South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 31 July 2018 at 9.30am
Small conference room, Wellbeing and learning centre, Fieldhead, Wakefield, WF1 3SP

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.31**	**Declarations of interest**	Chair	**Verbal item**	1	To receive
3.	**9.32**	**Minutes and matters arising from previous Trust Board meeting held 26 June 2018**	Chair	**Paper**	8	To approve
4.	**9.40**	**Service User Story**	Director of Delivery	**Verbal item**	10	To receive
5.	**9.50**	**Chair and Deputy Chief Executive's remarks**	Chair Deputy Chief Executive	**Verbal item** **Paper**	10	To receive
6.	**10.00**	**Risk and assurance**				
		6.1 Care Quality Commission (CQC) report	Director of Nursing & Quality	**Paper**	10	To receive
		6.2 Board Assurance Framework (BAF) 2018/19	Director of Finance & Resource	**Paper**	10	To receive
		6.3 Corporate / organisational risk register (ORR)	Director of Finance & Resource	**Paper**	15	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
7.	**10.35**	**Business developments**				
		7.1 South Yorkshire and Bassetlaw Shadow Integrated Care System (WYBsICS) update	Director of Strategy	**Paper**	10	To receive
		7.2 West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) update	Director of Strategy	**Paper**	10	To receive
8.	**10.55**	**Performance reports**				
		8.1 Integrated performance report (IPR) Month 3 2018/19	Director of Finance & Resource and Director of Nursing & Quality	**Paper**	40	To receive
		8.2 Out of Area Placements - update report	Director of Delivery	**Paper**	10	To receive
	11.45	*Break*			*10*	
9.	**11.55**	**Strategies**				
		9.1 Estates Strategy update	Director of HR, OD & Estates	**Paper**	10	To receive
		9.2 Organisational Development Strategy update	Director of HR, OD & Estates	**Paper**	5	To receive
10.	**12.10**	**Governance items**				
		10.1 Equality and diversity annual report 2017/18	Director of Nursing & Quality	**Paper**	5	To receive / approve

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		10.2 Proposal for the use of e-cigarettes	Director of Delivery	**Paper**	20	To receive / approve
11.	**12.35**	**Receipt of public minutes of partnership boards**	Chair	**Paper**	5	To receive
12.	**12.40**	**Assurance and receipt of minutes from Trust Board Committees** - Audit Committee 10 July 2018 - Nominations Committee 16 July 2018 - Workforce and Remuneration Committee 3 July 2018 - West Yorkshire Mental Health Services Collaborate (WYMHSC) Committees in Common 30 July 2018	Chairs of committees	**Paper**	10	To receive
13.	**12.50**	**Trust Board work programme**	Chair	**Paper**	1	To note
14.	**12.51**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 25 September 2018, Rooms 5&6, Laura Mitchell, Halifax	Chair	**Verbal**	1	To note
15.	**12.52**	**Questions from the public**	Chair	**Verbal**	8	To receive
	13.00	*Close*				

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 26 June 2018
Room 49, Folly Hall, Huddersfield

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Deputy Chair
	Laurence Campbell (LC)	Non-Executive Director
	Rachel Court (RC)	Non-Executive Director
	Chris Jones (CJ)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Mark Brooks (MB)	Director of Finance and Resources
	Dr. Subha Thiyagesh (SThi)	Medical Director
	Tim Breedon (TB)	Director of Nursing and Quality
	Alan Davis (AD)	Director of Human Resources, Organisational Development and Estates
Apologies:	Members	
	Nil	
	Other	
	Sean Rayner	District Director - Barnsley and Wakefield
In attendance:	Carol Harris (CH)	District Director - Forensics and Specialist Services, Calderdale and Kirklees
	Kate Henry (KH)	Director of Marketing, Communications and Engagement
	Karen Taylor (KT)	Director of Delivery
	Salma Yasmeen (SY)	Director of Strategy
	Emma Jones (EJ)	Company Secretary (author)

TB/18/45 Welcome, introductions and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. The apologies above were noted. There were five members of the public in attendance, including four governors. AM reminded members of the public that there would be an opportunity at the end of the meeting for questions and comments from members of the public. Questions asked and responses would be included in the meeting Minutes going forward and a form was available for completion if questions were not able to be answered to enable a response to be provided outside of the meeting.

TB/18/46 Declarations of interest (agenda item 2)

Chris Jones (CJ) declared a potential conflict of interest in agenda item 7.3 West Yorkshire Mental Health Services Collaborative (WYMHSC) Memorandum of Understanding, as the WYMHSC is doing some work in Bradford although not specifically related to Bradford College for which he is the Interim Chief Executive Officer.

There were no further declarations over and above those made in the annual return in March 2018 or subsequently.

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TB/18/47 Minutes and matters arising from previous Trust Board meeting held 24 April 2018 (agenda item 3)

AM advised that one of the attachments to the paper for TB/18/40b Audit Committee annual report including updated Terms of Reference for committees contained a typographical error. Within the Mental Health Act Committee Terms of Reference Salma Yasmeen (SY) remains a member of the committee.

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 24 April 2018 as a true and accurate record with the amendment of a typographical error. The following matters arising were discussed:

- TB/18/35a Safe Working Hours Doctors in Training annual report - Tim Breedon (TB) advised that Datix had been updated for inclusion.
- TB/18/36a Strategic overview of business and associated risks - KH advised that performance against the Communications, Engagement and Involvement Strategy was now included in the Integrated Performance Report (IPR).
- TB/18/40a Equality and Inclusion Forum annual report - AM advised that the annual report would now form part of the annual reporting process to the Audit Committee.
- TB/18/40a Equality and Inclusion Forum annual report - TB advised that the Workforce Race Equality Standard (WRES) indicators would be included in IPR in July
- TB/18/20a Integrated Performance Report Month 11 2017/18 - TB advised that the Clinical Governance & Clinical Safety Committee discussed the trajectory for the complaints process performance improvement.
- TB/18/28 Trust Board Work Programme 2018/19 - Emma Jones (EJ) advised that this would be completed once the Clinical Governance & Clinical Safety Committee confirmed their work programme for 2018/19.

TB/18/48 Service User Story (agenda item 4)

The Trust Board heard a service user story. Carol Harris (CH) advised that last week was Learning Disabilities (LD) awareness week and the following story was in relation to "Rachael" who had been admitted to Horizon, which is an assessment and treatment centre for people with LD.

"Rachael" is in her 30s and was admitted to Horizon in crisis. Rachael was admitted as an emergency due to an acute episode of mental illness resulting in placement breakdown. Rachael has a moderate Learning Disability and Schizophrenia. On admission Rachael was physically and verbally aggressive towards staff, suffering from self-neglect (not showering/washing and refusing to eat and socially isolating herself from her family), refusing to allow her mother to visit the ward. The level of physical aggression towards staff resulted in Rachael having to be restrained and on a couple of occasions seclusion was the only safe option left. Rachael also became distressed as she was convinced that staff were stealing her limbs and organs, asking questions such as "who has stolen my legs/ears/heart" and becoming very tearful and abusive.

Despite all of these behaviours, staff were able to see the potential in Rachael and after two weeks were able to get her to shower, she agreed to eat her meals in her bedroom and gradually began to gain weight. Rachael was treated with a mood stabiliser and atypical antipsychotic medication whilst the team developed a Positive Behaviour Support Plan to manage the physical aggression. After four weeks, Rachael finally agreed to let her mother onto the ward (her mother had visited at least twice a week from admission only not to see her daughter as Rachael refused).

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The incidents of physical aggression significantly reduced and the episodes of verbal aggression were less severe. After seven months Rachael was discharged to her new home. The following feedback was received from Rachael and her mother:

Rachael
I was very sick and think I had a mental breakdown. The staff helped me with my treatment. They were there when I needed them. I like food sometimes and I drink a lot of tea and there is always somebody to give it to me in times of need, I would like my family to come in hospital for treatment. I will come again if I had a mental breakdown. Staff are kind to me. Sometimes I don't like it here when people are talking about me. I like Doctor Marios, he sorted my medication out. I like Jade she is a good staff, she helped me when she is on shift. I like weekends because I can ring Mum and have takeaway.

Rachael's mother
When Rachael came to you she was really quite unwell but thanks to your excellent care, kindness and understanding she is now able to move on to the next positive stage in her life. Thank you.

CH commented that the Trust Board had previously talked about the use of prone restraint which is reported in the IPR. The story also provided an example of how service users can be complex and don't just have a LD or mental health issue and the importance of how we care for the whole needs of an individual.

Rob Webster (RW) commented that within the IPR it showed that physical violence on staff was up to 100 episodes a month and was an area to keep in view so as to continue to ensure the right clinical leadership and governance is in place and restrictions are appropriate.

The Board asked to pass on their thanks to the service user and her mother for sharing the story which demonstrated the pressures for staff as well as the service user and family when dealing with a complex individual who needs a lot of care and support.

It was RESOLVED to NOTE the Service User Story.

TB/18/49 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks
AM highlighted the following:

- This Trust Board meeting was a performance and monitoring one, with focus on the IPR plus areas of business development.
- As part of the Trust's values to be open, honest and transparent, the Trust Board aims to conduct as much business as possible in public. However sometimes, for reasons around commercial confidentiality or to enable free and frank discussion on areas that are in development, some items are considered in private session. The Trust Board approved some guidance in relation to matters considered for private discussion in January 2018. Further to this, the Board would be discussing today in private session ways to further improve the transparency of these discussions, to be reported at the next Trust Board meeting.

- The Non-Executive Director recruitment process was continuing for two upcoming vacancies. The Nominations' Committee met on 20 June 2018 and supported a shortlist of seven candidates for final interviews in July 2018. The final recommendations for appointment would be taken to the Members' Council meeting on 3 August 2018. Thank you to governors and staff for their involvement in the discussion panels.
- This would be Kate Henry (KH), Director of Marketing, Communications and Engagement's last meeting before maternity leave. Thank you to KH for the fantastic contribution she has made at Trust Board meetings and for the significant improvements to communications across the Trust.

Chief Executive's report

RW commented that "The Brief" communication to staff, that was included in the paper, provided an update on the local and national context as well as what was happening across the organisation. Last week was LD awareness week and this week is safeguarding week. As the debate continues around funding for the NHS and a five year plan, it is important to focus on safety first always. The historical story on the failings at Gosport Hospital in the 1980s and 1990s has dominated the headlines this week regarding the inappropriate prescribing regimes that led to the early deaths of hundreds of people. Alongside the detail, the critical messages for us are around culture and clinical safety. At the NHS ConfederationConference bullying and supporting leaders was discussed. As a Board we set the tone including the culture of the organisation. We have a shared accountability for all the staff we support and we need to keep asking ourselves 'is it safe and how do you know?' Non-Executive Directors have a role in that in relation to challenge and assurance on matters. It is important for all staff to have it at the forefront of their mind.

CJ commented that within The Brief it shows that the safer staffing fill rate was RAG rated as green for performance and asked if this was how it felt to staff. He commented that it was important to balance the communication to set the right tone. TB commented that the review of staffing establishment levels would be discussed at the Clinical Governance & Clinical Safety Committee meeting in September 2018. The six-monthly report to Trust Board reports against the levels set on an annual basis and the establishment levels are reviewed annually to ensure they are responding to local needs. Whilst some areas' performance is shown as overachieving, some of this relates to higher levels of acuity, which can distort the levels, and it may be proposed that some of those heightened levels become the normal establishment going forward. KH added that the Communications team was reviewing the way the performance levels are communicated to staff on areas that are RAG rated as green, as staff are under pressure in many of these areas

Rachel Court (RC) asked if there was a way to tie in the performance data with relevant areas from the staff survey. RW commented that within the IPR there was some data such as sickness absence and turnover which could provide an indication. During the recent Care Quality Commission (CQC) inspection, positive feedback was given around the provision of great care and professionalism of staff. In the staff listening events, issues were raised in relation to staffing levels, record keeping and estate which was variable. All of these areas would be triangulated.

CD advised that as part of the Shadow Board programme, she chaired a Shadow Board meeting on 25 June 2018 where they reviewed the Trust Board papers. As part of the discussion there was a focus on safer staffing in inpatient areas as well as a recognition of the pressure within community services, which is an area for the Clinical Governance & Clinical Safety Committee to discuss further. TB commented that it was noted within the IPR under staffer staffing to look further into caseloads and acuity in the community.

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TB/18/50 Performance reports (agenda item 6)

TB/18/50a Integrated performance report month 3 2018/19 (agenda item 6.1)

TB highlighted the following in relation to the Summary dashboard and Quality:

- Under 18 admissions - no admissions this month into acute mental health wrads, we want to be able to sustain that position, however recognise that it is not always in our control. We continue to work with partners to develop appropriate pathways, including inpatient beds
- Out of area beds - numbers reduced, however acuity and demand remains considerable across the Trust.
- Safer staffing - levels maintained with a reduced skill mix on occasions and can mask some of the pressures within the services.
- Use of restraint - has seen a spike and the hypothesis is that this relates to increased acuity, aa detailed report will be considered by the Clinical Governance & Clinical Safety Committee.
- Complaints - fewer new complaints received and showing a reduction on those not closed within 40 days. The position is still not where we want to be,the early indications show that action taken is moving position in the right direction.
- Falls - previously had seen spike which has now reduced to below last year's average, with action taken having a positive impact.
- Information Governance (IG) breaches - one or two areas require some focused work, however most are individual human error linked to incorrect addresses

MB commented that the summary dashboard was being developed in line with discussion at the last Trust Board strategic meeting. Information available has been included and further will be available in the next report to Trust Board.

LC noted the change in the Friends and Family Test. TB commented that it was primarily in relation to CAMHs and work was taking place to improve people's understanding. CH added that in Barnsley and Wakefield waits to treatment were challenging, which could impact the results. A detailed report is reviewed by the Clinical Governance & Clinical Safety Committee including the plans in place with commissioners to try to and address the issues.

CJ asked if there was a reason why fewer complaints had been received. TB commented that as part of reviewing processes, one-to-one conversations were now being put in place with a clinical lead to aid informal resolutions before they become a formal complaint. RC asked if they would still be recorded. TB commented that they were still recorded as concerns and the themes were reviewed collectively.

CJ asked whether the change in processes would assist the completion time. TB commented that 40 days completion was a self-set stretch target and it was too early to see if the reduction was a trend. CD commented that it was an area that had been raised by the Clinical Governance & Clinical Safety Committee and also by the Shadow Board and asked how the Trust was performing in comparison to others. TB commented that he was not aware of other Trusts locally that had a similar target of 40 days.

AM asked about the involvement of service users in Patient-Led Assessments of the Care Environment (PLACE) Programme work taking place. KH commented that volunteers are involved in the assessments who quite often had been service users. AGD commented that people who take part in an assessment team are trained and included service users and representatives from specialist providers and the community. RW asked whether governors could be trained to take part in assessments.

Action: Alan Davis

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RW commented that in relation to suicides there had been 41 in the last year which was higher than the 28-30 anticipated and asked if an exception report was needed in relation to the work taking place under the system wide Suicide Prevention Strategy. TB commented that this was an area that had been discussed by the Clinical Governance & Clinical Safety Committee to bring forward the suicide prevention report in order to review the learnings. This will be cross referenced with the Patient Safety Strategy action plan.

CD asked about the service users followed up within 7 days of discharge metric which was not achieved in April. CH commented that the follow up target was not missed due to staffing resources, it related to being unable to contact three service users and these exceptions were reviewed.

AM asked in relation to restraints how widely the statistical analysis data is used to understand areas of fluctuation. TB commented that there was a focus on areas that we are familiar with, such as restraint and safer staffing. This could be extended across other areas in line with the patient safety action plan and there was a need to ensure the right resource is available to undertake the analysis.

MB highlighted the following in relation to NHS Improvement indicators:

- Meeting the vast majority of national metrics including the 7 day follow up target, following a slight dip in performance in April 2018.
- Improving Access to Psychological Therapies (IAPT) - proportion of people completing treatment and moving to recovery remains above target.
- Out of area beds - agreed trajectory of reduction joint plan with commissioners, which is not currently being met.

The Board discussed out of area beds including whether the reduction since February and March was as a result of the Trust's actions or the system. KT commented that it was a result of both. The Trust can identify some actions where there has been a decrease such as in Calderdale, however a reduction in-month was not long enough to ensure sustained improvement. In addition usage is still well above historical averages. Demand was still the main issue and a significant risk with local variations and working taking place to address those. SY added that deep dives had provided improvement work, and nationally there was some work to learn from in relation to discharge. Shared learning was taking place with Bradford to look at improvement approaches that have worked there. Due to the 58% increase in use of out of area beds in this period compared to last year, the Board requested an exception report on work taking place as part of the priority programme and across West Yorkshire.

Action: Karen Taylor

AM asked how the performance against the percentage of clients in employment metric could be improved. MB commented that the metric did not cover all of the Trust's service users. CH added that there was also a difference in the way the Trust describes employment and there was a series of areas that need to be met to qualify as this national metric. It is important to ensure it is measured accurately and this would form part of the changes to the clinical record system. AM requested that narrative in future reports includes the work taking place to meet this metric.

Action: Tim Breedon

CJ asked about the proportion of people detained under the Mental Health Act (MHA) who are from Black, Asian and other non-white minority ethnic (BAME) backgrounds metric. This is considered by the MHA Committee who receive a report on this data and it is acknowledged that there was a need to ensure the data is accurate. TB commented that some new metrics around data quality have been identified which will be included in future

reports. KQ commented that this was also an area raised at by the Clinical Governance & Clinical Safety Committee in relation to the new clinical records system. TB commented that the issue of integrity of data would not impact on this particular indicator, it would be small numbers who would not have their ethnicity recorded.

CH highlighted the following from the Locality report in relation to Specialist Services:

- Waiting times for treatment in Wakefield and Barnsley - continue to review the on call arrangements across CAMHs, an initial proposal has been developed and will review the detail of our contract across each area. A workshop will take place around an all-ages liaison model, building on adult liaison services already in place, which would address part of the issue and offer a more accessible service.
- OFSTED visit of Wakefield local authority services - awaiting the formal report and working with the Wakefield system in improving access to CAMHs.
- Learning Disabilities - capital work will start in Horizon in June 2018 and it is hoped that beds can be opened for spot purchase for service users who have previously been sent out of area.
- Operational Delivery Network for Learning Disabilities - the Trust's bid to lead the network across the Yorkshire and Humber region has been successful.

CH highlighted the following from the Locality report in relation to Calderdale and Kirklees:

- Out of area beds - pressure predominately in Calderdale and Kirklees. The Calderdale Home Based Treatment Manager is actively managing the situation.
- Inpatients - showing pressures due to a number of highly acute male service users.

AM commented that she liked the format of the Calderdale and Kirklees narrative. CD added that this was also commented on by the Shadow Board.

KT highlighted the following from the Locality report in relation to Wakefield and Barnsley:

- Out of area beds - areas of focus are length of stay and a review of Home Based Treatment.
- IAPT Barnsley sustained performance

RW commented that at a Provider Alliance meeting in Barnsley a national push around systems and improvements was discussed which they referred to as "super stranded patients". All parts of the system have been asked to reduce the number of people out of area and Barnsley is seen as one of the best performing areas in the country. Work is taking place to understand their systems including support from the local authority in relation to social services. The Trust's services that link into intermediate care assists this.

SY highlighted the following in relation to Priority Programmes:

- Clinical Records System - slight delay around the migration of data to the new system which has now taken place successfully. A recommendation would go to the Executive Management Team (EMT) to agree to move to the next phase. There is a key risk in relation to training with work taking place to prepare and an approach approved by clinical management staff. The numbers booked onto training will be reported on weekly.
- Older People's Services - was a priority programme in 2017/18 and is moving into the next phase with formal discussions taking place with commissioners.
- The Communications team has done a significant amount of work around how the priorities and priority programmes are communicated to staff and the public.

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RC commented that in relation to the Clinical Records System a lot of the contingency had been used to date, however there was still a lot of confidence from the programme board that the timescales can be achieved.

CJ asked in relation to workforce productivity how the actions to date focus on productivity. SY commented that it was a new priority programme for 2018/19 which had just been scoped. AGD commented that last year the priority in relation to operational excellence focused on the use of bank staff and reducing sickness absence. This year the programme would focus on workforce redesign, establishment of new roles, and retention programmes to assist in making the workforce sustainable for the future. The programme would be an area of focus for the Workforce and Remuneration Committee. RC commented that it formed part of the Workforce Strategy and there was a need to ensure it was a focus in all areas of work.

MB highlighted the following in relation to Finance:

- In line with plan, although this is the first time the Trust has had a deficit plan, and the run rate is adverse to the full year plan.
- Need to recognise financial challenge in terms of income reduction in the second half of the year
- Out of area bed expenditure is adverse to plan and is 58% higher than the corresponding period for 2017/18.
- Net pay costs are showing a saving compared to temporary staffing costs.
- Agency costs are variable at this stage and connected to levels of acuity and vacancies in medical. There are also areas of disproportionate use in CAMHs and LD.
- Financial risk rating moved from 1 last year to 2 given the deficit positions, with a risk that it will move to 3 if there is a difference compared to plan.
- Cash has reduced from year end as expected
- CIP is below target with an overspend on drugs.
- The Carter 2 report has been released which looks at potential savings across mental health and community services.
- When the plan was set with a £2.6m deficit the Trust did not have full plans in place to meet this and there has since been a further risk in relation to out of area beds due to 40% of the annual budget now spent. Given the change in financial position, NHS Improvement have attend Operation Management Group (OMG) and Executive Management Group (EMT) meetings where financial discussions have taken place and they will provide formal feedback.

LC asked if there was a way the decision making in relation to CIPs could be accelerated without compromising quality and safety. MB commented that work has already been done to improve the governance processes with the schemes subject to weekly discussion at OMG and monthly at the EMT meeting that Non-Executive Directors are invited to attend. The remaining areas are those where OMG are yet to agree as they need to ensure rigor in the schemes or pace of the implementation.

