Committee and other Trust Board members towards the end of April to keep them appraised of progress on the year-end accounts and audit. These will be built into the timetable.

Paul Hewitson (PH) made the point that the Trust would need to sign the accounts prior to Deloitte being able to sign them. RA to work with EJ to arrange an appropriate date and time for these updates.

**ACTION: Rob Adamson**

**It was RESOLVED to RECEIVE the report and NOTE progress made.**

## AC/18/08 Annual review of Treasury management strategy and policy (agenda item 8)

RA confirmed the Treasury Management Strategy and Policy has been reviewed against other examples across the NHS to consider if any changes need to be made. Overall it was felt to be still fit for purpose and provided the right strategy, should market conditions support this, to maximise the Investment potential for the Trust.

LC reported that the policy needed to be more encompassing and to provide clarity of the link with the overall Trust strategy. It was suggested that this policy be reviewed bi annually rather than annually. Any future updates to the policy to include tracked changes. RA to review the wording of the strategy and make the link with the Trust strategy explicit.

**ACTION: Mark Brooks/Rob Adamson**

**It was RESOLVED to RECOMMEND the approval of the updated policy to the Trust Board.**

## AC/18/09 Self assessment of Committees effectiveness (agenda item 9)

EJ explained this was an annual exercise and she would be taking this process forward for all committees. EJ to make the arrangements for the self-assessment of Audit Committee effectiveness.

**ACTION: Emma Jones**

## AC/18/10 Annual Audit Committee report for Trust Board (agenda item 10)

EJ reported that the annual audit committee report would be generated in time for review at the Audit Committee in April, following this Trust Board. She will work with LC and MB to develop the report.

**It was RESOLVED to RECEIVE the update.**

## AC/18/11 Update of actions from ICO Audit (agenda item 11)

MB updated the Committee with regard to the progress and developments made in respect of actions being taken in response to the Information Commissioner's Office (ICO) data protection audit. It was reported that excellent progress has been made in training and awareness and all recommended actions for these scope areas have been implemented. Good progress has been made in subject access requests and almost all the recommended actions have been taken. MB confirmed some progress has been made against the recommended actions for data sharing, but there is still further working taking place. Significant resource pressures in the IG Team has meant delivery of training on data sharing and privacy impact assessments has not yet been completed, but arrangements are in place to ensure this is achieved by the end of February.

For a number of actions the impact of the General Data Protection Regulation (GDPR) needs taking into account.

**ACTION: Mark Brooks**

**It was RESOLVED to REVIEW and NOTE progress made.**

## AC/18/12 GDPR update (agenda item 12)

MB presented the GDPR update reporting that progress has been made on a number of actions in the implementation plan including the appointment of a Data Protection Officer, completion of Board training and identification of impacted policies. A risk relating to the introduction of GDPR has been added to the Corporate Risk Register. MB also pointed out that capacity within the IG team remains an issue following an unsuccessful recruitment round.

**It was RESOLVED to RECEIVE the update and NOTE the progress made.**

## AC/18/13 SystemOne implementation (agenda item 13)

MB presented a summary of the development of the risk register associated with the implementation of SystmOne for Mental Health services.

This information will be shared with the programme board as part of the inaugural programme board on 25 January 2018, and as such work continues to draft and finalise the content. Once agreed and base-lined these risks will be entered onto the Datix system to be managed throughout the life of the programme.

Audit Committee members would like clarity between key milestones associated with the project and the risk associated with each of these key milestones. Key points the Audit Committee members would like to see made clearer within the risk report include:

- Resources – ensuring we have and are able to retain the right expertise
- Ensuring decisions are made at the right time
- IT infrastructure capacity

It was felt a number of the risk scores looked high and it was questioned whether mitigations have been fully considered and taken into account

PH explained that Deloitte had reviewed the paper and felt it looked reasonable in terms of risk coverage. He did suggest that the complexity of the implementation could be made clearer within the risks and that a risk relating to supplier relationship management could be added. MB to discuss the points raised with Salma Yasmeen and Ed Reid.

**ACTION: Salma Yasmeen/Ed Reid**

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

## AC/18/14 Trust accounting policy (agenda item 14)

RA updated the Audit Committee in respect of accounting policy changes in 2017/18 accounts. He explained that these were minimal and a full copy of accounting policies was provided for information along with the recommended changes.

This update has been shared with Deloitte and incorporated their comments.

**It was RESOLVED to APPROVE the current draft accounting policy to be used within the 2017/18 annual accounts.**

## AC/18/15 Procurement update (agenda item 15)

Mark Brooks (MB) advised that six major contracts were let with a value of £47k. Eight major contracts are currently in progress including the supply of temporary medical locums and the provision of out of area beds. £492k CIP (Cost Improvement Plan) savings have been identified to date. It was confirmed that 37 Service Line Agreements (SLAs) have currently been signed.

MB presented contract update briefing on the Interpreting Services contract and suggested that this should be reviewed again at the April 2018 meeting.

**It was RESOLVED to RECEIVE the report and NOTE the progress made.**

## AC/18/16 Currency development (agenda item 16)

MB reported there no further changes to update. LC to discuss further at the next agenda setting meeting.

**ACTION: Laurence Campbell/Mark Brooks**

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

## AC/18/17 Treasury management update (agenda item 17)

RA reported that Government Banking Service (GBS) rates changed nationally on 2 November 2017 moving from 0.25% to 0.39%. All funds remain within the Government Banking Service (GBS) unless invested with the National loan Fund and the Trust continues to make no external investment. RA to continue to report back quarterly to Audit Committee.

**It was RESOLVED to NOTE the Treasury Management update report.**

## AC/18/18 Internal audit progress report (agenda item 18)

Leanne Hawkes (LH) 360 Assurance presented the progress report, recommendation tracker and technical update. LH advised good progress was being made on 2017/18 plan with five reports completed since the last meeting:

Integrity of the General Ledger and Financial Reporting which provided significant assurance identified processes could be improved in five areas, all of which are low risk areas, with one medium risk exception relating to control of journals. PH stated this was an issue previously raised at a year-end audit, but felt the Trust had appropriate compensating controls. CJ asked LH whether she was concerned by the issue. LH responded that she felt it appropriate to include in the report for management attention and suggested there may be ways to not make a solution overly burdensome. MB explained that he was discussing potential solutions with RA and there was a need to balance off the control with resource requirements. MB/RA to report back at the next meeting with regard to the proposed response to the point raised in relation to journal approval

**ACTION: Mark Brooks/Rob Adamson**

Data Quality Framework which provided significant assurance highlighted two low risk actions aimed at enhancing the operation of existing processes and having referenced best practice regarding the potential compilation of a data dictionary and the use of data quality kite marks in integrated performance report.

Quality Governance which provided significant assurance confirmed the Trust has reviewed and refreshed its strategic objectives and associated strategic priorities. The Trust is currently in the process of revising the Quality Strategy, this is due for approval by the Trust Board on 30 January 2018.

Procurement Process Review – advisory. MB explained that this was an audit undertaken on behalf of both the Trust and CCG in relation to the Care Home procurement that had taken place, but was halted following some identified issues with the process. MB stated that the Trust would implement the actions identified that relate to its own procurement, but other partners will no doubt take the report through their own governing bodies. He explained that he suggested caution before undertaking a similar exercise with a number of partners in the future.

IT Strategy – stage 1 - advisory.

Head of Internal Audit Opinion. Work has also been conducted on the Head of Internal Audit Opinion via a survey of Board members in relation to risk management.

LH asked whether Audit Committee members wished to see full internal audit reports or whether they were happy with the summaries as provided this month. It was agreed summaries would be provided for significant assurance reports and the full report were partial assurance is given.

**It was RESOLVED to NOTE the update provided.**

## AC/18/19 Counter fraud progress report (agenda item 19)

Olivia Townend (OT) reported that there were no further cases of fraud since last Audit Committee. OT also explained about the preventive work being undertaken having attended meetings with Junior Doctors and Finance Managers. A recent whaling alert and the anti-crime newsletter have also been provided to staff.

**It was RESOLVED to NOTE the update provided.**

## AC/18/20 External audit update (agenda item 20)

PH advised that there were no significant areas to update since the last Audit Committee meeting held on 10 October 2017. There were no sector updates and quality indicators within the Quality Account were not expected to change. PH requested an update on the annual Asset Revaluation exercise be provided. RA confirmed this work is currently being finalised and will be available at next EMT and Estates TAG. RA to share report and workings in respect of the asset revaluation work with Deloitte as soon possible. PH also explained that some new guidance has been provided in respect of what to include in the Annual Governance Statement. EJ to review the updated Annual Governance Statement (AGS) guidance to identify how it may impact on our 2017/18 AGS.