AGD highlighted in relation to Workforce:

- Sickness absence - positive start to the financial year, Wakefield and Barnsley in particular due to the positive actions taking place around wellbeing. There are hot spots for focus in relation to Specialist Services in LD. Calderdale and Kirklees CAMHs have seen a reduction with the Clinical Governance & Clinical Safety Committee reviewing a detailed report. A lot of good engagement work was taking place through local wellbeing groups and with management.

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- Staff turnover is currently reported as being 8.5% year-to-date.
- Mandatory training - Following discussion at the recent board development session it is suggested the training metrics included in the summary dashboard for 2018/19 are for compliance with Managing Aggression and Violence (MAV) and Moving and Handling training, which are nationally areas of focus.

RC asked, in relation to the staff turnover, if figures are shown in the same way as other trusts excluding TUPE to assist with comparison. AGD commented that the measurement was the same as others nationally and the detailed report was received by the Workforce & Remuneration Committee.

RW asked if there were themes from the turnover and sickness absence rates in Specialist CAMHs and Learning Disabilities. CH commented that there were different hot spots, turnover in CAMHs and sickness absence in Learning Disabilities. Information from leavers relates to pressure in caseloads, waiting lists, and on call. AGD commented that at the last EMT meeting the detailed report which goes to Clinical Governance & Clinical Safety Committee was discussed and an area for consideration is a CAMHs summit to engage staff and develop some actions. CD commented that CAMHs was a standing agenda item at each Clinical Governance & Clinical Safety Committee where there was recognition that there is a lot of good work going on, although still concerns for inclusion on the Corporate/Organisational Risk Register.

KQ asked in relation to the LeDeR report whether Learning Disability training should become mandatory. CH commented that a request in relation to the Greenlight toolkit would be discussed by the EMT.

It was RESOLVED to:

- **NOTE the Integrated Performance Report and COMMENT accordingly; and**
- **AGREE the training metrics in the summary dashboard for 2018/19 are for compliance with Managing Aggression and Violence (MAV) and Moving and Handling training.**

TB/18/50b Learning Disabilities Mortality Review (LeDeR) report (agenda item 6.2)
TB highlighted the following:

- National annual report published in May 2018 which will be discussed in detail by the Clinical Governance & Clinical Safety Committee.
- System coordinated by NHS England and Clinical Commissioning Groups (CCGs).
- Trust is required to ensure that deaths are reported as appropriate, support the CCG panel, and offer reviews where possible.
- Any learnings from reviews that relate to people within the Trust's services are included in our quarterly reports, which go to the Clinical Governance & Clinical Safety Committee.
- Areas that the Trust will review in response to the national report are outlined in the paper.

KQ commented that she felt the avoidable/preventable deaths were not clearly reflected in the national report and that seclusion and general care for LD differs nationally. The Trust was good at conducting the reviews, what more could be done and how can we be more ambitious? TB commented that the Trust was now the lead for the LD workstream in West Yorkshire. It is an area of specialism, experience and knowledge and becoming the lead reflected this. It is important to reflect learnings at a team level as well as reflecting across the system, including primary care, the importance of reasonable adjustments. The report

will be discussed in more detail by the Clinical Governance & Clinical Safety Committee in September 2018 along with an action plan.

CD commented that the Shadow Board asked how learning was shared across the organisation. TB commented that the greenlight toolkit is used along with specialist support the Trust provides to Mid Yorkshire Hospitals NHS Trust (Mid Yorks).

RW commented that one of the Trust's four strategic ambitions was to be a regional lead for LD, working in all of our localities and asking others what they are doing about it, such as the local Health & Wellbeing Boards. Operationally the Trust is leading on LD in West Yorkshire. We have discussed the work we have done with Mazars around mortality reviews and within this national report it challenges the work we have done to date and highlights what more we need to do. TB commented that the report would be considered at the next Mazars meeting, such as responsible adjustments for recording, how we are aligning the Serious Incident and other processes with the mortality review processes, the required speed of reporting, and data sharing across the system. The CCGs are the lead and we need to work with them. RW requested that the Executive Management Team through to the Clinical Governance & Clinical Safety Committee look at what the current arrangements are, what more do we need to do, whether a day to day lead is needed, and the training arrangements.

Action: Tim Breedon

It was RESOLVED to RECEIVE the report and NOTE the implications for the Trust and plans in place.

TB/18/50c Incident management annual report 2017/18 (agenda item 6.3)
TB highlighted the following:

- Report considered by the Clinical Governance & Clinical Safety Committee.
- Similar format to previous, with updated data analysis.
- Significant number of incidents reported, indicative of positive reporting culture.
- 87% low or no harm.
- 71 Serious Incidents reported, accounting for 0.58% of all incidents reported.
- Increase in apparent suicides, the Clinical Governance & Clinical Safety Committee considered in line with apparent suicide report to ensure we get the best learning.
- This report has been turned around faster than previous as it was important to have early sight of key findings.
- Improvement shown in the staff survey around reporting.
- Two internal audits received significant assurance.
- Positive feedback received from the CQC.
- Good signs from Patient Safety Strategy.
- Key messages from the Clinical Governance & Clinical Safety Committee included that the report was of good quality, well structured, understood, robust systems and processes were in place through assurances received, and the importance of weekly risk panel. The committee requested further assurance around actions and outcomes in the Integrated Performance Report and a deep dive on increase in apparent suicide in Kirklees, which would be considered at next meeting to complete assurance that actions are in place. CD added that further assurance in relation to apparent suicides was important and secondly the need to ensure we get learnings and actions.

CD commented that the Shadow Board had discussed that when the themes of learnings and concerns are considered they are consistent over time and it was important to understand what actions are taking place and what was being changed in response.

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CJ asked if it was known which themes of activity to reduce the incidents have worked. TB advised that all have measures within Patient Safety Strategy action plan. Examples are Safety Huddles which support culture and awareness and methodology which relates to human factors.

CJ asked if there had been any improvements in record keeping. TB advised that there has been some improvement but further work to do which relates to the clarity of recording.

LC asked about the risks and opportunities related to the implementation of the new Clinical Records System. SY commented that there is a clinical safety workstream lead by Mike Doyle, Deputy Director of Nursing, which includes a range of senior clinicians and has access to a wider reference group and the system maps are being reviewed with Trios. The new Clinical Record System would include some significant improvements in recording and reporting and there could be further developments to be included in a second phase. RW commented that it provided an opportunity to reinforce record keeping by clinical leadership and through staff communications.

LC asked if there were further actions that could be in place to manage aggression and violence to protect staff. TB commented that there may be some learnings as a result of restraint work along with a national position as a result of NHS staff surveys. The behavior of service users can be due to the circumstances in which people arrive into services as well as level of acuity.

RW commented that in relation to Duty of Candour requirements, a number were in relation to Barnsley BDU which are still awaiting review by BDU, which is higher in comparison and asked if it was due to infrastructure or cultural issues. TB commented that it had been considered at BDU governance groups. KT commented that it was felt to be an operational issue around the capturing of information. Information to be provided to the Clinical Governance & Clinical Safety Committee for review.

Action: Tim Breedon / Sean Rayer

It was RESOLVED to RECEIVE the report and NOTE plans for 2018/19.

TB/18/50d Healthy Eating CQUIN (agenda item 6.4)
AGD reported that the Trust has met the technical requirements for the 2017/18 CQUIN in full and there is an ongoing commitment to achieve full compliance as part of a three year requirement which has higher targets each year. The only wider impact of the CQUIN is financial as it is not anticipated that the reduction in sugary drinks will result in reduced sales as the low sugar options are the better sellers already as people take greater responsibility for their health.

CJ asked if there was more the Trust could do in relation to children and young people which is something outside the CQUIN reporting. AGD commented that it could be looked at as how the Trust operates.

It was RESOLVED to NOTE the content of the report and APPROVE the circulation of this report to the relevant Quality Boards.

TB/18/51 Business developments (agenda item 7)

TB/18/51a South Yorkshire and Bassetlaw Shadow Integrated Care System (SYBsICS) update (agenda item 7.1)
AGD highlighted the following:

- Setting up for next phase of ICS, number of negotiations taking place around technical elements such as control totals.

- Now appointed a Director of Finance.
- Revised version of the Memorandum of Understanding (MoU) due to come to Boards.
- Hospital Services review progressing.
- An update on priorities was received with most progressing well.
- Our work with the other mental health trusts is positive and with good sharing of learnings.

RW commented that the stroke programme had a material impact on the Trust's services and he had a discussion with partners in Barnsley about what the consequences might be such as working as a virtual Multi-Disciplinary Team (MDT) with the Hospital. There would be an allocation of funding in relation to suicide prevention in South Yorkshire and we need to understand whether the Trust would receive any of that funding.

SY commented that the mental health trusts would be working to try to address out of area beds across the system. Barnsley has been signed as a locality to learn from, with out of area beds defined differently in South Yorkshire to other areas.

It was RESOLVED to NOTE the update from the SYB sICS Collaborative Partnership Board.

TB/18/51b West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) update (agenda item 7.2)
SY highlighted the following:

- Formally part of the next wave of Integrated Care Systems (ICS).
- Lots of engagement work taking place across the system.
- Workforce plan under development.
- Trust to take a lead role for improving LD services across the system.

RW highlighted the following:

- The revised MoU would likely come to Trust Boards in September 2018 following a request from local authorities for more time given recent elections.
- A joint development programme for ICS would take place.
- Likely that there would be some delegated funding this year and the ICS would still be able to bid for funding including capital. One of the top priorities is for locked rehab and the West Yorkshire Mental Health Services Collaborative is supporting that work.
- Not required to deliver a combined control total this year, however need to agree performance trajectory with the centre, which would come back to the Trust Board.
- Professor Don Berwick would be visiting West Yorkshire on 27 June 2018 to spend time with clinical leadership in relation to cancer and a system developed based on mutual accountability.

KQ asked if a joint risk-sharing approach had been agreed and how are they included within the Trust's plans. RW commented that the Trust's priorities for 2018/19 include developments in both the South Yorkshire & Bassetlaw and West Yorkshire & Harrogate systems and we need to get better at reflecting risks as a Trust. Work would take place to develop how we would hold each other to account in the ICS. It was intended that there would be a system oversight assurance group, with a lead Chief Executive from the main sectors, where issues are raised and actions aligned.

It was RESOLVED to RECEIVE the update on the development of the West Yorkshire and Harrogate Health and Care Partnership.

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TB/18/51c West Yorkshire Mental Health Services Collaborative (WYMHSC) Memorandum of Understanding (agenda item 7.3)
AM reported that in the private sessions of Trust Boards in March 2018, the Boards of the four organisations comprising the West Yorkshire Mental Health Services Collaborative agreed the memorandum of understanding (MoU), subject to a number of points of clarification. These points were clarified with the members of the Committees in Common and at its first meeting on 30 April 2018 the Chairs of the four organisations signed the MoU. The final version was now provided in public for noting.

It was RESOLVED to RECEIVE the final version of the Memorandum of Understanding.

TB/18/52 Governance items (agenda item 8)

TB/18/52a Operational Plan 2018/19 (agenda item 8.1)
MB highlighted the following:

- The draft Operating Plan was submitted to NHS Improvement (NHSI) on 8 March 2018 in line with what was agreed by the Trust Board.
- Following discussion in the private session of Trust Board in April 2018 Trust Board, the final plan was approved by the Chair and Chief Executive and submitted ahead of the 30 April 2018 deadline. .
- The final plan is provided for noting in public along with the feedback received from NHSI. The feedback stresses the need to improve underlying performance for 2019/20 and to ensure achievement of the 2018/19 plan. It also offered the Trust the opportunity to re-submit its plan by 18 June 2018 given the points raised. The Trust has not changed or re-submitted the plan.

It was RESOLVED to NOTE the final operating plan submitted for 2018/19 and the COMMENTS provided as feedback by NHS Improvement.

TB/18/52b Update on Annual Report and accounts including the Quality Account 2017/18 (agenda item 8.2)
MB highlighted the following:

- The submission of the 2017/18 annual accounts, Annual Report and Quality Account took place in accordance with the requirements.
- The report explains the process undertaken to generate these submissions and provide assurance regarding the governance of the process.
- The reports generated by the external auditors, Deloitte LLP, following their annual audit were also included in the papers.
- The final Annual Report and accounts including the Quality Account for 2017/18 cannot be published until they are laid before parliament which is due to take place in July 2018.

AM commented that the Trust had produced a short 'Our Year' document, which highlighted the achievements of the Trust in 2017/18 and was available on the Trust's website.

It was RESOLVED to:

- **NOTE the update on the process relating the annual report, accounts and quality account process and submissions; and**
- **RECEIVE in public the external audit reports relating to the annual accounts and Quality Account.**

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TB/18/52c Trust Board self-certification (FT4) - corporate governance statement 2017/18 (agenda item 8.3)

MB reported that self-certifications (G6 and CoS7) against the NHS Provider Licence were agreed at the Trust Board meeting on 24 April 2018. The final self-certifications (FT4 and training of Governors) were now required to confirm that the Trust has complied with required governance arrangements through a Corporate Governance Statement and the training of governors.

LC asked whether the recent CQC report would impact on the Corporate Governance Statement. EJ commented that the report covered 2017/18 and as the report was yet to be published by the CQC any impact could not yet be reflected. The CQC report may impact the statement for 2018/19.

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

- **the Corporate Governance Statement 2017/18; and**
- **the training for Governors 2017/18.**

TB/18/52d General Data Protection Regulations (GDPR) update (agenda item 8.4)

MB highlighted the following:

- A report is made to each Audit Committee meeting on the progress to date against plan.
- Information Governance (IG) policies have been updated, approved and placed on the Trust's intranet.
- The Trust's public privacy notice has been updated and placed on the website.
- A programme of training on the completion of privacy impact assessments (PIAs) was delivered to management teams over the six months prior to the enforcement of the GDPR.
- Confidentiality leaflets for patients are being updated in readiness for sharing upon confirmation of a small number of points.
- The Trust is working towards full compliance by the end of October 2018 in line with requirements.

LC asked if the Trust had the resources in place to implement any requirements. MB commented that, whilst the number of staff was low there was very skilled resource in place.

CD commented that the Shadow Board had asked if anything had been sent to staff regarding the potential impact of GDPR. MB commented that no specific communication had been sent to staff individually however there was a comms plan in place.

RW asked if the Members' Council could provide additional oversight and assurance. MB to discuss with AM regarding possible scheduling at a future Members' Council meeting.

Action: Angela Monaghan

AM asked what the impact of GDPR was on the Trust's membership. MB advised that discussions were taking place with other trusts to ensure a consistent approach.

AM asked for a review to ensure that that any public facing policies were easy to access by members of the public. KH commented that this was currently being discussed. Previously, all policies were automatically published to the Trust's website, however due to technical issues that was ceased. Copies of policies can be requested via the Customer Service team

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and the Communications team will work with the Corporate Governance team regarding access on the website.

Action: Kate Henry

The Board noted the huge amount of work undertaken. MB commented that a number of other trusts have spent a large amount of money on implementing the new regulations, in comparison with SWYPFT.

It was RESOLVED to NOTE the work undertaken to date and that which will be completed in the coming weeks to ensure the Trust continues to strengthen its compliance with GDPR with the aim of achieving full compliance by 31 October 2018.

TB/18/53 Receipt of public minutes of partnership boards (agenda item 9)

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

- Calderdale Health & Wellbeing Board 21 June 2018
- Barnsley Health & Wellbeing Board 5 June 2018 - RW commented that the local health and care record exemplar was a national programme. Yorkshire & Humber had applied for the final place in the programme and if successful would mean and investment of £7.5m across the region to assist joined-up records.
- Kirklees Health & Wellbeing Board 28 June 2018 - RW commented that the leadership group has started to meet again and have requested work to take place similar to Calderdale Cares on the strategic direction for Kirklees.

It was RESOLVED to RECEIVE the updates provided.

TB/18/54 Assurance and receipt of minutes from Trust Board Committees (agenda item 10)

Audit Committee 22 May 2018

- Draft Annual Report and accounts and Quality Account for 2017/18.

Clinical Governance & Clinical Safety Committee 15 May 2018 and 19 June 2018

CD highlighted the following from 19 June 2018:

- Organisational Risk Register was discussed in relation to Child and Adolescent Mental Health Services (CAMHs) and whether the risk was described accurately. Mitigating actions and scoring will be discussed further by the Executive Management Team prior to reporting at the Trust Board meeting in July 2018. In relation to Out of Area Beds there was a need for greater assurance in relation to actions taking place. Once the CQC report is published this will be reviewed to ensure risks have been captured.
- Serious Incidents and Apparent Suicide reports.
- CAMHS report and the need to ensure the right level of assurance.
- Actions to be escalated to other committees and forums such as the management of Equality Impact Assessments (EIA) by the Equality and Inclusion Forum and recording of ethnicity which is also discussed by the Mental Health Act Committee.
- Approved Minutes of the Committee meeting held on 6 February 2018 (attached with the Trust Board papers).
- Approved Minutes of the Committee meeting held on 17 April 2018 (attached with the Trust Board papers).

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- Approved Minutes of the Committee meeting held on 15 May 2018 (attached with the Trust Board papers).

Equality & Inclusion Forum 12 June 2018
AM highlighted the following:

- Equality and diversity annual report, which will come to Trust Board in July 2018.
- Update on Equality Impact Assessment completion.
- Equality and Diversity Standard (EDS2) update.
- Update on inclusive leadership and development.
- The meeting was quorate, however there was a low attendance.
- Approved Minutes of the Committee meeting held on 6 March 2018 (attached with the Trust Board papers).

Mental Health Act Committee 15 May 2018
CJ highlighted the following:

- Recording of ethnicity.
- Bed availability and impact on our partners and patients.
- Lack of response of Yorkshire Ambulance Service (YAS) and Police.
- Section 136 increase and need to work together as Crisis Care Concordat.
- Good presentation from clinical leadership in Horizon.
- Approved Minutes of the Committee meeting held on 6 March 2018 (attached with the Trust Board papers).

RW commented that there had been a previous concern raised by the committee in relation to actions from MHA audits that were not always followed through and asked if further assurance had been provided. CJ commented that this was in relation to recurrent learnings where actions are tracked, however it was important to maintain a level of consistency. The committee felt assured in general that the Trust responds positively to those inspections.

Nominations Committee 20 June 2018
AM highlighted the following:

- Recommendation of the shortlisted Non-Executive Director candidates was discussed and supported for final interview.
- Committee annual report and updated Terms of Reference were approved, which will go to Members' Council meeting on 3 August 2018.
- Approved Minutes of the Committee meeting held on 10 April 2018 (attached with the Trust Board papers).

Workforce and Remuneration Committee 8 May 2018
RC highlighted the following:

- Workforce Strategy: 2018/2019 Action Plan.
- Organisational Development Strategy 2018/2019 Action Plan.
- Strategic Workforce Plan – Executive Summary.
- Human Resources Exception Report – Workforce Strategy Dashboard; Prototype.
- Approved Minutes of the Committee meeting held on 23 March 2018 (attached with the Trust Board papers).

West Yorkshire Mental Health Services Collaborative Committees in Common 30 April 2018
AM highlighted the following:

- Memorandum of Understanding, which was received at Trust Board today.

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- Update on workstreams.
- Draft Minutes of the Committee meeting held on 30 April 2018 would be received in the private session of Trust Board.

It was RESOLVED to RECEIVE the updates provided.

TB/18/55 Use of Trust Seal (agenda item 11)

It was RESOLVED to NOTE use of the Trust's seal since the last report in March 2018.

TB/18/56 Trust Board work programme (agenda item 12)

It was RESOLVED to NOTE the work programme.

TB/18/57 Date of next meeting (agenda item 13)

The next Trust Board meeting held in public will be held on Tuesday 31 July 2018 in the small conference room, Wellbeing and learning centre, Fieldhead, Ouchthorpe Lane, Wakefield.

TB/18/58 Questions from the public (agenda item 14)

Comments and questions were invited from members of the public in attendance. A summary of the questions and responses is provided below:

TB/18/58a - *Is it true that people in outpatients at Folly Hall are carrying weapons?*
CH commented that she was not aware of any incidents reported and if they had a concern for it to be reported outside of the meeting for follow-up.

TB/18/58b - *A visitor's badge was not given on sign in at Folly Hall as reception staff advised they were too busy. Should this be the case?*
CH commented that service users would be signed in so that services knew they had arrived for their appointments. AGD commented that he would review the local arrangements at Folly Hall to ensure the correct process was in place.

Action: Alan Davis

TB/18/58c - *In terms of the Trust's strategy to form and forge alliances, had anything been considered in relation to resource allocation and a formula that could be applied?*
RW commented that any opportunity would also have a cost. The Trust had done a lot of work over the last couple of years to streamline our priorities, vision, mission, and values, aligning our priorities to reflect the strategy of the organisation including the resources we have. Reviews undertaken by the CQC and others had noticed and commented on that work. The context continues to change nationally and it was important for the Trust to spend time with partners to understand the impact locally.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 26 JUNE 2018 – ACTION POINTS ARISING FROM THE MEETING

Actions from 26 June 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/50a Integrated performance report month 3 2018/19	Patient-Led Assessments of the Care Environment (PLACE) Programme - RW asked whether governors could be trained to take part in assessments.	AGD		
	Out of area beds - The Board requested an exception report on work taking place as part of the priority programme and across West Yorkshire.	KT	July 2018	Complete. Included on the agenda item 8.2.
	Percentage of clients in employment metric - AM requested that narrative in future reports includes the work taking place to meet this metric.	TB	July 2018	
TB/18/50b Learning Disabilities Mortality Review (LeDeR) report	RW requested that the Executive Management Team through to the Clinical Governance & Clinical Safety Committee look at what the current arrangements are, what more do we need to do, whether a day to day lead is needed, and the training arrangements.	TB	September 2018	To be discussed at the next Clinical Governance & Clinical Safety Committee meeting in September 2018.
TB/18/50c Incident management annual report 2017/18	RW commented that in relation to Duty of Candour requirements, a number were in relation to Barnsley BDU which are still awaiting review by BDU, which is higher in comparison and asked if it was due to infrastructure or cultural issues. TB commented that it had been considered at BDU governance groups. KT commented that it was felt to be an operational issue around the capturing of information. Information to be provided to the Clinical Governance & Clinical Safety Committee for review.	TB / SR	September 2018	To be discussed at the next Clinical Governance & Clinical Safety Committee meeting in September 2018.