**ACTION: Rob Adamson/Emma Jones**

**It was RESOLVED to RECEIVE the update.**

## AC/18/21 Losses and special payments report (agenda item 21)

RA reported that the Trust has made payments of £1,662 for losses and damage to goods since the last report to Committee. The year to date total expenditure is £9,523.

**It was RESOLVED to NOTE the losses and special payment report.**

## AC/18/22 Any other business agenda item 22 (agenda item 22)

No other business was raised.

## AC/18/23 Consideration of any changes to from the organisational risk register relevant to the remit of the Audit Committee (agenda item 23)

No changes to the organisational risk register were requested over those discussed under agenda item 5.

## AC/18/24 Items to report to Trust Board (agenda item 24)

These were agreed as:

- Risks from the corporate/organisational risk register aligned to the Audit Committee
- Treasury Management Strategy and Policy update supported for approval by Trust Board.
- Systmone continued oversight needed to understand any associated risks.
- Procurement update.
- General Date Protection Regulation (GDPR) session took place prior to the meeting for Directors and Non-Executive Directors.

## AC/18/25 Work programme (agenda item 25)

There were no further changes to work programme.

**It was RESOLVED to NOTE the work programme.**

## AC/18/26 Date of next meeting (agenda item 26)

The next meeting of the Committee will be held on Tuesday 10 April 2018 at 14.00 in Meeting Room 1, Fieldhead, Wakefield.

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# Minutes of the Nominations Committee held on 22 February 2018

| | | |
|---|---|---|
| **Present:** | Angela Monaghan | Chair of the Trust (Chair of the Committee) |
| | Jackie Craven | Lead Governor (Publicly elected governor, Wakefield) |
| | Rob Webster | Chief Executive |
| **Apologies:** | Members | |
| | Marios Adamou | Staff elected governor, medicine and pharmacy |
| | Nasim Hasnie | Publicly elected governor, Kirklees |
| | Ruth Mason | Appointed governor, Calderdale and Huddersfield NHS Foundation Trust |
| | Others | |
| | Alan Davis | Director of Human Resources, OD and Estates |
| **In attendance:** | Emma Jones | Company Secretary (author) |

## NC/18/01 Welcome, introduction and apologies (verbal item – Chair) (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. The apologies above were noted. AM advised that feedback on the papers had been received from Marios Adamou (MA) and Alan Davis (AGD) prior to the meeting.

## NC/18/02 Declarations of interest (verbal item – Chair) (agenda item 2)

There were no further declarations over and above those made in the annual return at Trust Board in March 2017 and Members' Council in April 2017 or subsequently.

## NC/18/03 Minutes of and matters arising from previous meeting held on 24 October 2017 (attached – Chair) (agenda item 3)

**It was RESOLVED to APPROVE the minutes from the meeting on 24 October 2017.** All matters arising from the meeting were complete.

## NC/18/04 Non-Executive Director terms of office (agenda item 4)

NC/18/04a Re-appointment of Non-Executive Directors – recommendation to the Members' Council (agenda item 4.1)

AM reported that there were three Non-Executive Directors (NEDs) who were due to complete their first three-year term in 2018. It was recommended that Charlotte Dyson (CD) be re-appointment for a second three-year term from 1 May 2018 to 30 April 2021. Rachel Court (RC) was not seeking re-appointment for a full three-year term of office, due to changes in her personal circumstances, but she was willing to be flexible with her end date if that was helpful to the Trust, therefore it was recommended that she be re-appointed for a further term of up to 12 months from 1 October 2018 to 30 September 2019. Confirmation of CD and RC's performance was included in the papers, noting that further discussion was needed in relation to mandatory training for all NEDs to ensure the right training schedules were in place. There was a separate paper on the agenda in relation to future NED recruitment.

AM advised further to this, that CD had been appointed as Deputy Chair / Senior Independent Director by Members' Council from 1 August 2017 to 31 July 2018 which did not align with her appointment term. A paper would come to the next Nominations Committee meeting with a recommendation for a Deputy Chair / Senior Independent Director.

**Action: Angela Monaghan**

Rob Webster (RW) asked for the rationale behind the recommendation to re-appoint RC for 12 months. AM advised that it had been discussed by the NEDs who collectively thought that it would be helpful to have some continuity on the Board and retain some of her skills, expertise and experience on the committees.

The Committee discussed the performance of CD and RC and supported their re-appointment.