With all of us in mind.

Min reference	Action	Lead	Timescale	Progress
TB/18/52d General Data Protection Regulations (GDPR) update	RW asked if the Members' Council could provide additional oversight and assurance. MB to discuss with AM regarding possible scheduling at a future Members' Council meeting.	AM		
	AM asked for a review to ensure that that any public facing policies were easy to access by members of the public. KH commented that this was currently being discussed. Previously, all policies were automatically published to the Trust's website, however due to technical issues that was ceased. Copies of policies can be requested via the Customer Service team and the Communications team will work with the Corporate Governance team regarding access on the website.	SY		
TB/18/58 Questions from the public (TB/18/58b)	*A visitor's badge was not given on sign in at Folly Hall as reception staff advised they were too busy. Should this be the case?* CH commented that service users would be signed in so that services knew they had arrived for their appointments. AGD commented that he would review the local arrangements at Folly Hall to ensure the correct process was in place.	AGD		

Outstanding actions from 24 April 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/36c Corporate / organisational risk register	AM commented that the dates of completion for actions was sometimes vague and requested if individual dates for actions could be added to assist the Board in tracking progress.	MB	July 2018	Complete. Expected completion dates for actions added in brackets next to the individual actions for each risk, unless they are ongoing.
TB/18/38a Integrated performance report month 12 2017/18	RW asked for assurance from the Audit Committee after their next meeting in relation to the milestone plans, mitigation of risk around data migration, and overview of gateway signoff including Non-Executive Director oversight.	SY / TB	July 2018	To be discussed under agenda item 12 - Assurance and receipt of minutes from Trust Board Committees
TB/18/38b Customer services report	CD commented that equality data slide indicated that more white British people raised complaints at 69% and asked if the processes supported people from	TB	October 2018	To be discussed at the Equality and Inclusion Forum meeting in October 2018.

Min reference	Action	Lead	Timescale	Progress
Quarter 4 2017/18	other backgrounds to raise concerns. TB commented that this could be an area reviewed further by the Equality and Inclusion Forum.			

Outstanding actions from 27 March 2018

Min reference	Action	Lead	Timescale	Progress
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	October 2018	To be discussed at the Equality and Inclusion Forum meeting in October 2018.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 5

Title:	**Deputy Chief Executive's report**
Paper prepared by:	Deputy Chief Executive
Purpose:	To provide the strategic context for the Trust Board conversation.
Mission/values/Objectives:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers/ previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.
Executive summary:	The June edition of *The Brief* is attached at Annex 1. This provides details of the national and local strategic context, performance, staffing and other issues. Board members will notice the strong internal focus of The Brief reflecting the significant challenges of operating in a system where demand and expectation is increaing. Since publication of The Brief, there are areas to update and of emphasis to draw to the attention of the Board: **1. New Secretary of State for Health and Social Care** The Rt Hon Matt Hancock MP was appointed Secretary of State for Health and Social Care on 9 July 2018. He has set out his early priorities across the whole health and social care system: workforce, technology, and prevention, working in collaboration, not competition, towards our common goal. Clearly we will need to remain alert to any changes in emphasis during the early stages of his tenure. **2. Social Care Green Paper** The recent cabinet changes raised concern that this may be delayed. Mr Hancock has said that there are no planned changes to the timetable for publication of the green paper "at this stage". Given the significance of this paper upon whole system working we will need to keep progress in view during the next few months. **3. Reform to the Deprivation of Liberty Safeguards (DoLS) legislation** The government introduced on 3 July, and published on 4 July, a draft Bill – the Mental Capacity (Amendment) Bill. The Bill abolishes the Deprivation of Liberty Safeguards, by deleting Mental Capacity Act 2005 (MCA), and adds a new Schedule which we anticipate will be known as the 'Liberty Protection Safeguards'. This will be a important piece of legislation for us as it brings new responsibilities that will need some thought, resources and training. **4. NHS 70 Celebrations** NHS 70 celebrations received positive press both nationally and regionally. Events across the trust including a tea party at Fieldhead

	log cabin. This featured the Fieldhead choir as well as lots of tea and cake. The event raised more than £200 for Ey Up! **5. Increased acuity and demand** Acuity and demand is increasing across all of our services and can be difficult to manage. Our inpatient mental health services are a good example of this. I took the opportunity to meet with staff in Barnsley and Dewsbury recently to get a detailed understanding of the impact upon our staff and service users. As always, our staff are rising to the challenge and it was good to hear about the hard work we've been doing in acute and community mental health services to reduce these issues. Inevitably you will see some of the impact reflected in our papers today. **6. Excellence** The Excellence awards have now been launched with applications coming in daily. Award judging is taking place on 10 September in Fieldhead and the awards will take place on 13 November 2018. The awards will form part of a day of staff celebration, with the long service awards and learners celebration event in the afternoon, and the Excellence awards in the evening.
Recommendation:	**Trust Board is asked to NOTE the Deputy Chief Executive's report.**
Private session:	Not applicable.

NHS
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NHS Foundation Trust

The Brief

28 June 2018

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

With **all of us** in mind.

Our mission and values

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

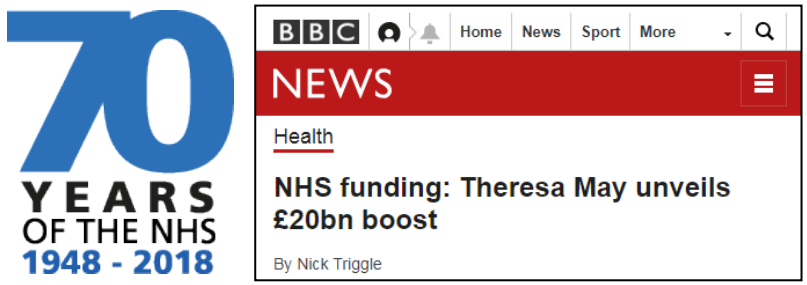
EASI World Cup
held in Barnsley (European Association for Sport and Social Integration)

With **all of us** in mind.

What's happening externally

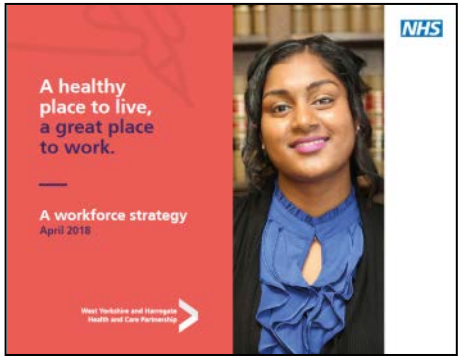
National and local news

Health and Social Care Committee publish report on integrated care



Funding announced averaging 3.4% a year over 5 years, in exchange for a 10 year plan

Visa rules relaxed to help address NHS workforce pressures



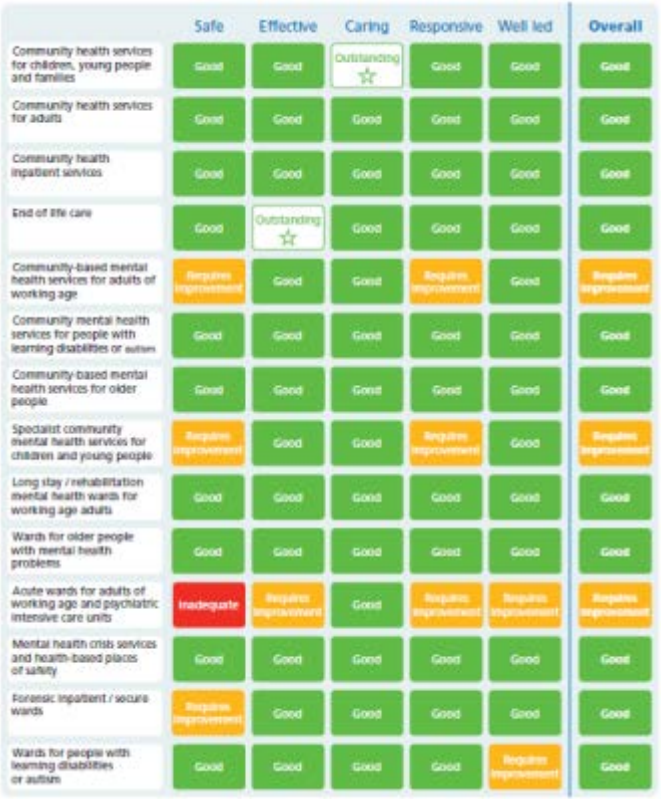
Workforce plan for West Yorkshire and Harrogate published

With **all of us** in mind.

What's happening internally

Focus on: CQC findings

- We welcomed the CQC's independent view – our report is being published on Tues 3 July
- They highlighted areas of strength and improvement, as well as areas of real challenge
- 11 of 14 core services are rated **Good** – and all rated **Good** for being caring
- More than 85% of individual domains rated **Good** or **Outstanding** (60 out of 70)
- Overall, we're rated **Good** for well-led, caring and effective domains, and **Requires Improvement** for safe and responsive domains
- This means that we have been rated **Requires Improvement** as a Trust
- We're addressing safety issues first and foremost and responding in line with our values



	Safe	Effective	Caring	Responsive	Well led	Overall
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Good	Good
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Outstanding ☆	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Long stay / rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

With **all of us** in mind.

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What's happening internally

Safety and quality

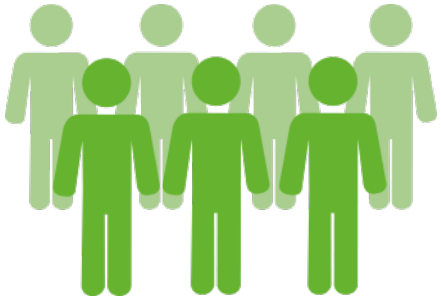
Trust Board recently discussed our 2017/18 **incident management annual report**, which showed:

- 12,303 incidents reported on Datix – a 6.3% decrease in reporting compared to 2016/17
- 89% of incidents resulted in **low or no harm** – indicative of a positive safety culture
- 71 serious incidents (0.58% of all incidents)
- 43 apparent suicides – up from 27 in 2016/17
- No never events

In May, we had:

- 1,062 incidents - 936 rated **green** (no/low harm)
- 3 Serious Incidents – all apparent suicides

Please make sure you report incidents on Datix



Safer staffing

We know our wards are seeing increased acuity and demand. We're reviewing our safer staffing approach to see what else we can do to help ease pressures.

With **all of us** in mind.

NHS
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NHS Foundation Trust

What's happening internally

Performance (May)

- **100%** of people recommend our community services
- **75%** recommend our mental health services – significantly lower in CAMHS
- **37%** of people in CAMHS receiving treatment within 18 weeks of referral
- **99%** follow ups within 7 days of discharge
- **89%** of people dying in their place of choice
- **11** confidentiality breaches
- **310** inappropriate out of area bed days
- **61%** of prone restraint lasted ≤3mins

With **all of us** in mind.

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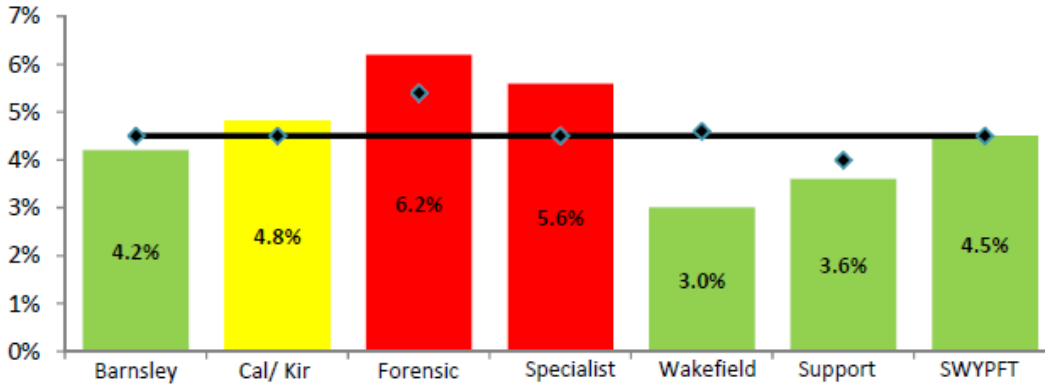
What's happening internally

Staffing

- Share your views in our wellbeing survey – it'll be sent by Robertson Cooper on 3 July
- By 30 June, all bands 6 and above should have had an appraisal – please record it on the intranet. Staff in bands 5 and below have until the end of Sept to have theirs.
- Thanks for all your work to reduce sickness absence – it was 4.4% in May and 4.5% so far this year to date, in line with our target



Get your holidays booked

Book all your annual leave in plenty of time – it's important for your health and wellbeing.

As per our leave policy, you wont be able to carry it over to next year unless there are exceptional circumstances, such as for clinical staff where there would be a significant impact on the safety of the service.

With **all of us** in mind.

What's happening internally

Month 2 finances (May)

- We had a £0.2m deficit in May (£0.5m so far this year) – this is slightly better than planned, but our run rate is worse than our full year target
- We spent £0.5m on agency in May, which is 8% above our monthly cap agreed by NHS Improvement – we've spent £1m so far this year
- We generated £0.6m in cost improvements so far this year - we need to save £9.7m in total this year, £1m of which is still to be identified

We're planning for a £2.6m deficit at the end of 2018/19 – largely due to cost pressures and loss of income

With **all of us** in mind.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

What's happening internally

Infrastructure

SystmOne for mental health is coming in Jan 2019 – sign up for training now

All staff need to complete **two modules**:

- 'SystmOne: Getting Started'
- Plus one option from: 'SystmOne: Admin', 'SystmOne: Community', 'SystmOne: Inpatient'

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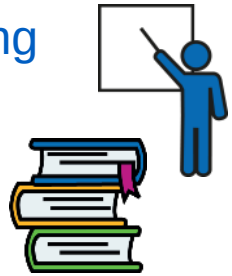


Find out more and get signed up on the SystmOne intranet page

With **all of us** in mind.

What's happening internally

Service change

- We won the recent tender to continue providing Barnsley IAPT services – we'll be working towards implementing the new model by August.
- Commissioners have agreed to provide more funding for our Kirklees IAPT service – approx £600k in 2018/19. The funding will help address current pressures and target those with long term conditions.
- Barnsley CCG is reviewing the Rapid Access Clinic we run – they're carrying out a 6 week engagement exercise to inform their future plans.

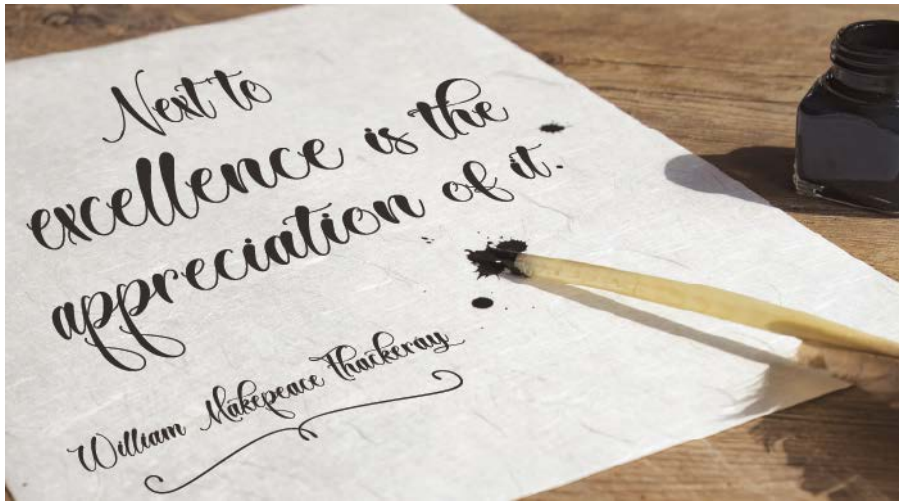
Beyond Places of Safety grant

We've received a share of £135,000 to improve the environment of our Section 136 suite at The Dales in Calderdale. We'll be able to make it less clinical so that people feel more relaxed and comfortable.

With **all of us** in mind.

What's happening internally

Quality improvement and innovation



Celebrate your team or colleagues by nominating them for an Excellence award

Closing date is 20 August – more info on intranet

We're working with Huddersfield University to pioneer the use of artificial intelligence in predicting suicide

Congrats to Evelyn Beckley, winner of a Windrush 70 award

And to Debs Taylor, named 5th in the UK's health and care top 70 stars

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We welcome the CQC's view of our services and will continue to improve and aim to be outstanding

We need to keep focused on our hotspots – including those highlighted by the CQC

We take safety seriously and all incidents are reviewed – continue logging them on Datix

In this tough climate, our financial challenge remains - we need to spend every penny wisely

Our new clinical system for mental health launches in Jan – you have a range of training options available

Your wellbeing matters to #allofus - complete the wellbeing survey and book your annual leave

Recognise and celebrate achievements – submit an Excellence nomination

With **all of us** in mind.

28 June 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

- The Health Committee undertook an inquiry into Sustainability and Transformation Partnerships (STPs), Accountable Care Systems (ACSs) and Accountable Care Organisations (ACOs), and published a report.
- Immigration rules capping the number of foreign doctors and nurses working in the UK are set to be relaxed to allow the NHS to recruit more staff, Downing Street has confirmed.
- The NHS in England is to get an extra £20bn a year by 2023, Theresa May says. It means the £114bn budget will rise by an average of 3.4% annually.
- The West Yorkshire and Harrogate Health and Care Partnership published a workforce plan which sets out how they will support staff, carers and volunteers to move towards a better future.

What's happening internally?

Focus on: CQC inspection

We welcomed the CQC's independent view following their inspection in March/April – our report is published on Tuesday 3 July.

They highlighted areas of strength and improvement, as well as areas of real challenge. 11 of our 14 core services are rated Good – and all of them are rated Good for being caring. We're proud that more than 85% of individual domains were rated Good or Outstanding (60 out of 70).

Overall, we're rated Good for well-led, caring and effective domains, and Requires Improvement for safe and responsive domains. This means that we have been rated Requires Improvement as a Trust.

We're addressing safety issues first and foremost and responding in line with our values. We are disappointed that our overall rating has gone down and we must be careful not to lose sight of all the positive comments and good practice identified in the report. We remain grateful for the continuing effort and hard work of all our staff right across the organisation.

28 June 2018

South West Yorkshire Partnership NHS Foundation Trust

Safety and quality

Trust Board recently discussed our 2017/18 **incident management annual report**, which showed:

- 12,303 incidents reported on Datix – a 6.3% decrease in reporting compared to 2016/17
- 89% of incidents resulted in **low or no harm** – indicative of a positive safety culture
- 71 serious incidents (0.58% of all incidents)
- 43 apparent suicides – up from 27 in 2016/17
- No never events

In May, we had:

- 1,062 incidents - 936 rated **green** (no/low harm)
- 3 serious incidents – all apparent suicides

A high number of reported incidents indicates that we have a strong reporting culture. Please make sure you report all incidents on Datix.

Safer staffing

We know our wards are seeing increased acuity and demand. We're reviewing our safer staffing approach to see what else we can do to help ease pressures.

Performance (May)

- **100%** of people recommend our community services
- **75%** recommend our mental health services – significantly lower in CAMHS
- **37%** of people in CAMHS receiving treatment within 18 weeks of referral
- **99%** follow ups within 7 days of discharge
- **89%** of people dying in their place of choice
- **11** confidentiality breaches
- **310** inappropriate out of area bed days
- **61%** of prone restraint lasted ≤3mins

Staffing

- Share your views in our wellbeing survey – you'll get an email from Robertson cooper with a link to fill it in. Your responses are completely confidential and help us make real changes. Your wellbeing matters to all of us.
- By 30 June, all bands 6 and above should have had an appraisal – please record it on the intranet. Staff in bands 5 and below have until the end of September to have theirs.
- Thanks for all your work to reduce sickness absence – it was 4.4% in May and 4.5% so far this year to date, in line with our target.

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South West Yorkshire Partnership NHS Foundation Trust

Get your holidays booked
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-

There are **two ways** to complete your training:

- Sign up to attend classroom training and pass the competency check
- Study the online training materials and pass the competency check

Speak to your manager before booking training. Find out more and book on the intranet.

Service change

- We won the recent tender to continue providing Barnsley IAPT services – we'll be working towards implementing the new model by August.
- Commissioners have agreed to provide more funding for our Kirklees IAPT service – approximately £600k in 2018/19. The funding will help address current pressures and target those with long term conditions.
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Quality improvement and innovation

Celebrate your team or colleagues by nominating them for an Excellence award. The closing date is 20 August. There'll be more information on the intranet.

We're working with Huddersfield University to pioneer the use of artificial intelligence in predicting suicide.

Congratulations to Evelyn Beckley, who was the winner in the Operational Service Excellence category at the NHS70 Windrush awards, which celebrated the contributions of black and minority ethnic (BME) staff to the NHS.

Well done also to Debs Taylor, who was ranked 5th in a list of the UK's top 70 health and care stars.

Take home messages

1. We welcome the CQC's view of our services and will continue to improve and aim to be outstanding
2. We need to keep focused on our hotspots – including those highlighted by the CQC
3. We take safety seriously and all incidents are reviewed – continue logging them on Datix
4. In this tough climate, our financial challenge remains - we need to spend every penny wisely
5. Our new clinical system for mental health launches in January – you have a range of training options available
6. Your wellbeing matters to #allofus - complete the wellbeing survey and book your annual leave
7. Recognise and celebrate achievements – submit an Excellence nomination

NHS
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NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 6.1

Title:	**Care Quality Commission (CQC) inspection report**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To provide an update to Trust Board in relation to the outcome of the Care Quality Commission 2018 inspection.
Mission/values:	All areas of the CQC revisit and report are aimed at identifying how we provide a safe and effective service, reflect areas that we need to improve upon and celebrate our successes. All of the key lines of enquiry are in line with our mission and values.
Any background papers/ previously considered by:	Various CQC update reports have been provided to both Trust Board and the Clinical Governance & Clinical Safety Committee.
Executive summary:	The Trust was subject to a well-led inspection by the Care Quality Commission (CQC) in March & April 2018. As a learning organisation, the Trust's values are at the heart of everything it does, and the CQC visit and independent view of services was welcomed. Draft reports were provided to the Trust for factual accuracy checking which was undertaken by corporate support and operational teams. The Trust was not required to take any immediate actions during or following inspection. The Trust has received its final reports, which consist of six core service reports and one overall quality report, which were published by the CQC early July 2018. Key findings from the reports highlight our areas of strength and improvement, e.g. ➢ The improvements seen in our community learning disability services. ➢ That staff felt supported, valued and were proud of the work they did. ➢ Our open culture with good reporting of incidents, thorough investigations and learning when things go wrong. ➢ Our clear vision, values and strategy that are person-centred and focused on sustainability. ➢ The good learning from deaths processes in place, with learning events following all death investigations. ➢ Our strong relationships with partners, investing in relationships to ensure sustainable care. ➢ Our strong, approachable and visible leadership. ➢ Our established and experienced Board.

With all of us in mind.

	The CQC have also provided a fair representation of the areas where we're facing significant challenges: ➢ Our services are under pressure, in particular our acute and community mental health services and our child and adolescent mental health services (CAMHS) ➢ We still have long waits in some of our services ➢ We need to improve how we measure service user and carer experience ➢ We need to address specific issues, such as: • Our approach to nurse call systems across our inpatient areas • On-call arrangements in CAMHS • Restrictive practices • Our pharmacy strategy The overall rating for the Trust is requires improvement, with 11 of our 14 core services are rated Good, and all services rated Good or Outstanding for being caring The SAFE domain is the area where we have seen most change and where immediate attention has been focussed. Services have taken immediate actions in areas of high risk and action plans are in development. **Next steps** ➢ Maintain momentum on immediate actions against the regulatory breaches. Submission of action plan against regulatory breaches to CQC – 30 July 2018 ➢ Develop an overarching action plan (Quality Improvement &Assurance Team / Business Delivery Unit's/ support services), as an internal working document to include all CQC actions (regulatory breaches, must do's and should do's) for Operational Management Group/ Executive Management Team sign off. ➢ Integrate CQC improvement actions into Trust work streams / agree new work streams where required ➢ Instigate formal monitoring of action plans in BDU's and in corporate teams as described in the CQC action plan governance framework ➢ Agree formal reports and frequency of these to Trust Board and relevant committees.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the report,** ➢ **SUPPORT the approach described in the CQC action plan governance framework; and** ➢ **CONSIDER the next steps required.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

SWYPFT CQC inspection 2018

Summary, actions & next steps

1. Summary

The Trust was inspected by the Care Quality Commission (CQC) throughout March and April 2018. Six core services were inspected in March and a well led inspection was carried out from 9th – 11th April 2018. At the time of the inspection each core service received informal feedback at the end of their specific visit, and the Trust was not required to take any immediate actions. As a learning organisation, the Trust's values are at the heart of everything it does, the CQC visit and its independent view of services was welcomed.

The Trust received the draft reports in May 2018. There was a 10 day period for factual accuracy checking. We received an Evidence document (293 pages), which detailed the information the CQC has considered and the findings from the inspection, and a Quality Report which summarised the findings and ratings. The reports are in a different format from those received previously.

2. Factual accuracy process

The draft reports were checked for factual accuracy by senior members of operational and corporate support services. We focussed on the areas where we felt the CQC had not considered all the information we provided, had misinterpreted the data we submitted or misunderstood what had been told to them. We prioritised the SAFE domain for action, as we had strong evidence in a number of core services, that we were performing better in April 2018, than we were in Jan 2017 but this was not reflected in the report. We submitted a significant amount of evidence to challenge the mental health acute wards and psychiatric intensive care unit (PICU), child & adolescent mental health services (CAMHS) and community mental health teams inspection findings.

The factual accuracy reports were submitted within the required timeframe (by 11th June) and a scheduled engagement meeting was held with the SWYPFT inspection manager, on 13th June, who confirmed that they would reconsider the evidence submitted. It was also noted that there would need to be further Management Review Meetings for the three core services, noted above, to consider our evidence.

A letter detailing the areas the Trust requested that the CQC reconsider was discussed with the Inspection Manager, by the Director of Nursing & Quality.

3. Outcome of factual accuracy check

Feedback from the factual accuracy check was received on 26th June and the reports published on 3rd July. From the factual accuracy check the total number of 'must do' actions was reduced from 22 to 18 and 'should do' actions reduced by 1, leaving a total of 47. However the number of regulatory breaches remained at 5. The regulation areas where breaches occurred are:

Regulation 9:	person centred care	(x 2 breaches)
Regulation 12:	safe care & treatment	(x 8 breaches)
Regulation 15:	premises and equipment	(x 2 breaches)
Regulation 17:	good governance	(x 5 breaches)
Regulation 18:	staffing	(x 1 breaches)

4. Key findings from the report

Their findings highlight our areas of strength and improvement, e.g.

- The improvements seen in our community learning disability services
- That staff felt supported, valued and were proud of the work they did
- Our open culture with good reporting of incidents, thorough investigations and learning when things go wrong
- Our clear vision, values and strategy that are person-centred and focused on sustainability
- The good learning from deaths processes in place, with learning events following all death investigations
- Our strong relationships with partners, investing in relationships to ensure sustainable care
- Our strong, approachable and visible leadership
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The CQC have also provided a fair representation of the areas where we're facing significant challenges:

- Our services are under pressure, in particular our acute and community mental health services and our child and adolescent mental health services (CAMHS)
- We still have long waits in some of our services
- We need to improve how we measure service user and carer experience
- We need to address specific issues, such as:
- Our approach to nurse call systems across our inpatient areas
- On-call arrangements in CAMHS
- Restrictive practices
- Our pharmacy strategy

5. The overall ratings

The overall rating for the Trust is requires improvement, with 11 of our 14 core services are rated Good, and all services rated Good or Outstanding for being caring 60 out of 70 domains (85%) are rated as good or outstanding:

- Our community services for people with a learning disability or autism have improved and are now rated Good
- Our acute mental health / psychiatric intensive care wards remain Requires Improvement
- Two core services have been re-rated as Requires Improvement:
    - Community mental health services for adults
    - CAMHS

The SAFE domain is the area where we have seen most change and where immediate attention has been focussed.

6. Actions

Under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must send the CQC a written report of the actions we are going to take to meet the Health and Social Care Act 2008, associated regulations and any other legislation they have identified where we have a breach. A standard template has been provided to the Trust for completion. The Trusts intended actions against the regulatory breaches must be submitted to the CQC by 30th July and this is on target for submission.

Operational teams commenced taking action against feedback they received from the CQC, directly following the visits. They have responded to the formal reports by reviewing their actions and updating action plans. All action plans will be monitored via the Clinical Governance Group and reported in the Board Integrated Performance Report (IPR) and to Clinical Governance & Clinical Safety Committee in line with our CQC action plan governance framework (appendix 1).

6.1. Immediate actions taken in response to formal CQC report for services:

6.1.1. Trustwide:

A **restrictive practice** group**,** which will report to the Mental Health Act Committee**,** is being established. Terms of reference are being developed and the group will commence in September 2018

Nurse call system: a working group has been established. Estates are preparing information of nurse call systems for clinical services to review.

6.1.2. CAMHS:

A review of out of hour's arrangements has commenced.

6.1.3. Acute wards:

A comprehensive trust wide response is being prepared in response to all must do actions

Reiterated expectations in adherence to policy and standards to staff with regards to seclusion, rapid tranquilisation, risk assessments and medicines management whilst formal processes for review are established

Review of section 17 leave policy and practice is in progress

Environmental issues have been addressed, for example, sign for Oxygen cylinder on Ashdale has been ordered, a mirror has been fitted in the seclusion room on Ward 18 and additional levels of assurance have been implemented at ward level to ensure clinic room checks are completed as required

An immediate formal review was undertaken, by specialist advisors, on staff practice with regards to seclusion. This review concluded that based on the evidence reviewed, staff did practice in line with our seclusion policy. The findings will be discussed with the CQC to seek further clarification during our engagement meetings.

Administrative processes have been reviewed to ensure accurate filing of mental health act paperwork

Staffing pressures are being responded to in a number of ways, i.e. recruitment of staff to work annualised hours

Review of child visiting arrangements on Stanley ward by specialist advisor for safeguarding which has led to a local work instruction being implemented.

6.1.4. Community based mental health services for adults of working age

Reiterated expectations in adherence to policy and standards to staff with regards to risk assessments Action plan is in place to ensure risk assessments have been completed and a monitoring system is being established.

Temporary signs re access to a disabled toilet have been put up and sign ordered.

6.1.5. Wards for people with learning disability or autism

A risk assessment tool has been devised and implemented to address blanket restrictions
A number of actions have been agreed to ensure the team seek feedback, including service user forums post discharge questionnaires, parent/carer forum to be established and a carer's welcome pack to be devised with relevant contact details.

7. Next steps

- Continue to take immediate action against the regulatory breaches. Priority for action is the acute wards and PICU where care is deemed by the CQC as not safe. Implement the plans for 'should do' actions
- Submission of action against regulatory breaches to CQC – 30th July 2018
- Develop an overarching action plan (Quality Improvement &Assurance Team / Business Delivery Unit's/ support services), as an internal working document to include all CQC actions (regulatory breaches, must do's and should do's) for Operational Management Group/ Executive Management Team sign off.
- Integrate CQC improvement actions into Trust work streams / agree new work streams where required
- Instigate formal monitoring of action plans in BDU's and in corporate teams as outlined in Appendix 1.
- Agree formal reports and frequency of these to Trust Board and relevant committees.

South West Yorkshire Partnership NHS Foundation Trust

CQC Action Plan Governance Framework

Revised July 2018

CQC Action Plan Governance Framework

The following framework ensures we have robust measures in place to respond and address the CQC requirement notices, 'must do's' and 'should do's' as identified at our recent inspection visit and ultimately to improve the service we deliver in relation to SAFE, EFFECTIVE, CARING, RESPONSIVE & WELL LED domains.

Our internal action plan includes;

- Regulatory breaches," must do" actions & "Should do" actions
- Action services will take to improve the issue
- Completion date
- Identified Lead
- Progress report
- RAG rating of progress against the given timescale (completion date)

Key responsibilities

Business delivery unit

BDU is responsible for the delivery and local monitoring of their action plan.

The teams are **r**esponsible for implementing the actions and escalating any issues, within the BDU, which may impact on actions being met.

The Trios (General Manager, Clinical lead & Quality Governance Lead) will be responsible for ensuring that the evidence threshold is met before sign off and for escalating, to Deputy District Director & BDU governance group, where action is behind schedule.

BDU Governance group – role is to oversee and monitor the progress of the actions on the plan. This group will escalate any issues of concern to the Clinical Governance Group. (see early alert system below).

Deputy District Directors are responsible and accountable for the delivery of the actions and escalation of any issues to the Clinical Governance Group.

Key governance groups

These are the support groups that will provide specialist advice to assist BDU's to deliver their actions. These groups will have an oversight and monitoring function of specific Trust wide actions. Each key governance group (and BDU) will be given a list of the actions from the plan that they are expected to oversee. This group will need to maintain links with BDU governance groups, Deputy District Directors and Clinical Governance Group.

Clinical Governance Group

This group will be responsible for the overview and monitoring of the Trust wide action plan. This will include, evaluation of the evidence submitted to provide assurance that the expected outcomes are being met. A check and challenge approach will be adopted. This group is responsible for providing assurance that the action plan is being delivered and escalating any concerns to EMT and Clinical Governance and Clinical Safety Committee.

The Nursing, Quality & Professions Directorate

This team is responsible for the provision of advice and guidance around compliance and evidence required. The directorate will support any cross system learning and provide a Trust wide evaluation of progress and achievements.

Executive Management Team (EMT)

EMT will review CQC action plan progress as part of the performance reporting cycle on a monthly basis.

Clinical Governance & Clinical Safety Committee (CGCSC)

CGCSC is responsible for receiving updates on the progress of the action plans and providing assurance to Trust Board that the delivery of the actions is meeting standards of quality and safety. CGCSC are responsible for escalating any concerns to Trust Board.

Trust Board

The Trust Board is responsible for making sure the plan is being delivered to the expected standards in line with our strategic objectives, and providing assurance to our stakeholders and the public.

Process

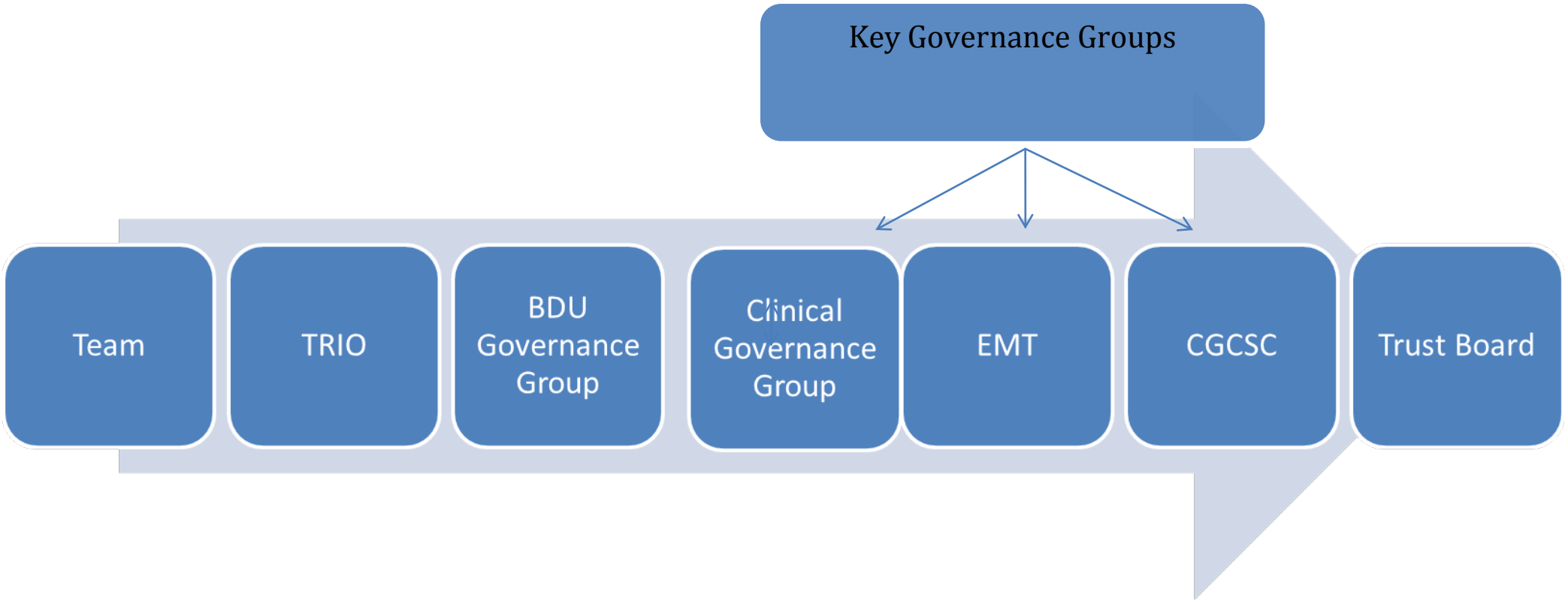
The following mechanisms will be put into place in each BDU to monitor the progress of the action plans:

- For each core service there is a service specific action plan
- The TRIO's will oversee their action plan at team and service level and report into the BDU Governance Group.
- The respective BDU Governance Groups will monitor their action plans through each of their BDU meetings as a standing agenda item on a monthly basis.
- Each BDU will be asked to provide an assurance report (using an agreed template) that highlights progress and achievements in implementing the action plan to the monthly Clinical Governance Group.
- Key governance groups (Committee's, TAGs and other identified groups) will support BDU Governance Groups to deliver their action plan.
- The Clinical Governance Group will review progress and achievements, RAG rate level of assurance and escalate any concerns to EMT & CGCSC.
- A progress report about the implementation of the CQC action plan will be provided by the Quality Improvement and Assurance Team to EMT, Clinical Governance and Clinical Safety Committee and the Trust Board on a monthly basis.
- Strategic Governance System – action plan outcomes will be evaluated through our existing quality monitoring processes, e.g. clinical audit programme, internal mock inspection visits, external CQC visits, CQC MHA visits and risk reporting and management system.

Early alert system

Deputy District Directors/ District Directors are asked to escalate any issues of concern to the Quality Improvement & Assurance Team ***at the earliest opportunity***, in the event of them not being able to progress actions or meet given timescales.

Structure



Corporate support

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 6.2

Title:	**Board Assurance Framework (BAF) 2018/19**
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. Changes to format and strategic risks for 2018/19 supported the Executive Management Team on 5 July 2018 and Audit Committee on 10 July 2018.
Executive summary:	**Board Assurance Framework** The Board Assurance Framework (BAF) 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 BAF for 2018/19, 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: ➢ key controls and/or systems the Trust has in place to support the delivery of the objectives. ➢ assurance on controls (where the Trust Board will obtain assurance). ➢ 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. ➢ gaps in control (if the assurance is found not to be effective or in place). ➢ 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. A schematic of the BAF process is set out as an attachment. The BAF is used by the Trust Board in the formulation of the Trust 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.

With all of us in mind.

In line with the Corporate/Organisational Risk Register (ORR), the BAF has been aligned to the Trust's strategic objectives:

Improving health	Improving care	Improving resources
a priority for joining up care	a priority for safety first, quality counts	a priority for operational excellence

Changes to the BAF in 2018/19

Consideration has been given to the format of the BAF following some feedback provided by the Care Quality Commission (CQC) and discussion at Trust Board. To provide greater clarity, there is now a separate section for each strategic risk such that it is clear which controls and assurance align to which strategic risk.

The strategic risks continue to be aligned to each strategic objective and in the majority of cases those identified and used in 2017/18 remain relevant for 2018/19. There are two exceptions to this above. It was recommended by EMT and supported by the Audit Committee that the previous strategic risk 1.2 (Trust plans for service transformation are not aligned to a multiplicity of stakeholder requirements) was no longer as significant a risk given the fact that many of the transition programmes are complete or underway. Similarly much work had been carried out on the previous strategic risk 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).

Considering the current operating environment, two new strategic risks were identified by EMT and supported by the Audit Committee for inclusion in the BAF for 2018/19:

- Strategic risk 1.2 - Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans.
- Strategic risk 2.4 - Increased demand for and acuity of service users leads to a negative impact on quality of care.

EMT have reviewed and aligned the controls and assurance for each strategic risk and indicated an overall current assurance level of 'yellow'. The rationale and the individual risk RAG ratings are set out in the attached report.

Overview of current assurance level:

Strategic objective	Strategic risk (abbreviated)	Assurance level Q4 17/18	Assurance level Q1 18/19
Improving health - a priority for joining up care	1.1 Differences in published local priorities could lead to service inequalities across the footprint	**A**	**Y**
	1.2 Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans	**N / A**	**Y**

		1.3 Differences in the services may result in inequitable services offers across the Trust	**Y**	**Y**
	Improving care - a priority for safety first, quality counts	2.1 Lack of suitable and robust information systems leading to lack of high quality management and clinical information	**Y**	**Y**
		2.2 Inability to recruit and retain skilled workforce leading to poor service user experience	**Y**	**Y**
		2.3 Failure to create learning environment leading to repeat incidents	**Y**	**Y**
		2.4 Increased demand for and acuity of service users leads to a negative impact on quality of care	**N / A**	**Y**
	Improving resources - a priority for operational excellence	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to deliver capital programme	**A**	**A**
		3.2 Failure to develop commissioner relationships to develop services	**A**	**Y**
		3.3 Failure to deliver efficiency improvements / CIPs	**A**	**A**
		3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	**Y**	**G**
Recommendation:	**Trust Board is asked to:** ➢ **COMMENT on the slightly revised format of the BAF for 2018/19;** ➢ **AGREE the changes recommended by EMT and supported by the Audit Committee to strategic risks 1.2 and 2.4 for 2018/19;** ➢ **NOTE and the controls and assurances against the Trust's strategic objectives for Q1 2018/19; and** ➢ **AGREE to an ongoing target for addressing gaps in control given the nature of the gaps and risks identified.**			
Private session:	Not applicable.			

BOARD 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

Board Assurance Framework (BAF) 2018/19

Key:
Lead Directors: CEO=Chief Executive Officer, DFR=Director of Finance and Resources, DHR=Director of HR, OD and Estates, DNQ=Director of Nursing and Quality, MD=Medical Director, DS=Director of Strategy, DD= Director of Delivery, BDU=Business Delivery Unit Directors

Key Committees: AC=Audit Committee, EMT=Executive Management Team, CGCS=Clinical Governance & Clinical Safety Committee, MHA=Mental Health Act Committee, WRC=Workforce & Remuneration Committee. OMG= Operational Management Group. MC=Members Council, ORR=Organisational Risk Register.

RAG ratings:

G	=On target to deliver within agreed timescales
Y	=On trajectory but concerns on ability / confidence to deliver actions within agreed timescales
A	=Off trajectory and concerns on ability / capacity to deliver actions within agreed timescales
R	=Actions will not be delivered within agreed timescales
B	=Action complete

Overview of current assurance level:

The rationale and the individual risk RAG ratings are set out in the following pages.