**It was RESOLVED to:**

- **SUPPORT the recommendation to the Members' Council to re-appoint Charlotte Dyson for a second term of office for three years from 1 May 2018 to 30 April 2021;**
- **SUPPORT the recommendation to the Members' Council to re-appoint Rachel Court for a period of up to 12 months from 1 October 2018 to 30 September 2019, the actual departure date to be agreed with the Chair following NED recruitment; and**
- **SUPPORT IN PRINCIPLE that Charlotte Dyson be re-appointed as Deputy Chair / Senior Independent Director, with a paper to come to the next Nominations Committee for recommendation to the Members' Council.**

NC/18/04a Future Non-Executive Director recruitment (agenda item 4.2)

- Terms of office and forthcoming vacancies

AM reported that in addition to RC not seeking re-appointment for a full term of office, Chris Jones (CJ) was due to complete his first three-year term on 31 July 2018 and would not be seeking re-appointment. CJ had advised the following: "As discussed, I can confirm my decision not to seek a second term as a Non-Executive Director (NED). My decision is based on the recent changes in my working situation, which will inevitably impact on my ability to discharge my role as NED to the standard I would want, and which colleagues on the Board should expect. I will continue to support the Board and the committees I am a member of until the end of my three-year term." This will create a vacancy from 1 August 2018. A document showing the terms of office of the Chair and all NEDs was included in the papers.

- Recruitment timescales and process

AM advised that she had discussed future recruitment with Mark Brooks, Director of Finance and Resources (MB) and Emma Jones (EJ) and it was felt that the recruitment for the two future vacancies should take place at the same time to assist with time and resources. Comments were received from AGD prior to the meeting, stating that it was his view that the previous NED recruitment had been very slick, professional and robust and he would see no reason to change this for future appointments. A draft timetable for recruitment was tabled at the meeting based on previous NED recruitment processes.

The Committee discussed the draft timetable and agreed the following:

- Appointment start date (NED 1) - The three business day vacancy from the end of CJ's term and the formal approval by Members' Council of a new appointment and did not pose a large risk.

- Appointment start date (NED 2) - draft timetable proposed a commencement date of 1 March 2019 to be confirmed. Commencement date to be changed to be the same as NED 1 if possible, with AM to discuss and agree an end date with RC once the two new NEDs have been fully inducted.
- Recruitment / information events - held across each place worked well previously and produced a lot of interest in the role.
- Use of recruitment consultants - review options for internal recruitment support as well as external recruitment consultants, noting that external consultants assist the robustness of the process by providing a degree of separation and further ensures there is not a potential conflict of interest. A competition analysis including price analysis should be conducted for the use of external consultants on the procurement framework.
- Potential for a shared role - explore the future possibility to share a NED with another mental health trust to support future collaborative working. EJ will check whether this is possible in accordance with the Trust's Constitution and seek advice from NHS Providers.

**Action: Angela Monaghan / Emma Jones**

- Job description and advertisement

AM advised that the NEDs had discussed the skills and experience they felt were needed by the Board at this time. The NED job description / person specification and advertisement used for previous NED recruitment was included in the papers.

The Committee discussed and agreed the following in relation to the person specification:

- Finance qualification and strong financial experience (essential), noting that CJ and the previous Chair were both qualified accountants and that at least one of the new NEDs would become an Audit Committee member.
- Legal skills (desirable), as the Trust moves towards collaborative working arrangements
- Workforce / Human Resources (desirable), noting that RC has some skills and background in relation to this and currently chairs the Remuneration and Terms of Service Committee. People skills and engagement is important.
- IT / digital skills and experience (desirable)
- Experience of leading large-scale change (desirable).
- Clinical and health services experience (desirable).
- Positively welcoming applications from all aspects of society including BAME, younger people and service users, in order to improve Board diversity

The NED job description / person specification and advertisement will be reviewed and updated in relation to the areas discussed.

**Action: Angela Monaghan / Emma Jones**

**It was RESOLVED to SUPPORT the procedure discussed for the appointment of two Non-Executive Directors.**

## NC/18/05 Update on Director recruitment (agenda item 5)

AM confirmed that Dr Subha Thiyagesh had been appointed Medial Director, commencing 19 April 2018. AM confirmed that this appointment had been communicated to governors, staff, stakeholders and the public.

**It was RESOLVED to NOTE the update provided.**

**NC/18/06 Any other business (agenda item 6)**
No further items were discussed.

**NC/18/07 Issues and items to bring to the attention of Trust Board / Members' Council (agenda item 7)**
Issues were identified as:

- Non-Executive Director re-appointment recommendation to Members' Council.
- Future Non-Executive Director recruitment.