Strategic objective	Strategic risk	Page Ref	Assurance levels				
			2017/18	2018/19			
			Q4	Q1	Q2	Q3	Q4
Improving health - a priority for joining up care	1.1 Differences in published local priorities could lead to service inequalities across the footprint	4	**A**	**Y**			
	1.2 Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans	7	**N / A**	**Y**			
	1.3 Differences in the services may result in inequitable services offers across the Trust	10	**Y**	**Y**			
Improving care - a priority for safety first, quality counts	2.1 Lack of suitable and robust information systems leading to lack of high quality management and clinical information	13	**Y**	**Y**			
	2.2 Inability to recruit and retain skilled workforce leading to poor service user experience	15	**Y**	**Y**			
	2.3 Failure to create learning environment leading to repeat incidents	17	**Y**	**Y**			
	2.4 Increased demand for and acuity of service users leads to a negative impact on quality of care	19	**N / A**	**Y**			
Improving resources - a priority for operational excellence	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to deliver capital programme	21	**A**	**A**			
	3.2 Failure to develop commissioner relationships to develop services	25	**A**	**Y**			
	3.3 Failure to deliver efficiency improvements / CIPs	27	**A**	**A**			
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	28	**Y**	**G**			

Strategic Objective:	Lead Director(s)	Key Board or Committee	Overall Assurance Level			
1. Improving health - a priority for joining up care	As noted below	EMT, CGCS, MHA	Q1	Q2	Q3	Q4
			Y			

Strategic Risks - that need to be controlled and consequence of non-controlling and current assessment

Ref	Description	RAG Rating
1.1	**Differences in published local priorities could lead to service inequalities across the footprint.**	Y
1.2	**Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans**	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

Rationale for current assurance level (Strategic Objective 1)

- Effective and involved members of the Board.
- Health & Wellbeing Board place based plans – contributed to through board discussions and commented on.
- Active and full membership of Health & Wellbeing Boards
- 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.
- Trust involved in development of place based plans and priority setting
- Involved in development of Integrated Care Partnerships in Barnsley, Calderdale, Kirklees and 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 requires improvement, number of areas rated good or outstanding, action plan to address recommended improvements.
- Integrated Performance Report (IPR) summary metrics re improving people's health and reduce inequalities – IPR Month 2 out of area beds – red, Improving Access to Psychological Therapies (IAPT) – green, % service users followed up within 7 days green (M3), 0 children/young people accommodated on an Inpatient ward
- 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: Risk Management, Data Quality, Mental Health Act governance significant assurance

Strategic Risk 1.1
Differences in published local priorities could lead to service inequalities across the footprint.

Controls (Strategic Risk 1.1)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval	C01	DNQ	1.1
Cross-BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas	C02	DD	1.1
Senior representation on West Yorkshire mental health collaborative and associated workstreams	C03	DS	1.1
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	C04	DS	1.1, 1.2
Annual Business planning process, ensuring consistency of approach, standardised process for producing businesses cases with full benefits realisation	C05	DFR	1.1, 1.2, 3.1
Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board	C06	DFR	1.1, 1.2
Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT	C07	BDU	1.1, 1.3
Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services	C08	DFR	1.1, 3.2
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.	C09	DD	1.1, 3.3

Gaps in control - 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	Ongoing
Impact on services as a result of local authority cuts – actions identified on the Organisational Risk Register	Ongoing
Impact of local place based solutions and ICS initiatives – recognition that some of this is out of our control and ensure engagement takes place in each area impacted	Ongoing

Assurance (Strategic Risk 1.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Care Quality Commission (CQC) registration in place and assurance provided that Trust complies with its registration	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.	A03	DNQ	1.1
Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives	Quarterly Board strategic meetings.	A04	CEO	1.1
Independent PLACE audits undertaken and results and actions to be taken	Service users and Directors involved in assessments.	A05	DHR	1.1, 1,2, 1.3

Assurance (Strategic Risk 1.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
reported to Executive Management Team (EMT), Members' Council and Trust Board				
Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities	Clinical audit and practice effectiveness (CAPE) annual plan CG&CS Committee April 2017.	A06	DNQ	1.1, 1.2, 1.3
Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT).	A07	DS	1.1, 1.2, 1.3, 2.1, 3.4
Service user survey results reported annually to Trust Board and action plans produced as applicable	NHS Mental Health Service User Survey Results will be report to Trust Board when available.	A08	DNQ	1.1, 1.2, 1.3, 2.3, 2.4
Transformation change and priority programme 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	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.	A09	EMT	1.1, 1.2, 1.3, 2.4, 3.4
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	Contracting risks, bids & tenders update standing item on delivery EMT agenda. Report to Board bi-annually.	A10	BDU	1.1, 1.2, 2.1, 3.1
Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Objectives for 2018/19 set for all Directors. Monthly one to one meetings between Chief Executive and Directors.	A11	CEO	1.1, 1.2, 2.1, 3.1, 3.2, 3.3, 3.4
Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board , CG&CS and MC	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	A12	DNQ	1.1, 1.2, 2.4
Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement	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.	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan	Audit Committee and Trust Board – April 2018.	A14	DFR	1.1, 1.3, 2.4
Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	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 2018, monthly engagement with stakeholders (the Focus), various SU & carer engagement events across the year plus Annual Members' Meeting September 2018. Engagement through Members	A15	DHR, DS	1.1, 1.3, 2.4

Assurance (Strategic Risk 1.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
	Council. Stakeholder engagement through involvement in NMoC in each place.			

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Internal audit reports with partial assurance (see below) management actions agreed by lead Director.	As per audit report
Assessment of commissioning intentions.	Dec 18
Assessment of place based plans in each ICS.	Dec 18

Strategic Risk 1.2
Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans

Controls (Strategic Risk 1.2)			
Systems and processes - what are we currently doing about the Strategic Risks?	**Control Ref**	**Director lead**	**Strategic risk/s**
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	C04	DS	1.1, 1.2
Annual Business planning process, ensuring consistency of approach, standardised process for producing businesses cases with full benefits realisation	C05	DFR	1.1, 1.2, 3.1
Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board	C06	DFR	1.1, 1.2
Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon	C10	DNQ	1.2
Governors engagement and involvement on Members' Council and on working groups, holding Non-Executive Directors (NEDs) to account	C11	DFR	1.2
Partnership Fora established with staff side organisations to facilitate necessary change	C12	DHR	1.2
Introduction of a Trustwide operational Director role to enhance Trustwide approach to delivery	C13	DD	1.2
Priority programmes supported through robust programme management approach	C14	DS	1.2
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	C15	DS	1.2, 1.3
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	C16	DNQ	1.2, 2.2

Gaps in control - what do we need to do to address these and by when?	**Date**
Implementation plan for Trustwide operational management arrangements.	Oct 18

Assurance (Strategic Risk 1.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Independent PLACE audits undertaken and results and actions to be taken reported to Executive Management Team (EMT), Members' Council and Trust Board	Service users and Directors involved in assessments.	A05	DHR	1.1, 1,2, 1.3
Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities	Clinical audit and practice effectiveness (CAPE) annual plan CG&CS Committee April 2017.	A06	DNQ	1.1, 1.2, 1.3
Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT).	A07	DS	1.1, 1.2, 1.3, 2.1, 3.4
Service user survey results reported	NHS Mental Health Service User Survey	A08	DNQ	1.1, 1.2,

Assurance (Strategic Risk 1.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
annually to Trust Board and action plans produced as applicable	Results will be report to Trust Board when available.			1.3, 2.3, 2.4
Transformation change and priority programme 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	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.	A09	EMT	1.1, 1.2, 1.3, 2.4, 3.4
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	Contracting risks, bids & tenders update standing item on delivery EMT agenda. Report to Board bi-annually.	A10	BDU	1.1, 1.2, 2.1, 3.1
Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Objectives for 2018/19 set for all Directors. Monthly one to one meetings between Chief Executive and Directors.	A11	CEO	1.1, 1.2, 2.1, 3.1, 3.2, 3.3, 3.4
Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board , CG&CS and MC	Unannounced and planned visits programme in place – regular report to CG&CS Committee and included in annual report to Board and Members Council. Visit plan in place for 18/19	A12	DNQ	1.1, 1.2, 2.4
Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement	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.	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
Monitoring of organisational development plan through Executive Management Team (EMT), deviations identified and remedial plans requested	Update reports into EMT	A16	DHR	1.2
Update reports on WY and SY ICS progress	Routine report into EMT and Board	A17	DS	1.2
Reports from Transforming Care Board and Calderdale, Kirklees and Wakefield Partnership Board	Update reports into EMT	A18	DFR	1.2, 1.3
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	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to EMT, Clinical Governance & Clinical Safety Committee and Trust Board.	A19	DNQ	1.2, 2.3, 2.4
Benchmarking of services and action plans in place to address variation	Benchmarking reports are received by Executive Management Team (EMT) and any action required identified.	A20	DFR	1.2, 3.1, 3.2, 3.3
Quarterly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity	Monthly bids and tenders report to Executive Management Team (EMT).	A21	DFR	1.2, 3.1, 3.2, 3.3
CQUIN performance monitored through Operational Management Group (OMG) and Executive Management Team (EMT), deviations identified and remedial plans requested	Monthly Integrated Performance reporting (IPR) to OMG, EMT and Trust Board.	A22	DD	1.2, 3.1, 3.3

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 Risks 1.3
Differences in the services provided due to unnecessary internal variation in practice, may result in inequitable service offers across the whole Trust.

Controls (Strategic Risk 1.3)			
Systems and processes - what are we currently doing about the Strategic Risks?	**Control Ref**	**Director lead**	**Strategic risk/s**
Director lead in place to support revised service offer through transformation programme, change programmes and work streams, overseen by EMT	C07	BDU	1.1, 1.3
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 in line with the Integrated Change Framework	C15	DS	1.2, 1.3
Strategic Priorities and underpinning programmes supported through robust programme and change management approaches and in line with the Integrated Change Framework	C17	DS	1.3
All senior medical staff participate in a job planning process which reviews and restates priority areas of work for these senior clinical leaders	C18	MD	1.3
Clear Trustwide policies in place that are agreed by the Executive Management team	C19	DS	1.3
Implications of Carter report for services considered at OMG and actions identified	C20	DD	1.3
Participate in national benchmarking activity for mental health services and act on areas of significant variance	C21	DFR	1.3

Gaps in control - what do we need to do to address these and by when?	**Date**
Impact of local place based solutions and ICS initiatives – recognition that some of this is out of our control and ensure engagement takes place in each area impacted.	Ongoing

Assurance (Strategic Risk 1.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Independent PLACE audits undertaken and results and actions to be taken reported to Executive Management Team (EMT), Members' Council and Trust Board	Service users and Directors involved in assessments.	A05	DHR	1.1, 1,2, 1.3
Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities	Clinical audit and practice effectiveness (CAPE) annual plan CG&CS Committee April 2017.	A06	DNQ	1.1, 1.2, 1.3
Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT).	A07	DS	1.1, 1.2, 1.3, 2.1, 3.4
Service user survey results reported annually to Trust Board and action plans produced as applicable	NHS Mental Health Service User Survey Results will be report to Trust Board when available.	A08	DNQ	1.1, 1.2, 1.3, 2.3, 2.4
Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks,	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to Audit Committee and CG&CS Committee re. quality impact.	A09	EMT	1.1, 1.2, 1.3, 2.4, 3.4

Assurance (Strategic Risk 1.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
reported through Transformation Boards and IPR				
Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan	Audit Committee and Trust Board – April 2018.	A14	DFR	1.1, 1.3, 2.4
Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	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.	A15	DHR, DS,	1.1, 1.3, 2.4
Reports from Transforming Care Board and Calderdale, Kirklees and Wakefield Partnership Board	Update reports into EMT	A18	DFR	1.2, 1.3

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Assessment of commissioning intentions.	Dec 18

Strategic Objective:	Lead Director(s)	Key Board or Committee	Current Assurance Level			
2. Improving care - a priority for safety first, quality counts	As noted below	EMT, WRC, CGCS	**Q1**	**Q2**	**Q3**	**Q4**
			Y			

Strategic Risks - that need to be controlled and consequence of non-controlling and current assessment

Ref	Description	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	**Increased demand for and acuity of service users leads to a negative impact on quality of care**	**Y**

Rationale for current assurance level (Strategic Objective 2)

- 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 requires improvement, number of areas rated good or outstanding, action plan to address improvement recommendations
- Internal audit reports – Risk management, Information Governance, Data Quality, Staff Engagement, Mental health Act Governance, Quality Governance – significant assurance
- CQUIN targets largely achieved.
- Regular analysis and reporting of incidents
- Data warehouse implementation taking place, but at slower pace than originally planned to ensure alignment with SystmOne implementation
- Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 2 shows: Friends & Family Test MH red, F&F Test Community green, safer staff fill rates green, IG confidentiality breaches yellow.
- Dedicated project team, significant staff engagement and project plan in place for implementation of SystmOne for mental health

Strategic Risk 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

Controls (Strategic Risk 2.1)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
Development of data warehouse and business intelligence tool supporting improved decision making	C22	DFR	2.1
Digital strategy in place with quarterly report to Executive Management Team (EMT) and half yearly report Trust Board in place.	C23	DFR	2.1
Programme established for implementing new clinical record system	C24	DS	2.1
Risk assessment and action plan for data quality assurance in place	C25	DFR	2.1
Customer services reporting includes learning from complaints and concerns	C26	DNQ	2.1, 2.2, 2.3
Datix incident reporting system supports review of all incidents for learning and action	C27	DNQ	2.1, 2.2, 2.3
Integrated change management arrangements focus on co-design	C28	DS	2.1, 2.2, 2.3
Patient Safety Strategy developed to reduce harm through listening and learning	C29	DNQ	2.1, 2.2, 2.3
Weekly risk scan where all red and amber incidents are reviewed for immediate learning	C30	DNQ/MD	2.1, 2.2, 2.3
Quality Improvement network established to provide trustwide learning platform	C31	DNQ	2.1, 2.2, 2.3
Quality Strategy achieving balance between assurance and improvement	C32	DNQ	2.1, 2.2, 2.3
Performance management system in place with Key Performance Indicators (KPIs) covering national and local priorities reviewed by EMT and Trust Board	C33	DFR	2.1, 2.2, 2.3, 3.1, 3.2

Gaps in control - what do we need to do to address these and by when?	**Date**
Limited assurance internal audit report for clinical record system implementation governance	Q2
Limited use of reports generated using the data warehouse tool	Q3

Assurance (Strategic Risk 2.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through the Integrated Performance Report (IPR)	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Annual review of impact of priority programmes received by EMT.	A07	DS	1.1, 1.2, 1.3, 2.1, 3.4
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	Contracting risks, bids & tenders update standing item on delivery EMT agenda. Report to Board bi-annually.	A10	BDU	1.1, 1.2, 2.1, 3.1

Assurance (Strategic Risk 2.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Objectives for 2018/19 set for all Directors. Monthly one to one meetings between Chief Executive and Directors.	A11	CEO	1.1, 1.2, 2.1, 3.1, 3.2, 3.3, 3.4
Data quality focus at OMG and ICIG	Regular agenda items and reporting of at ICIG and OMG	A23	DNQ	2.1
Data quality improvement plan monitored through Executive Management Team (EMT) deviations identified and remedial plans requested	Included in monthly IPR to EMT and Trust Board. Regular reports to CG&CS Committee.	A24	DFR	2.1
Progress against SystmOne implementation plan reviewed by Programme Board, EMT and Trust Board	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board.	A25	DS	2.1
Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken	Quarterly BAF and risk register reports to Board. Triangulation of risk, performance and governance present to each Audit Committee.	A26	DFR	2.1
Customer service reports to board and CGCS	Monthly reports to board/EMT and bi-monthly into CGCS	A27	DNQ	2.1 2.2 2.3
Priority programmes reported to board and EMT	Monthly reports to board/EMT and bi-monthly into CGCS	A28	DS	2.1 2.2 2.3
Quality strategy implementation plan reports into CGCS	Routine reports into CGCS	A29	DS	2.1 2.2 2.3
Attendance of NHS Improvement/Monitor at Executive Management Team (EMT) and feedback on performance against targets	NHS Improvement hold Quarterly Review Meetings with EMT.	A30	DFR	2.1, 3.1, 3.3

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Further updates to Clinical Governance & Clinical Safety Committee and Audit Committees on capture of clinical information and impact on data quality.	Quarter 3
Implementation of actions identified in internal report on SystmOne implementation governance arrangements	Quarter 2
Development plan and implementation to more extensively generate and use management reports using the data warehouse	Quarter 3
Follow up of actions identified in data quality internal audit	Quarter 3
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

Strategic Risk 2.2
Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience

Controls (Strategic Risk 2.2)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
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	C16	DNQ	1.2, 2.2
Customer services reporting includes learning from complaints and concerns	C26	DNQ	2.1, 2.2, 2.3
Datix incident reporting system supports review of all incidents for learning and action	C27	DNQ	2.1, 2.2, 2.3
Integrated change management arrangements focus on co-design	C28	DS	2.1, 2.2, 2.3
Patient Safety Strategy developed to reduce harm through listening and learning	C29	DNQ	2.1, 2.2, 2.3
Weekly risk scan where all red and amber incidents are reviewed for immediate learning	C30	DNQ/MD	2.1, 2.2, 2.3
Quality Improvement network established to provide trustwide learning platform	C31	DNQ	2.1, 2.2, 2.3
Quality Strategy achieving balance between assurance and improvement	C32	DNQ	2.1, 2.2, 2.3
Performance management system in place with Key Performance Indicators (KPIs) in place covering national and local priorities reviewed by OMG, EMT and Trust Board	C33	DFR	2.1, 2.2, 2.3, 3.1, 3.2
A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme	C34	DHR	2.2
Annual Learning Needs Analysis undertaken linked to Service and Financial Meeting	C35	DHR	2.2
Education and training governance group established to agree and monitor annual training plans	C36	DHR	2.2
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	C37	DHR	2.2
Mandatory clinical supervision and training standards set and monitored for service lines	C38	DHR	2.2
Medical Leadership Programme in place with external facilitation	C39	MD	2.2
Organisational Development Framework and plan re support objectives “the how” in place with underpinning delivery plan, strategic priorities and underpinning programmes supported through robust programme management approach	C40	DHR	2.2
Recruitment and Retention Action agreed by EMT	C41	DHR	2.2
Recruitment and Retention Task Group established	C42	DHR	2.2
Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs)	C43	DHR	2.2
Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures	C44	DHR	2.2
Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity	C45	DHR	2.2
Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of service	C46	BDU	2.2, 2.3

Gaps in control - what do we need to do to address these and by when?	**Date**
Need to strengthen links with local universities on increasing numbers into Nurse training. DN and DHR	September 2018
Exit interviews and questionnaire have a poor response rate and therefore Trust does not have a	September

Gaps in control - what do we need to do to address these and by when?	Date
complete picture of why are leaving. Recruitment and Retention Task group streamlining process and monitoring response rate	2018

Assurance (Strategic Risk 2.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Customer service reports to board and CGCS	Monthly reports to board/EMT and bi-monthly into CGCS	A27	DNQ	2.1 2.2 2.3
Priority programmes reported to board and EMT	Monthly reports to board/EMT and bi-monthly into CGCS	A28	DS	2.1 2.2 2.3
Quality strategy implementation plan reports into CGCS	Routine reports into CGCS	A29	DS	2.1 2.2 2.3
Annual Mandatory Training report goes to Clinical Governance & Clinical Safety Committee	Clinical Governance & Clinical Safety Committee receive annual report	A31	DHR	2.2
Appraisal uptake included in IPR	Monthly IPR goes to the Trust Board and EMT	A32	DHR	2.2
ESR competency framework for all clinical posts	Monitored through mandatory training report	A33	DHR	2.2
Mandatory training compliance is part of the IPR	Monthly IPR goes to the Trust Board and EMT	A34	DHR	2.2
Recruitment and Retention performance dashboard	Quarterly report to the Workforce and Remuneration Committee	A35	DHR	2.2
Safer staffing reports included in IPR and reported to Clinical Governance & Clinical Safety Committee	Monthly IPR goes to the Trust Board and EMT	A36	DNQ	2.2
Workforce Strategy performance dashboard	Quarterly report to the Workforce and Remuneration Committee	A37	DHR	2.2

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Report to Workforce and Remuneration Committee on reasons for leaving extracted from exit interviews.	Oct 2018

Strategic Risk 2.3
Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation

Controls (Strategic Risk 2.3)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
Customer services reporting includes learning from complaints and concerns	C26	DNQ	2.1, 2.2, 2.3
Datix incident reporting system supports review of all incidents for learning and action	C27	DNQ	2.1, 2.2, 2.3
Integrated change management arrangements focus on co-design	C28	DS	2.1, 2.2, 2.3
Patient Safety Strategy developed to reduce harm through listening and learning	C29	DNQ	2.1, 2.2, 2.3
Weekly risk scan where all red and amber incidents are reviewed for immediate learning	C30	DNQ/MD	2.1, 2.2, 2.3
Quality Improvement network established to provide trustwide learning platform	C31	DNQ	2.1, 2.2, 2.3
Quality Strategy achieving balance between assurance and improvement	C32	DNQ	2.1, 2.2, 2.3
Performance management system in place with Key Performance Indicators (KPIs) in place covering national and local priorities reviewed by OMG, EMT and Trust Board	C33	DFR	2.1, 2.2, 2.3, 3.1, 3.2
Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services	C46	BDU	2.2, 2.3
Learning lessons reports, BDUs, post incident reviews	C47	DNQ	2.3
Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training	C48	DFR	2.3
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	C49	DNQ	2.3

Gaps in control - what do we need to do to address these and by when?	**Date**

Assurance (Strategic Risk 2.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Service user survey results reported annually to Trust Board and action plans produced as applicable	NHS Mental Health Service User Survey Results will be report to Trust Board when available.	A08	DNQ	1.1, 1.2, 1.3, 2.3, 2.4
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	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to EMT, Clinical Governance & Clinical Safety Committee and Trust Board.	A19	DNQ	1.2, 2.3, 2.4

Assurance (Strategic Risk 2.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Customer service reports to board and CGCS	Monthly reports to board/EMT and bi-monthly into CGCS	A27	DNQ	2.1 2.2 2.3
Priority programmes reported to board and EMT	Monthly reports to board/EMT and bi-monthly into CGCS	A28	DS	2.1 2.2 2.3
Quality strategy implementation plan reports into CGCS	Routine reports into CGCS	A29	DS	2.1 2.2 2.3
Weekly risk scan update into EMT	Weekly risk scan update into EMT	A38	DNQ	2.3
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	Quarterly report to CG&CS Committee of risks aligned to the committee for review.	A39	DNQ	2.3, 2.4

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 Risk 2.4 Increased demand for and acuity of service users leads to a negative impact on quality of care

Controls (Strategic Risk 2.4)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
Bed management programme board	C50	DD	2.4
Out of area bed reduction joint action plan with CCG	C51	DFR	2.4
Performance management process and IPR at various levels of the organisation	C52	DD	2.4
Safer staffing policies and procedures in place to respond to changes in need	C53	DNQ	2.4
TRIO management system monitoring quality, performance and activity on a routine basis	C54	DD	2.4
Use of trained and appropriately qualified temporary staffing through bank and agency system	C55	DD	2.4
Waiting list management improvement plan in place to support people awaiting a service/treatment	C56	DD	2.4

Gaps in control - what do we need to do to address these and by when?	**Date**

Assurance (Strategic Risk 2.4)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Service user survey results reported annually to Trust Board and action plans produced as applicable	NHS Mental Health Service User Survey Results will be report to Trust Board when available.	A08	DNQ	1.1, 1.2, 1.3, 2.3, 2.4
Transformation change and priority programme 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	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.	A09	EMT	1.1, 1.2, 1.3, 2.4, 3.4
Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board , CG&CS and MC	Unannounced and planned visits programme in place – report to CG&CS Committee and included in annual report to Board. Visits planned during 2018/2019	A12	DNQ	1.1, 1.2, 2.4
Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan	Audit Committee and Trust Board – April 2018.	A14	DFR	1.1, 1.3, 2.4
Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	Communication, engagement and involvement strategy 2016-2019 (approved October 2016). Weekly and	A15	DHR, DS, DMCEC	1.1, 1.3, 2.4

Assurance (Strategic Risk 2.4)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
	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.			
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	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to EMT, Clinical Governance & Clinical Safety Committee and Trust Board.	A19	DNQ	1.2, 2.3, 2.4
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	Quarterly report to CG&CS Committee of risks aligned to the committee for review.	A39	DNQ	2.3, 2.4
Health Watch undertake unannounced visits to services providing external assurance on standards and quality of care	Unannounced visits as scheduled by Health Watch.	A40	BDU	2.4
Staff wellbeing survey results reported to Trust Board and/or Remuneration and Terms of Service Committee and action plans produced as applicable	Staff wellbeing and work results – WRC July 2017.	A41	DHR	2.4
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)	Included as part of the IPR to EMT and Trust Board.	A42	DHR	2.4, 3.4

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Current performance information is primarily focussed on inpatient service provision. Further assurance in respect of community services caseload is required. Additional reporting metrics to be developed for IPR.	Sep 18

Strategic Objective: 3. Improving resources - a priority for operational excellence	Lead Director(s)	Key Board or Committee	Current Assurance Level			
	As noted	AC, EMT, WRC	Q1 A	Q2	Q3	Q4

Strategic Risks - that need to be controlled and consequence of non-controlling and current assessment

Ref	Description	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**	Y
3.3	**Failure to deliver efficiency Improvements/CIPs**	A
3.4	**Capacity and resources not prioritised leading to failure to meet strategic objectives**	G

Rationale for current assurance level (Strategic Objective 3)

- Contracts agreed with commissioners for 2018/19.
- NHS Improvement Single Oversight Framework rating of 2 – targeted support.
- Deterioration in financial performance since mid 2017/18.
- Impact of non-delivery of Cost Improvement Programmes (CIPs), non-recurrent CIPs and out of area placements on financial performance.
- Underlying profitability after adjusting for non-recurrent measures being taken.
- Integrated Care System (ICS) and place based driven change may impact on our service portfolio.
- Internal audit reports – Risk Management, Data Quality and Integrity of general ledger and financial reporting – significant assurance. Additional pay spend (agency) – limited assurance.
- Integrated Performance Report (IPR) summary metrics provide assurance on majority of our performance and clearly identifies where improvement is required.
- Income reducing year on year.
- Procurement intentions in Barnsley.
- 2018/19 deficit plan.
- Current cash balance and cash management processes.
- Positive well-led results following Care Quality Commission (CQC) review.
- Capital investment prioritisation process.
- Priority programmes agreed for 2018/19 which are aligned to strategic objectives.

Strategic Risk 3.1
Deterioration in financial performance leading to unsustainable organisation and insufficient cash to deliver capital programme

Controls (Strategic Risk 3.1)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
Annual Business planning process, ensuring consistency of approach, standardised process for producing businesses cases with full benefits realisation	C05	DFR	1.1, 1.2, 3.1
Performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board	C33	DFR	2.1, 2.2, 2.3, 3.1, 3.2
Finance managers aligned to Business Delivery Units (BDUs) acting as integral part of local management teams	C57	DHR	3.1
Standardised process in place for producing businesses cases with full benefits realisation	C58	DFR	3.1
Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities	C59	DFR	3.1
Annual financial planning process CIP and Quality Impact Assessment (QIA) process	C60	DFR	3.1, 3.3
Financial control and financial reporting processes	C61	DFR	3.1, 3.3
Regular financial reviews at Executive Management Team (EMT) including monthly focus when non-executive directors are also invited	C62	DFR	3.1, 3.3
Service line reporting / service line management approach	C63	DFR	3.1, 3.3
Weekly Operational Management Group (OMG) chaired by Director of Delivery providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks	C64	DD	3.1, 3.3

Gaps in control - 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 (ORR Risk ID 1077, 1214)	Ongoing
Risk of inability to achieve transitions identified in our plan (ORR Risk ID 695, 1114)	Ongoing
Trust has a history of not fully achieving its recurrent CIP targets (ORR Risk ID 1076)	March 2019
Reduction in Local Authority budgets negatively impacting on financial resource available to commission staff / deploy social care resource (ORR Risk ID 275)	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 (ORR Risk ID 275)	Ongoing
All financial risk for out of area bed costs currently sits with the Trust (ORR Risk ID TBC)	March 2019
Increased risk of redundancy / lack of ability to redeploy if services are decommissioned at short notice (ORR Risk ID 1156, 1214)	Ongoing

Assurance (Strategic Risk 3.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated Performance Report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Business cases for expansion/change of services approved by Executive Management Team (EMT) and/or Trust	Contracting risks, bids & tenders update standing item on delivery EMT agenda. Report to Board bi-annually.	A10	BDU	1.1, 1.2, 2.1, 3.1

Assurance (Strategic Risk 3.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Board subject to delegated limits ensuring alignment with strategic direction and investment framework				
Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Objectives for 2018/19 set for all Directors. Monthly one to one meetings between Chief Executive and Directors.	A11	CEO	1.1, 1.2, 2.1, 3.1, 3.2, 3.3, 3.4
Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement	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.	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
Benchmarking of services and action plans in place to address variation	Benchmarking reports are received by Executive Management Team (EMT) and any action required identified.	A20	DFR	1.2, 3.1, 3.2, 3.3
Quarterly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity	Monthly bids and tenders report to Executive Management Team (EMT).	A21	DFR	1.2, 3.1, 3.2, 3.3
CQUIN performance monitored through Operational Management Group (OMG) and Executive Management Team (EMT), deviations identified and remedial plans requested	Monthly Integrated Performance reporting (IPR) to OMG, EMT and Trust Board.	A22	DD	1.2, 3.1, 3.3
Attendance of NHS Improvement/Monitor at Executive Management Team (EMT) and feedback on performance against targets	NHS Improvement hold Quarterly Review Meetings with EMT.	A30	DFR	2.1, 3.1, 3.3
Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited	Annual Governance Statement 2017/18 reviewed by Audit Committee and approved by Trust Board in May 2018.	A43	DFR	3.1
Half-yearly strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats	Strategic business and risk analysis reviewed by Trust Board in the first half of 2018.	A44	DS	3.1, 3.2
Monthly investment appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity	Monthly bids and tenders report to Executive Management Team (EMT). Trust Board reviews the investment appraisal report every six months.	A45	DFR	3.1, 3.2
Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources	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. Further update to Scheme of Delegation reviewed by Audit Committee on April 2017 prior to approval by Trust Board and Members' Council.	A46	DFR	3.1, 3.3
Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG)	Standing agenda for OMG.	A47	DD	3.1, 3.3

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Update 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 not fully identified.	Quarter 2
Internal audit reports with partial assurance management actions agreed by lead Director.	As per Audit

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
	reports
There is a significant increase in spend on out of area bed placements and an overspend against budget.	Quarter 3
Cash position is largely dependent on us delivering a surplus.	Ongoing
Balanced financial plan for 2018/19 not yet in place.	Quarter 2

Strategic Risk 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

Controls (Strategic Risk 3.2)			
Systems and processes - what are we currently doing about the strategic risks?	**Control Ref**	**Director lead**	**Strategic risk/s**
Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services	C08	DFR	1.1, 3.2
Performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board	C33	DFR	2.1, 2.2, 2.3, 3.1, 3.2
Clear strategy in place for each service and place to provide direction for service development	C65	DS	3.2
Forums in place with commissioners to monitor performance and identify service development	C66	DO	3.2
Independent survey of stakeholders perceptions of the organisation and resulting action plans	C67	DS	3.2
Strategic Business and Risk Report including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power	C68	DS	3.2
Quality Impact Assessment (QIA) process in place	C69	DNQ	3.2, 3.3

Gaps in control - what do we need to do to address these and by when?	**Date**
Risk of loss of business	Ongoing
Level of tendering activity taking place	Ongoing

Assurance (Strategic Risk 3.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated Performance Report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Objectives for 2018/19 set for all Directors. Monthly one to one meetings between Chief Executive and Directors.	A11	CEO	1.1, 1.2, 2.1, 3.1, 3.2, 3.3, 3.4
Benchmarking of services and action plans in place to address variation	Benchmarking reports are received by Executive Management Team (EMT) and any action required identified.	A20	DFR	1.2, 3.1, 3.2, 3.3
Quarterly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity	Monthly bids and tenders report to Executive Management Team (EMT).	A21	DFR	1.2, 3.1, 3.2, 3.3
Half-yearly strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats	Strategic business and risk analysis reviewed by Trust Board in the first half of 2018	A44	DS	3.1, 3.2
Monthly investment appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity	Monthly bids and tenders report to Executive Management Team (EMT). Trust Board reviews the investment appraisal report every six months.	A45	DFR	3.1, 3.2
Attendance at external stakeholder meetings including Health & Wellbeing	Minutes and issues arising reported to Trust Board meeting on a monthly basis	A48	DO	3.2

Assurance (Strategic Risk 3.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
boards				
Documented update of progress made against comms and engagement strategy	Monthly IPR to Executive Management Team (EMT) and Trust Board.	A49	DS	3.2

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Refresh of actions to support the stakeholder engagement plans	Oct 2018
Assessment of updated commissioning intentions	Dec 2018
Assessment of place based plans within the Integrated Care Systems	Dec 2018

Strategic Risk 3.3
Failure to deliver efficiency Improvements/CIPs

Controls (Strategic Risk 3.3)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
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	C09	DD	1.1, 3.3
Annual financial planning process CIP and Quality Impact Assessment (QIA) process	C60	DFR	3.1, 3.3
Financial control and financial reporting processes	C61	DFR	3.1, 3.3
Regular financial reviews at Executive Management Team (EMT) including monthly focus when non-executive directors are also invited	C62	DFR	3.1, 3.3
Service line reporting / service line management approach	C63	DFR	3.1, 3.3
Weekly Operational Management Group (OMG) chaired by Director of Delivery providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks	C64	DD	3.1, 3.3
Quality Impact Assessment (QIA) process in place	C69	DNQ	3.2, 3.3
Participation in benchmarking exercises and use of that data to shape CIP opportunities	C70	DFR	3.3
Gaps in control - what do we need to do to address these and by when?			**Date**
Trust has a history of not fully achieving its recurrent CIP targets			March 2019

Assurance (Strategic Risk 3.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated Performance Report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Objectives for 2018/19 set for all Directors. Monthly one to one meetings between Chief Executive and Directors.	A11	CEO	1.1, 1.2, 2.1, 3.1, 3.2, 3.3, 3.4
Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement	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.	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
Benchmarking of services and action plans in place to address variation	Benchmarking reports are received by Executive Management Team (EMT) and any action required identified.	A20	DFR	1.2, 3.1, 3.2, 3.3
Quarterly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity	Monthly bids and tenders report to Executive Management Team (EMT).	A21	DFR	1.2, 3.1, 3.2, 3.3
CQUIN performance monitored through Operational Management Group (OMG)	Monthly Integrated Performance reporting (IPR) to OMG, EMT and Trust	A22	DD	1.2, 3.1, 3.3

and Executive Management Team (EMT), deviations identified and remedial plans requested	Board.			
Attendance of NHS Improvement/Monitor at Executive Management Team (EMT) and feedback on performance against targets	NHS Improvement hold Quarterly Review Meetings with EMT.	A30	DFR	2.1, 3.1, 3.3
Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources	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. Further update to Scheme of Delegation reviewed by Audit Committee on April 2017 prior to approval by Trust Board and Members' Council.	A46	DFR	3.1, 3.3
Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG)	Standing agenda for OMG.	A47	DD	3.1, 3.3

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
CIP delivery is currently behind plan and not fully identified	Quarter 2
Balanced financial plan for 2018/19 not yet in place	Quarter 2

Strategic Risk 3.4
Capacity and resources not prioritised leading to failure to meet strategic objectives

Controls (Strategic Risk 3.4)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
Agreed workforce plans in place which identify staffing resources required to meet current and revised service offers. Also describe how we meet statutory requirements re training, equality and diversity	C71	DHR	3.4
Director portfolios clearly identify director level leadership for strategic priorities	C72	CEO	3.4
Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes	C73	DS	3.4
Integrated Change Team 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	C74	DS	3.4
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	C75	DFR	3.4
Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 18/19 priorities	C76	DS	3.4

Gaps in control - what do we need to do to address these and by when?	**Date**
Integrated Change Framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority	

Assurance (Strategic Risk 3.4)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.	A02	DFR	All
Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Annual review of impact of priority programmes received by EMT.	A07	DS	1.1, 1.2, 1.3, 2.1, 3.4
Transformation change and priority programme 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	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.	A09	EMT	1.1, 1.2, 1.3, 2.4, 3.4
Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Objectives for 2018/19 set for all Directors. Monthly one to one meetings between Chief Executive and Directors.	A11	CEO	1.1, 1.2, 2.1, 3.1, 3.2, 3.3, 3.4
Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement	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	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4

Assurance (Strategic Risk 3.4)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
	30 April 2018.			
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)	Included as part of the IPR to EMT and Trust Board.	A42	DHR	2.4, 3.4
Integrated Change Framework includes escalation process for issues/risks to be brought to the attention of the Executive Management Team	Included as part of priority programme agenda item	A50	DS	3.4
Integrated Change Framework includes gateway reviews at key points and post implementation reviews. Capacity and resources are considered at these key points	Included as part of priority programme agenda item	A51	DS	3.4
Strategic priority programmes report into CG&CS Committee and Audit Committee on regular basis to provide assurance on risk and quality issues	Strategic priority programmes report into CG&CS Committee and Audit Committee	A52	DS	3.4

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Assessment of place based plans within the Integrated Care Systems to include understanding of capacity required for implementation and any implications this has on capacity overall	Dec 2018

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 6.3

Title:	**Organisational Risk Register Quarter 1 2018/19**
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:	**Corporate/Organisational Risk Register** The Corporate/Organisational Risk Register (ORR) 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 Business Delivery Units (BDUs), corporate or project specific risks and the removal of risks from the register. The organisational level risks are aligned to the Trust's strategic priorities 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		
Improving health	**Improving care**	**Improving resources**
A priority for joining up care	A priority for safety first, quality counts	A priority for operational excellence

The ORR 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.
	1319	Quality of care will be compromised if people continue to be sent out of area.

With all of us in mind.

The following changes have been made to the ORR since the last Board report in April 2018:

	Risk ID	Description	Status	Update (what changed, why, assurance)
	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.	Risk closed	Reviewed at EMT and confirmed that relevant reports are now being received.
	1119	Risk that Forensic BDU locks are now out of patent.	Risk now reviewed at BDU level	Reviewed at EMT and agreed the risk can be managed at BDU level.
	164	Risk of non-submission of statutory returns resulting in non-compliance with constitution and licence.	Risk now reviewed at BDU level	Reviewed at EMT and agreed the risk can be managed at BDU level.
	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.	Current risk level reduced	Reviewed by lead director, risk likelihood reduced to '3 possible' – current risk level is now 9 and remains 'amber / high'.
	1155	Risk that pay restraint and new terms and conditions could cause increased industrial action and impact on morale.	Risk closed	Reviewed by lead director and Workforce and Remuneration Committee. Agreed to close the risk given the recent pay award and that most unions are recommending acceptance.
	1156	Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy.	Current risk level reduced	Reviewed by lead director, risk likelihood reduced to '2 unlikely' – current risk level is now 6 and is now 'yellow / moderate'.
	1196	Risk that the use of multi-functional devices for scanning and printing patient identifiable information leads to a breach in information governance.	Risk now reviewed at BDU level	Reviewed at EMT and agreed the risk can be managed at BDU level.
	1215	Risk of scanning records on to the clinical system and destroying paper records without paper light accreditation leading to loss of data integrity as scanned images are not legally admissible.	Risk closed	Reviewed and ISO 10008 has now been achieved as at 19 April 2018 that means that electronic records are legally admissible therefore risk closed.
	1216	Risk that the impact of General Data Protection Regulations (GDPR)	Current risk level reduced	Reviewed at EMT and current risk level reduced, likelihood

			results in additional requirements placed on the Trust that are not met or result in a financial penalty.		reduced from '3 possible' to '2 unlikely', current risk level is now 8 and remains 'amber / high'.

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.

Risk appetite

The ORR supports the Trust in providing safe, high quality services within available resources, in line with the Trust's Risk Appetite Statement.

The risks in the Quarter 1 report for 2018/19 have been aligned to the updated Risk Appetite Statement that was approved by the Trust Board in April 2018.

Recommendation:	**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** ➢ **DISCUSS if the target risk levels that fall outside of the risk appetite are acceptable or whether they require review.**
Private session:	Not applicable.

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk appetite:
Clinical risks (1-6): Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.
Commercial risks (8-12): 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.
Compliance risks (1-6): Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.
Financial risks (1-6): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.
Strategic risks (8-12): 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	Application
Minimal / low - Cautious / moderate (1-6)	• Risks to service user/public safety. • Risks to staff safety • Risks to meeting statutory and mandatory training requirements, within limits set by the Board. • Risk of failing to comply with Monitor requirements impacting on license • Risk of failing to comply with CQC standards and potential of compliance action • Risk of failing to comply with health and safety legislation • Meeting its statutory duties of maintain expenditure within limits agreed by the Board. • Financial risk associated with plans for existing/new services as the benefits for patient care may justify the investment • Risk of breakdown in financial controls, loss of assets with significant financial value.
Open / high (8-12)	• Reputational risks, negative impact on perceptions of service users, staff, commissioners. • Risks to recruiting and retaining the best staff. • Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance Trusts current and future services.

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		
Improving health	**Improving care**	**Improving resources**
A priority for joining up care	A priority for safety first, quality counts	A priority for operational excellence

KEY:
CEO=Chief Executive Officer
DFR=Director of Finance and Resources
DHR=Director of HR, OD and Estates
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

Actions in green are ongoing by their nature.

Trust Board – business and risk 31 July 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. ➢ Security patching regime covering all servers, client machines and key network devices. ➢ Annual infrastructure, server and client penetration testing. ➢ Appropriately skilled and experienced staff who regularly attend cyber security events. ➢ Disaster recovery and business continuity plans which are tested annually. ➢ Data retention policy with regular back-ups and off-site storage. ➢ NHS Digital Care Cert advisories reviewed on an on-going basis & where applicable applied to Trust infrastructure. ➢ Key messages and communications issued to staff regarding potential cyber security risks.	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low – Cautious / moderate (1 – 6)	➢ The Trust has signed up to be an early adopter for the simulated phishing training tool being developed by NHS Digital – time scales are awaited for this. (DFR). (31 December 2018) ➢ 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 – timescales are to be scheduled by NHS Digital during 18/19. (DFR). (31 December 2018) ➢ The Implementation of year 2 of the data centre infrastructure plan focusing on improvements to (DFR) (31 March 2019): ➢ Data centre/disaster recovery. ➢ Infrastructure/wide area network. ➢ Server hardware refresh. ➢ Network switch upgrades.	DFR	Ongoing	IM&T Managers Meeting (Monthly) EMT Monthly (bi-Monthly) Audit Committee (Quarterly) IT Services Department service management meetings (Trust / Daisy) (Monthly)	5 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 2 & 3 The Trust was not impacted by the WannaCry Ransomware cyber-attack on NHS and private industry, 12 May 2017. Cyber security review conducted by Daisy completed in March 2018.	Every three months prior to business and risk Trust Board – July 2018

With all of us in mind.