**NC/18/08 Date of next meeting (agenda item 8)**
The date of the next meeting is to be confirmed.

**Action: Angela Monaghan / Emma Jones**

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# Trust Board annual work programme 2018-19

| Agenda item/issue | Apr | June | July | Sept | Oct | Dec | Jan | Mar |
|---|---|---|---|---|---|---|---|---|
| **Standing items** | | | | | | | | |
| Declaration of interest | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Minutes of previous meeting | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Chair and Chief Executive's report | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Business developments | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Integrated performance report | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Assurance from Trust Board committees | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Receipt of minutes of partnership boards | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| **Quarterly items** | | | | | | | | |
| Assurance framework and risk register | ✘ | | ✘ | | ✘ | | ✘ | |
| Customer services quarterly report | ✘ | | ✘ | | ✘ | | ✘ | |
| Guardian of safe work hours | ✘ | | ✘ | | ✘ | | ✘ | |
| Serious incidents quarterly report | | ✘ | | ✘ | | ✘ | | ✘ |
| Use of Trust Seal | | ✘ | | ✘ | | ✘ | | ✘ |
| Corporate Trustees for Charitable Funds# (annual accounts presented in July) | ✘ | | ✘ | | ✘ | | ✘ | |
| **Half yearly items** | | | | | | | | |
| Strategic overview of business and associated risks | ✘ | | | | ✘ | | | |
| Investment appraisal framework | ✘ | | | | ✘ | | | |
| Information Management and Technology update | ✘ | | | | ✘ | | | |
| Safer staffing report | | ✘ | | | | ✘ | | |
| Estates strategy update | | | ✘ | | | | ✘ | |
| **Annual items** | | | | | | | | |
| Draft Annual Governance Statement | ✘ | | | | | | | |
| Audit Committee annual report | ✘ | | | | | | | |
| Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)* | ✘ | | | | | | | |

| Agenda item/issue | Apr | June | July | Sept | Oct | Dec | Jan | Mar |
|---|---|---|---|---|---|---|---|---|
| Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs | ✘ | | | | | | | |
| Annual report, accounts and quality accounts - update on submission | | ✘ | | | | | | |
| Customer services annual report | | ✘ | | | | | | |
| Health and safety annual report | | ✘ | | | | | | |
| Serious incidents annual report | | ✘ | | | | | | |
| Equality and diversity annual report | | | ✘ | | | | | |
| Medical appraisal/revalidation annual report | | | ✘ | | | | | |
| Sustainability annual report | | | | ✘ | | | | |
| Workforce Race Equality Standard (WRES) | | | | | ✘ | | | |
| Assessment against NHS Constitution | | | | | | ✘ | | |
| Trust Board annual work programme | | | | | | | | ✘ |
| Eliminating mixed sex accommodation (EMSA) declaration | | | | | | | | ✘ |
| Information Governance toolkit | | | | | | | | ✘ |
| Strategic objectives | | | | | | | | ✘ |
| Operational plan (two year) *(next due in December 2019 - date to be confirmed by NHS Improvement)* | | | | | | | | |
| **Policies and strategies** | | | | | | | | |
| Membership Strategy *(next due for review in April 2019)* | ✘ | | | | | | | |
| Quality Improvement Strategy *(was due for review in July 2017)* | ✘ | | | | | | | |
| Constitution (including standing orders), Scheme of Delegation and Standing Financial Instructions *(next due for review in January 2019 or as required)* | | | | | | | ✘ | |
| Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) | | | | | | | ✘ | |
| Risk Management Strategy | | | | | | | ✘ | |
| Communication, Engagement and Involvement strategy *(next due for review in December 2019)* | | | | | | | | |
| Organisational Development Strategy *(next due for review in December 2019)* | | | | | | | | |
| Treasury Management Policy *(next due for review in January 2020)* | | | | | | | | |
| Workforce Strategy *(next due for review in March 2020)* | | | | | | | | |
| Digital Strategy *(next due for review in January 2021)* | | | | | | | | |

Business and Risk (includes quarterly performance reports and quarterly reports to Monitor/NHS Improvement)

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|---|---|
| | Performance and monitoring |
| Strategic sessions are held in February, May, September and November which are not meetings held in public. | |
| There is no meeting scheduled in August. | |
| # Corporate Trustee for the Charitable Funds which are not meetings held in public. | |