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
		➢ Microsoft software licensing strategic roadmap in place. ➢ Cyber security has been incorporated into mandatory Information Governance Training, revised during 17/18. The Trust achieved the compliance requirement for level 2.					➢ Finding from the cyber essentials evaluation against cyber essentials standards have been incorporated into the technical plans and priorities incorporating intrusion detection and intrusion prevention. (DFR) (31 March 2019)						Internal assurance report for the Trust controls and mechanisms in relation to the WannaCry Ransomware cyber-attack produced and all actions complete.	
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. ➢ Staff engagement processes. ➢ Performance management processes. ➢ Wakefield and Barnsley Staff Partnership Forum briefings. ➢ Staff retention plan. ➢ Staff health and wellbeing offer. ➢ Implementation of workforce strategy action plan agreed by the Workforce and Remuneration Committee.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Open / high (8 – 12)	➢ Implementation of staff survey action plans (DHR) (September 2018) ➢ Horizon scanning for potential tender activity and work with staff in relevant services (DFR / DS) ➢ Lessons learned from tenders being systematically actioned (e.g. Barnsley IAPT service) (DFR) ➢ Development of provider alliance in Barnsley (BWBDU)	CEO	Ongoing	Staff Partnership Forum briefings Regular updates to EMT Board context report	9 Amber / High (8-12)	AC	Risk appetite: Commercial risk 8 – 12 Links to BAF, SO3	Every three months prior to business and risk Trust Board – July 2018
1319	Quality of care will be compromised if people continue to be sent out of area.	➢ Bed management process. ➢ Critical to Quality map to identify priority change areas. ➢ Joint action plan with commissioners. ➢ Internal programme board. ➢ Weekly oversight at OMG.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of local plans of change activity to reduce admissions and plans to reduce length of stay. (DD) (End of June 2018) ➢ Development of local plans of change activity to reduce PICU bed usage (DD) (July 2018) ➢ Development of pathway for supporting people with Emotionally Unstable Personality Disorder. (DD) (Pathway ready September 2018, implemented by December 2018) ➢ Implementation of actions agreed in the joint action plan. (DD) (December 2018) ➢ Implement changes via PDSA cycles. (DD) (PDSA cycles to be undertaken by December 2018 (some sooner)) ➢ Negotiation with commissioners to develop a risk share agreement. (DD) (to be in place by January 2019) ➢ Working with STP partners to review bed management across West Yorkshire. (DD)	DD	January 2019	OMG	9 Amber / high (8-12)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – July 2018

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

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
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. ➢ Monthly review through Delivery EMT of key indicators and regular review at OMG. ➢ Weekly risk scan by Director of Nursing and Medical Director. ➢ BDU / commissioner forums – monitoring of performance. ➢ In all geographic areas the Trust is a partner in developing integrated working to reduce overall costs in the system. ➢ 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. ➢ 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. ➢ At least monthly review of bids management in relation to services commissioned by local authorities. ➢ Regular ongoing review of contracts with local authorities. ➢ Decision tree process in place to review bids through EMT.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ New organisational change policy to include further support for the transfer and redeployment of staff. (DHR) (September 2018) ➢ Consider a Trustwide approach where appropriate to review across all areas. (BWBDU / CKFSBDU) (31 December 2018) ➢ Creation of alternate delivery of services and mitigate financial risks. (BWBDU / DD / CKFSBDU) (1 April 2019) ➢ 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) ➢ 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) ➢ 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) ➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation plans / CEO leads the West Yorkshire STP. (CEO / DHR)	BW BDU	Ongoing risk given external influenc e outside our control	BDU (monthly) EMT (monthly) OMG (regular) Trust Board (each meeting through integrated performanc e report) Annual review of contracts and annual plan at EMT and Trust Board	12 Amber / High (8-12)	CG&CS AC	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – July 2018
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. ➢ Service quality metrics in place highlighting potential hotspots and areas for action to be taken as appropriate. ➢ Post implementation review process. ➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation Plans (STP) / CEO leads the West Yorkshire STP. ➢ Regular review and update of the strategy by Trust Board. ➢ Review by the CG&CS Committee on QIAs updated at gateway review stages of the integrated change framework process.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives. (DS / CKFSBDU / BWBDU) ➢ Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. (DS) ➢ Active engagement in place based plans. (DS / CKFSBDU / BWBDU) ➢ 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)	DS	As per strategic priority delivery timetabl es.	EMT (monthly) Transforma tion board (monthly) OMG (weekly) Trust Board (quarterly)	8 Amber / high (8-12)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO1 & 2	Every three months prior to business and risk Trust Board – July 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
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. ➢ Progress on Transformation reviewed by Trust Board and EMT. ➢ Robust CIP planning and implementation process. ➢ 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. ➢ Secure 5YFV MH funding.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ The Trust is developing external engagement and communications to explain the benefits of mental health transformation for external stakeholders. (DS) (Ongoing – delivery dates specific to each priority programme) ➢ Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – July 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. ➢ Safer staffing project manager is currently implementing appropriate actions. ➢ Recruitment and retention plan agreed.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Review of establishments will be considered by OMG and recommendations made to EMT (DNQ) (September 2018) ➢ There are action plans are in place and monitored from Board to ward level. (CKFSBDU / BWBDU) ➢ Safer staffing group meets on a monthly basis. (DNQ)	BW BDU / CK FS BDU	Ongoing	EMT (monthly)	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 & 3	Every three months prior to business and risk Trust Board – July 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. ➢ Demand management process with commissioners to manage ASD waiting list within available resource. ➢ Commissioners have established an ASD Board and local commissioning plans are in place to start to address backlog for ASD. ➢ Future in Mind investments are in place to support the whole CAMHS system. ➢ Healthwatch Barnsley and Wakefield have carried out monitoring visits and are supporting local teams with the action plans. ➢ CAMHS performance dashboard for each district. ➢ Work has taken place to implement care pathways and consistent recording of activity and outcome data. ➢ Kirklees has a new ASD pathway in place. ➢ System wide work was undertaken in Wakefield to improve access to assessment for ASD. ➢ There is ongoing dialogue with people on the waiting list to keep in touch and to carry out well-being checks. ➢ Active participation in STP CAMHS initiative.	4 Major	3 Possible	12 Amber / High risk (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ The team is working with commissioners to implement additional solutions for people waiting for ASD assessment and treatment in Calderdale and Barnsley (BWBDU / CKFSBDU) (1 October 2018). ➢ FPOC has demonstrated a positive impact in Kirklees and has been implemented in all areas. This is still being embedded. (CKFSBDU). ➢ Recruitment to vacant positions is underway to increase capacity. This includes the consideration of new roles to improve opportunities to recruit. (CKFSBDU)	CK FS BDU	Review every three months	Performanc e reporting to EMT - monthly Assurance report to Clinical Governanc e Committee Individual district performanc e reports reviewed by BDU	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2	Every three months prior to business and risk Trust Board – July 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
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. ➢ Waiting lists are reported through the BDU business meetings. ➢ Alternative services are offered as appropriate. ➢ People waiting are offered contact information if they need to contact someone urgently. ➢ Individual bespoke arrangements are in place within services and reported through the BDU business meetings. ➢ Bespoke arrangements to review pathways in individual services.	4 Major	3 Possib le	12 Amber / high risk (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Waiting list information being developed with P&I and reported to EMT on the IPR. (BWBDU / CKFSBDU / DFR) (September 2019) ➢ The impact of reviewed pathways is to be monitored in the BDU management meetings (BWBDU / CKFSBDU). ➢ Maintaining communication with commissioners to push for waiting list initiatives where demand has exceeded an optimal service supply. (BWBDU / CKFSBDU) ➢ The risks at BDU level will be monitored in BDU meetings (BWBDU / CKFSBDU). ➢ Work ongoing with the commissioners to agree additional capacity in specific services. (BWBDU / CKFSBDU)	BW BDU / CK FS BDU	July 2018	Performanc e reporting to OMG and EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performanc e reports reviewed by BDU.	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2	Every three months prior to business and risk Trust Board – July 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. ➢ Quarterly review undertaken by Estates TAG. ➢ 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 ➢ In line with regulations the Trust is complying with the following: 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; o The identification of standards for the control of combustible, flammable or explosive materials; 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; o The allocation of responsibilities and duties of staff for monitoring and auditing all fire safety management systems and procedures;	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 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) (September 2018) ➢ Smoking group established to review the smoking policy (CKFSBDU)	DHR	Ongoing	EFM (weekly and monthly) Estates TAG (quarterly)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO2 & 3 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 – July 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
		o The development and delivery of suitable staff training in fire safety awareness; o 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. ➢Participation in system transformation programmes. ➢Robust process of stakeholder engagement and management in place through EMT. ➢Progress on Transformation reviewed by Trust Board and EMT. ➢Robust CIP planning and implementation process. ➢Trust is proactive in engaging leadership of key leaders across the service footprint. ➢Active role in STPs. ➢Skilled business development resource in place.	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢Commercial strategy development (DFR) (July 2018) ➢Financial recovery plan to the satisfaction of the regulators (DFR) (September 2018) ➢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) ➢The Trust is developing external engagement and communications to explain the benefits of mental health transformation for external stakeholders. (DS) (Ongoing – delivery dates specific to each priority programme) ➢Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – July 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% ➢ Trust employs appropriate skills and capacity to advise on policies, procedures and training for Information Governance. ➢ Trust has appropriate policies and procedures that are compliant with GDPR. ➢ 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 place. ➢ Improving Clinical Information and Governance group in place which is the governance group with oversight of IG issues. ➢ Monthly report of IG issues to EMT. ➢ Internal audit perform annual review of IG as part of IG Toolkit. ➢ GDPR implementation plan.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢Completion of actions from the GDPR implementation plan (DFR) (October 2018) ➢Targeted approach to advice and support from IG Manager through proactive monitoring of incidents and 'hot-spot- areas (DFR). ➢IG awareness raising sessions through an updated communications plan (DFR). ➢Rebranded materials and advice to increase awareness in staff and reduce incidents (DFR). ➢Increase in training available to teams including additional e-learning and face-to-face training (DFR). ➢Implement recommendations from ICO audit (DFR).	DFR	ICO external monitori ng of progres s by external evidenc e / desk based reviews	Progress monitored through EMT and weekly risk scans	4 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 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
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. ➢ Working capital management process including credit control and creditor payments to ensure income is collected on time and creditors paid appropriately. ➢ Capital prioritisation process to ensure capital is funded where the organisation most needs it. ➢ Stated aim of development of financial plans that achieve at least a small surplus position. ➢ Estates strategy with the intent of selling surplus buildings. ➢ CIP identification and review process. ➢ Treasury Management policy.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Increased robustness of CIP and expenditure management (DFR) (October 2018) ➢ Increased focus on prioritisation of capital expenditure (DHR / DFR) ➢ Increased focus on raising of invoices to ensure timely payment (DFR) ➢ Increased focus on robust financial management via training (DFR) ➢ Collaborative working within West Yorkshire STP (DFR / CEO / BWBDU)	DFR	31/03/17 – TBC	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO3	Every three months prior to business and risk Trust Board – July 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. ➢ Regular reporting of contract risks to EMT and Trust Board. ➢ Play full role in STPs in both West and South Yorkshire. ➢ Communication, engagement and involvement strategy. ➢ Updated Trust strategy in place. ➢ Liaison with regulators	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Commercial strategy development (DFR) (July 2018) ➢ Development and maintenance of longer term financial sustainability plan (DFR) (September 2018) ➢ Formulation and delivery of proactive contract risk management plans for specific services. (BWBDU / CKFSBDU) (To be in place for 2019/20 Contract round discussions (likely start in October 2018)) ➢ Develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care. (BWBDU / CKFSBDU) (To be in place for 2019/20 Contract round discussions (likely start in October 2018)) ➢ Implement actions from stakeholder survey (DS). (December 2018) ➢ Development of targeted programme of business growth focused on specific services and markets and aligned to strategy (BWBDU / DD / CKFSBDU). ➢ 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). (Ongoing – delivery dates specific to each priority programme) ➢ Ongoing response to the rapidly changing operating environment and the role the Trust plays in each place (DS). (Ongoing – delivery dates specific to each priority programme)	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 1 & 3	Every three months prior to business and risk Trust Board – July 2018
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. ➢ Active engagement in West Yorkshire and South Yorkshire STPs / CEO leads the West Yorkshire STP. ➢ Active engagement on place based plans. ➢ Enhanced management of CIP programme. ➢ Updated integrated change management processes.	3 Moder ate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of longer term financial sustainability plan (DFR) (September 2018) ➢ Devise plans based on NHS I benchmarking data (DFR) (December 2018) ➢ Increased use of service line management information by directorates (DFR) ➢ Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable	DFR	Annual review	EMT (monthly) Trust Board (quarterly)	8 Amber / high (8-12)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 3	Every three months prior to business and risk Trust Board – July 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
		➢ Director role focussing on delivery of operational excellence.					services (DS)							
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. ➢ Agreed turnover and stability rates part of IPR. ➢ Weekly risk scan by DNQ and MD to identify any emerging issues, reported weekly to EMT. ➢ Reporting to the Board through IPR/ ➢ Datix reporting on staffing levels. ➢ Strong links with universities. ➢ New students supported whilst on placement. ➢ Regular advertising. ➢ Development of Associate Practitioner. ➢ Workforce plans incorporated into new business cases. ➢ Workforce strategy implementation of action plan ➢ Retention plan developed.	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Marketing of the Trust as an employer of choice (DHR) (October 2018) ➢ Workforce plans linked to annual business plans (DHR) ➢ Develop new roles e.g. Advanced Nurse Practitioner (DNQ / DHR / MD) ➢ Safer staffing reviewing establishment levels (DNQ) ➢ Working in partnership across W Yorks on international recruitment. (DHR) ➢ Development of Physician Associate role (DHR / MD)	DHR	Ongoing given external influenc e outside our control	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performanc e report)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO 2 & 3	Every three months prior to business and risk Trust Board – July 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. ➢ Exit interviews. ➢ Flexible working guidance. ➢ Flexible working arrangements promoted. ➢ Investment in health and well-being services. ➢ Retire and return options. ➢ Apprenticeship scheme balancing the age profile. ➢ Recruitment and Retention action plan agreed.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Workforce planning includes age profile (DHR)	DHR	Ongoing	EMT and Trust Board reporting through IPR (monthly) RTSC exception reports	6 Yellow / moder ate (4-6)	RTSC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 2018
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	➢ Absence management policy. ➢ Occupational Health service. ➢ Trust Board reporting. ➢ Health and well-being survey. ➢ Enhanced occupational health service. ➢ Well-being at Work Partnership Group. ➢ Health trainers. ➢ Well-being action plans. ➢ Core skills training on absence management. ➢ Extend use of e-rostering. ➢ Retention plan developed.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Wellbeing plan to be established in each BDU (ALL)	DHR	31/08/1 8	BDU (weekly) EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	RTSC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 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
1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and DES.	➢Annual Equality Report. ➢Equality and Inclusion Form. ➢Equality Impact Assessment. ➢Staff Partnership Forum. ➢Development of joint WRES and EDS2 action plan. ➢Targeted career promotion in Schools. ➢Focus development programmes. ➢Review of recruitment with staff networks complete. ➢Actions identified in the equality and diversity annual report 2017/18.	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	➢ Establishment of staff disability network and LGBT network (DHR) (September 2018) ➢ Links with Universities on widening access (DHR / DNQ)	DHR	Ongoing	EMT (quarterly) E&I Forum (quarterly)	6 Yellow / moderate (4-6)	RTSC E&I Forum	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 2018
1158	Risk of over reliance on agency staff which could impact on quality and finances.	➢Board self-assessment. ➢Reporting through IPR. ➢Safer Staffing Reports. ➢Agency induction policy. ➢Authorisation levels for approval of agency staff now at a senior level. ➢Restrictions on Administration and Clerical Staff. ➢Extension of the Staff Bank. ➢Development of Medical Bank. ➢OMG to Overview. ➢Director of Delivery supporting reduction in agency usage. ➢Retention plan developed.	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	➢ Recruitment to Consultant Roles (DHR / MD) (September 2018) ➢ Development of new roles e.g. Advanced Clinical Nurse Practitioners to reduce the need for medical locum (DNQ)	DHR	September 2018	EMT (monthly) Board (monthly)	6 Yellow / moderate (4-6)	RTSC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 2018
1169	Risk that improvements in performance against the metrics covering open referrals, unvalidated 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. ➢A regular summary is reviewed at Operational Management Group (OMG) to track progress	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	➢ Track movement in performance (DD)	DFR	Ongoing	ICIG OMG	3 Green / low (1-3)	CG&CS	Risk appetite: Financial risk target 1 - 6 Links to BAF, SO3	Every three months prior to business and risk Trust Board – July 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 ➢Existing data protection policies reviewed and compliant by 25 May 2018 ➢Attendance at Yorkshire & Humber IG meetings ➢Internal audit completed on readiness and all actions closed ➢Training provided by Deloitte to Board members ➢Regular updates to Board and audit committee	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	➢GDPR compliance plan submitted to EMT 16 May 2018 by Julie Williams. ➢Closure of internal audit GDPR audit action plan completed by 31 May 2018. ➢Update report on progress presented to June 2018 Trust Board. ➢Implementation plan monitored by ICIG group which includes the update of policies and staff awareness training (DFR / DNQ) ➢React to national guidance when provided (DFR / DNQ)	DFR DNQ	Implementation plan – 31/10/18	Regular reports to ICIG group Reports to Audit Committee	6 Yellow / moderate (4-6)	AC	Risk appetite: Compliance risk 1 – 6 Links to BAF, SO3	Every three months prior to business and risk Trust Board – July 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
							➢ Ongoing actions to complete internal audit recommendations (DFR / DNQ) ➢ Progress updates at EMT and Audit Committee (DFR / DNQ)							
1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	➢ Bed management process. ➢ Joint action plan with commissioners. ➢ Internal bed management programme board. ➢ Weekly oversight at EMT and OMG. ➢ In-depth financial reviews at OMG, EMT and Trust Board.	3 Moderate	4 Likely	12 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	➢ Completion of actions identified on joint action plan (DD) (October 2018) ➢ Review financial risk share with commissioners (DFR) (December 2018)	DD / DFR	December 2018	OMG monthly EMT monthly Trust Board monthly	4 Yellow / moderate (4-6)	Trust Board	Risk appetite: Financial risk 1 – 6	Every three months prior to business and risk Trust Board – July 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)	Minimal / low – cautious / Moderate (1-6)	Yellow/ Moderate (4-6)
773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	Amber / high (8-12)	Open / high (8-12)	Yellow/ Moderate (4-6)
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.	Amber / high (8-12)	Open / high (8-12)	Amber / high (8-12)
1004	Risk that a decentralised model for health records results in inconsistent application of standards and / or loss of health records.	Yellow / moderate (4-6)	Open / high (8-12)	Yellow/ Moderate (4-6)
1156	Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy.	Yellow / Moderate (4-6)	Minimal / low – cautious / moderate (1-6)	Yellow/ Moderate (4-6)
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.	Amber / high (8-12)	Open / high (8 – 12)	Amber / high (8-12)
1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	Amber / high (8-12)	Open / high (8 – 12)	Amber / high (8-12)

Risk profile – Trust Board 31 July 2018

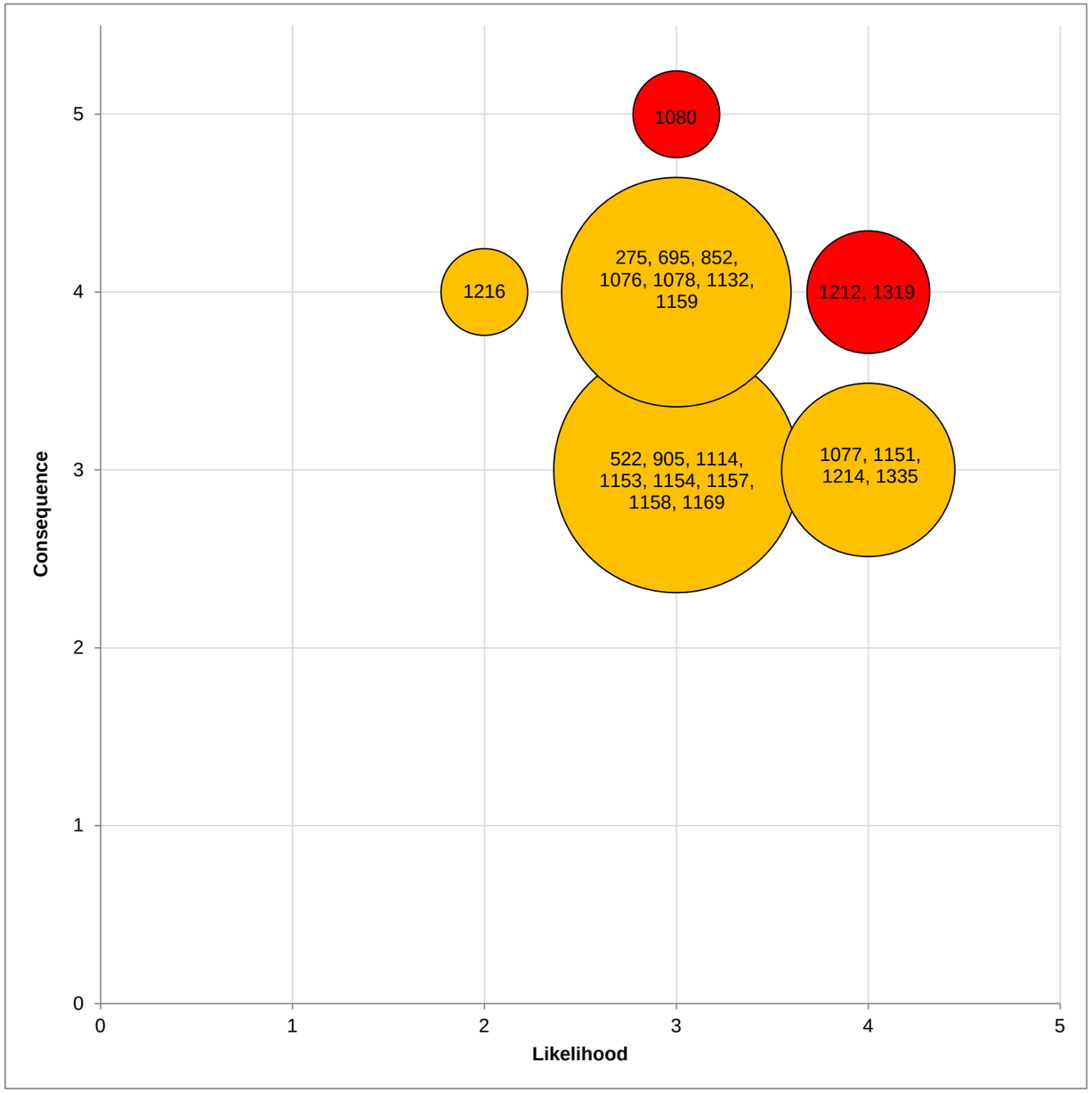
South West Yorkshire Partnership NHS Foundation Trust

Consequence (impact / severity)	Likelihood (frequency)				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)			= Risk that 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 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)	= Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding. (275) = Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy. (695) = Risk of information governance breach leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk. (852) = 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) = Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment. (1078) = Risks to the Trust's reputation caused by long waiting lists delaying treatment and recovery. (1132) = Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity. (1159) RA (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. (1212) ! Quality of care will be compromised if people continue to be sent out of area. (1319)	
Moderate (3)			= Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements. (522) = Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications. (905) = Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan. (1114) < 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) = Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc. (1154) = Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and DES. (1157) = Risk of over reliance on agency staff which could impact on quality and finances. (1158) = 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) = 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. (1151) = Risk that local tendering of services will increase, impacting on Trust financial viability. (1214) ! Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total. (1335)	
Minor (2)			RA (275), (522), (695), (852), (905), (1076), (1077), (1078), (1080), (1114), (1132), (1151), (1153), (1154), (1155), (1156), (1157), (1158), (1159), (1169), (1214), (1216), (1319), (1335)		
Negligible (1)					

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

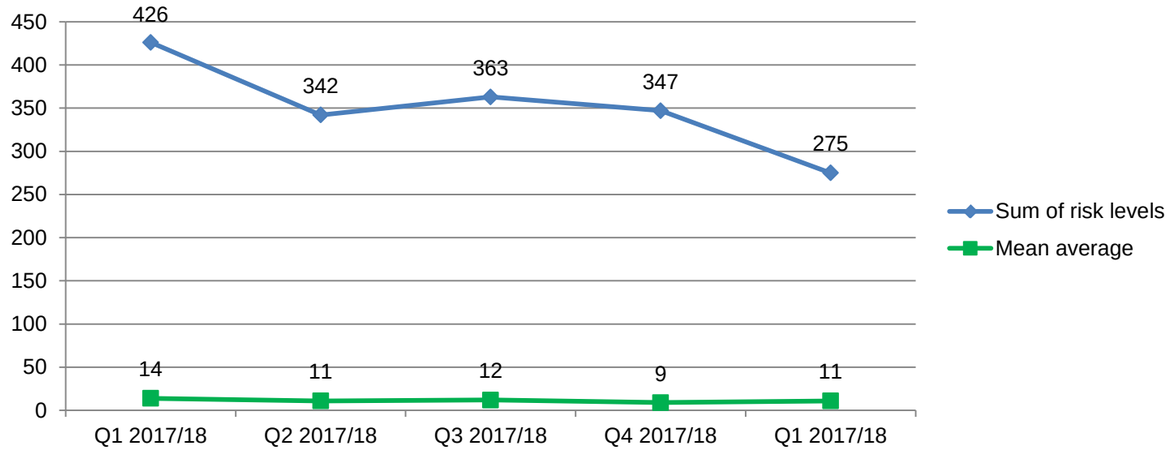
With **all of us** in mind.

Risk profile – Trust Board 31 July 2018



	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.
	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.
	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.
	1114	Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan.
	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.
	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.
	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.
	1214	Risk that local tendering of services will increase, impacting on Trust financial viability
	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.
	1319	Quality of care will be compromised if people continue to be sent out of area.
	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.

Average risk level 2017/18				**2018/19**
Q1 (31 risks)	**Q2** (31 risks)	**Q3** (33 risks)	**Q4** (35 risks)	**Q1** (23 risks)
14	**11**	**12**	**9**	**11**



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 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 Human Resources, Organisational Development and Estates and Director of Strategy
Purpose:	The purpose of this paper is to update the Trust Board on the developments within the South Yorkshire and Bassetlaw shadow Integrated Care System (sICS), including the Hospital Services Review and Barnsley CCG proposal for future health care provision.
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. 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), including the Hospital Services Review.
Executive summary:	**1. Hospital Services Review (HSR)** The South Yorkshire and Bassetlaw Collaborative Partnership Board met on the 8 June 2018 and discussed the HSR and agreed a briefing paper to be produced for Boards and Governing Bodies. Attached is the briefing paper prepared for Boards and Governing bodies. The Hospital Services Review engaged all the acute service providers across the South Yorkshire and Bassetlaw area and agreed to focus on five key services: ➢ Paediatrics ➢ Maternity ➢ Urgent and Emergency Care ➢ Gastroenterology and Endoscopy ➢ Stroke The major issues identified by clinicians were: ➢ Workforce ➢ Clinical Variation ➢ Uptake of Innovation ➢ IT systems The paper attached provides an update on work to date and next steps. The Trust has discussed the review on a number of occasions and has given general support to the direction of travel. The work on Stroke

	has a clear impact for the Trust and Barnsley Acute Hospitals. Both organisations are working in partnership to ensure an integrated approach and clear clinical pathways. The Trust responded to the Strategic Outline Case (SOC) in line with this position. The Trust has discussed the HSR at its public meeting previously and did respond to the consultation by the due date of the 12 July 2018, along the lines mentioned above. **2. Barnsley Place Based Commissioning** The Barnsley Clinical Commissioning Group (CCG) have been working with partners including the Trust to develop joined up integrated care. The CCG have been discussing with partner organisations, including the Trust, proposals for a new model for health care provision and commissioning for Barnsley involving an integrated care system. It was agreed by all the partner organisations that as part of the early engagement process, a series of Staff Side and Staff briefings should take place in July about the CCG proposals to develop a single integrated care organisation. A number of briefing sessions on the CCGs proposals have taken place in Barnsley and with corporate services **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board is asked to NOTE the update from the SYB sICS on the Hospital Services Review and the latest position on Barnsley's CCG proposals for a new model of service provision and commissioning.**
Private session:	Not applicable.

SYB ICS Briefing paper

for

Foundation Trust Boards and CCG Governing Bodies

on the

Independent Hospital Services Review

June 2018

Purpose

1. The purpose of this paper is to set out the next steps, timeline and requirements for Foundation Trust (FT) Boards and CCG Governing Bodies following the publication of the independent Hospital Services Review (HSR) report in public on the 9th May 2018.

2. The Collaborative Partnership Board received the report at its meeting on the 8th June and supported the review to be shared with Boards and Governing Bodies in public sessions.

3. The report will be discussed by the commissioners of the Joint Committee of Clinical Commissioning Groups (JC CCGs) on the 27th June to consider the commencement of detailed work including site-specific modelling to support the development of business cases.

4. The SYB Providers Working Together Committees in Common (CsIC) will receive the report on the 2nd July.

5. Boards and Governing Bodies are asked to receive the report and provide their comments to feed into the next stages. Comments received will be used to inform the development of the Strategic Outline Case (SOC) which will set out the SYBMYND system's response to the Hospital Services Review. The SOC will be presented to the Joint Committee of Clinical Commissioning Groups (JC CCG) on 25th July, for support as part of the mandated NHS England assurance process and to the Collaborative Partnership Board (CPB) on 10th August.

6. **Please send comments following Board and Governing Body discussions to** Jane Anthony **jane.anthony1@nhs.net** by 12th July 2018.

HSR Background

7. In April 2017 the Chief Executives and Chairs of the five South Yorkshire and Bassetlaw (SYB) NHS Foundation Trusts, Chesterfield Royal Hospital NHS Foundation Trust and the Mid Yorkshire Hospitals NHS Trust agreed to fully engage in an independent review of hospital services across the SYB. The Review was also fully supported by the SYB commissioners comprising of Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG and Sheffield CCG.

8. The purpose of the review was to identify vulnerable services which required a different model of delivery to achieve sustainability and resilience for the future, and to consider the future role of the District General Hospital.

9. The Hospital Services Review was launched in June 2017 with a remit to develop ways in which acute services within SYBMYND can be put on a sustainable footing for the long term. It was an independent review supported by all members of the SYB ICS.

Summary of the Hospital Services Review

10. The Review examined all the acute services provided in SYBMYND and through an agreed methodology five services were identified as the focus of the Review: paediatrics, maternity, urgent and emergency care, gastroenterology and endoscopy, stroke. Major issues identified by clinicians included workforce; clinical variation across trusts; and the uptake of innovation including IT systems.

HSR Recommendations

11. The majority of the recommendations in the Review focus on transformation, through shared working between the trusts. There are also recommendations to undertake site-specific modelling of reconfiguration in a number of areas which are outlined in the report.

Shared working transformation.

11.1 The HSR identified a large number of challenges which the Clinical Working Groups felt could be addressed through better shared working between the Trusts. Recommendations were developed around a series of Hosted Networks, linked to the new integrated regulatory functions of the ICS. These would see one trust leading on each of the specialties, to deliver a number of workforce functions, addressing clinical variation, and developing innovation.

11.2 A number of the SYBMYND Trusts are already working together in some of these ways, and the intention is to support this shared working to develop to the next level as the Integrated Care System develops.

Reconfiguration

11.3 In some cases, the scale of the workforce challenges was so great that the HSR concluded that sustaining services could not be addressed through shared working alone. The Review considered a number of possible reconfiguration options for the services within South Yorkshire and Bassetlaw and North Derbyshire, and evaluated them. (Mid Yorkshire was excluded because it has already completed a reconfiguration.)

11.4 The reconfiguration recommendations of the Review are shown in Figure 1:

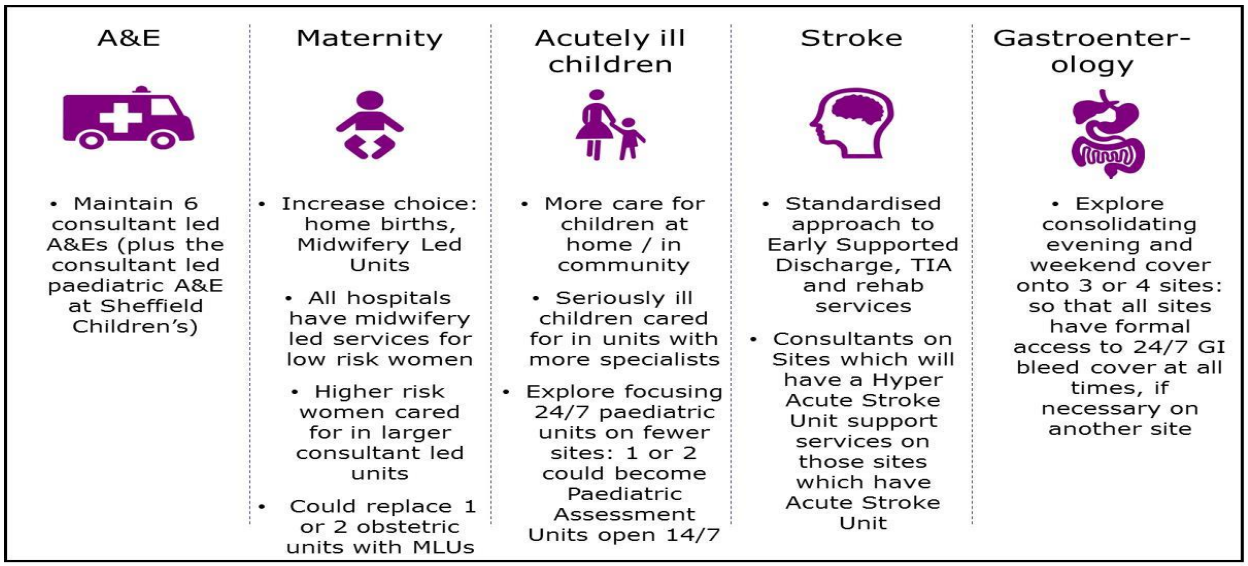


Figure 1: Recommendations of the HSR around reconfiguration

11.5 Whilst reconfiguration is likely to be the focus of much of the public's attention on the Review, the majority of the recommendations are focussed on the transformational element of the Review's proposals around shared working. It is important that this priority is not lost going forward.

11.6 The reconfiguration options as they are known so far are being used to inform the current capital bid for SYB ICS. The exact scope of reconfiguration options is not known. However, there will only be one opportunity to bid for capital funding for the next 5 years so the bid is being prepared using a number of agreed assumptions.

Engagement with the public and staff

12. The HSR team has engaged widely with the public during the development of the Review and its recommendations. The engagement consisted of the following strands:

12.1 Public

- **Citizens' Panel**: Establishment of a Citizens' Panel which has advised on the public engagement process and has helped to draft the public-facing materials;
- **Online presence**: An online survey; a website which contains all the documents for the Review as well as animations and videos explaining the proposals; social media;
- **Public events**: Three events open to any member of the public; specific engagement events in individual Places and in the reception areas of some acute providers;
- **Telephone survey**: A telephone survey of 1000 people designed to mirror the demographic makeup of the area.

12.2 Seldom heard groups

- **Targeted engagement**: interviews and group sessions with 96 members of seldom heard groups, e.g. young carers, BME groups, asylum seekers and the Deaf community.
- **Young patients**: involvement with the Youth Forum of Sheffield Children's Hospital, which includes patients under the age of 16 from across SYBMYND.

12.3 Clinicians and staff

- **Clinical Working Groups:** Engagement with clinicians via Clinical Working Groups for each specialty, each of which has met for five workshops. These groups have a remit to communicate with the wider staff body in their trusts
- **Briefings in Trusts** to engage the wider workforce.

12.4 Further engagement

- **Patients, the public and staff** have an opportunity to send their comments on the HSR by 12 July. This will ensure that their feedback is taken into consideration in the development of the Strategic Outline Case.

Next Steps - Implementing the Review Timeline

The high level timeline is set out below:

Agreeing the system response to the HSR – June to September 2018

13. All responses to the Review should be submitted by 12th July 2018 to inform the SOC which will set out the system's response to the HSR. The SOC will be discussed with the Executive Steering Group on 17th July and the JCCCG on 25th July. It is expected to be signed off by the Collaborative Partnership Board in September.

NHS England Gateway assurance process - June 2018

14. The total financial cost of the services covered in the independent Review triggers the national assurance for service change process (>£500m). The assurance process will be led by NHS England (North Region) and will oversee from a scrutiny perspective the development of the business cases and planning arrangements. The North East Senate has agreed to undertake the clinical review assurance process with NHSE. The first step (gateway 1) is planned to commence at the end of June.

Preparatory work over the summer (June-September)

15. In order to ensure that work can proceed as quickly as possible once the Collaborative Partnership Board has agreed the SOC, a number of workstreams will be progressed over the summer as the work shifts to implementing the recommendations once accepted. This work focusses on preparing information or processes to be ready for the autumn - none of which pre-empts decision making on the system's response to the HSR.

16. **Preparing governance:** The ICS team will refresh the proposed governance of the Steering Group and clinical working groups. A part of this will be a review of which of the HSR recommendations can be taken forward as part of the core business of the ICS including next phase of work on provider development. A travel and transport reference group will also be established. The refreshed membership will inform the Terms of Reference for the next stage of the review, which will be signed off by the CPB. The ICS is also working with partners to consider any changes that are required to the wider governance in preparation for next stage of ICS development.

16.1 **Preparing data**: Whilst it is not yet clear which reconfiguration options the system will

decide to take forward, the model can be mapped and data collected as necessary to explore any options. To do this, a small Senior Stakeholder Group will be convened which has been discussed by the HSR Steering Group. The Senior Stakeholder Group (including finance, estates and operational leads, and clinicians) will help to design the specification for the model, and advise on data requirements to populate it. Data collection will begin in July so that the data is in place to start building the model once the CPB has agreed which recommendations and options are in scope.

16.2 **Desk research and internal thinking**. We will begin some desk research in three main areas: the approaches that other systems have taken to modelling reconfiguration options; the approaches that other systems have taken to shifting activity out of hospital; and evidence on the safety of transfer times. We will also start some thinking within the ICS to map the process for developing Hosted Networks. This work will then inform discussions with clinicians once the CPB has agreed the way forward.

16.3 **Tendering for support**. The tendering process for support on reconfiguration modelling has commenced. The contract will not be issued until after the Executive Steering Group has discussed the feedback from Boards and Governing Bodies and the direction of travel is clear.

Programme Governance

17. The governance of the HSR programme is being currently being updated, now that its focus has moved from an independent review to implementing change. The HSR programme will work through the ICS governance processes and will continue to report to the CPB.

18. The membership of the HSR Steering Board is also being updated to ensure representation from medical directors and nursing / operational leads from all trusts; commissioning representation from all CCGs; primary care; community care; and the ambulance services. There is also likely to be a number of Clinical Working Groups for each HSR programme specialty established.

Recommendations

Members of FT Boards and CCG Governing Bodies are asked to:

- note the content of the paper including process and next steps of the HSR
- to provide comments following board and Governing Body meetings in public to **Jane.Anthony1@nhs.net** by 12th July
- Confirm acceptance of the Review recommendations on behalf of their organisation.

Paper prepared by
Alexandra Norrish, HSR Programme Director
Alexandra.Norrish@nhs.net

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 7.2

Title:	**West Yorkshire & Harrogate Health and Care Partnership (WYHHCP) update**
Paper prepared by:	Director of Strategy
Purpose:	The purpose of this paper is to provide the Trust Board with an update on the development of the West Yorkshire & Harrogate Health and Care Partnership (WYHHCP)
Mission/values:	The development of joined up care through place-based plans is central to the **Trust's strategy**. As such it is supportive of our mission, particularly to **help people to live well in their communities.** **The way in which the Trust approaches strategy and strategic developments must be in accordance with our values**. The approach is in line with our values - **being relevant today and ready for tomorrow**. This report aims to assist the Trust Board in shaping and agreeing the strategic direction and support for collaborative developments that support the Trusts strategic ambitions.
Any background papers/ previously considered by:	Strategic discussions and updates on place based plans have taken place regularly at Trust Board including an update to June Trust Board.
Executive summary:	The Trust Strategy refresh outlines the importance of the Trust's role in each place it provides services, including the WYHHCP. Progress and key developments are summarised below: **Integrated Care System- National Memorandum of Understanding (MoU)** As part of becoming a Shadow Integrated Care System (ICS) the ICS has been asked to sign up to the National ICS MoU. This document sets out the terms of the agreement between the WYHHCP partnership and NHS England / NHS Improvement with a specific focus on 2018/19. The expectation is that it will be refreshed annually. This is work in progress and will be shared with partner organisations including Trust Board once it is complete. **WYHHCP MoU** The Draft MoU has been in development since November 2017. There has been significant engagement from all partner organisations, Health & Wellbeing Boards and Council Cabinets. It is anticipated that the MoU will be available for formal sign off at the Trust Board in September 2018.

With all of us in mind.

WYHHCP revised Collaborative governance arrangements

A new Partnership Board will be established in 2018/19 to provide formal leadership. The Board will be responsible for setting strategic direction and have oversight of all Partnership business. The Board will be made up of the chairs and CEOs of all NHS organisations, chairs of Health & Wellbeing Boards, Council CEOs and senior representatives from other partner organisations.

The System Leadership Executive (SLE) Group will continue to meet and will include representation from across the partnership. This group will be responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for shared objectives.

A new System Oversight and Assurance Group (SOAG) will be established in 2018/19 to provide a mechanism for partner organisations to take ownership of system performance and delivery. It will be chaired by the Partnership and Trust CEO Lead Rob Webster and include representation covering each sector / type of organisation. It will regularly review a dashboard of key performance and transformation metrics and receive updates from West Yorkshire and Harrogate programme boards.

WYHHCP Public Panel Workshop held on the 10 July 2018 in Leeds. The main aim of the workshop was to strengthen public engagement and involvement in the work of the partnership.

West Yorkshire Mental Health Services Collaborative (WYMHSC) joint Non-Executive Director & Governor event was held in Leeds on 17 July 2018, following on from the event held in February 2018. It provided an update on the work of the WYHHCP & WYMHSC and opportunity for participants to engage in discussions related to the programmes.

Mental Health programme update - Progress is being made against all programmes as reported through the Trust Integrated Performance Report (IPR).

Risk Appetite

The development of key partnerships within each place-based plan is in line with the Trust's risk appetite supporting the development of strategic partnerships that enhance the Trusts sustainability. Risks to the Trust services in each place will need to be reviewed and managed as the partnerships develop to ensure that they do not have a negative impact upon services, clinical and financial flows.

Recommendation:	**Trust Board is asked to RECEIVE the update and DISCUSS and COMMENT on the development of the West Yorkshire & Harrogate Health and Care Partnership.**
Private session:	Not applicable.

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 8.1

Title:	**Integrated Performance Report Month 3 2018/19**
Paper prepared by:	Director of Finance and Director of Quality & Nursing
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for June 2018.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	➢ IPR is reviewed at Trust Board each month ➢ IPR is reviewed at Executive Management Team meeting on a monthly basis
Executive summary:	**Quality** ➢ Safer staffing fill rates continue to be maintained but significant pressures remain in terms of recruitment and patient acuity. ➢ The three admissions of under 18's to acute mental health wards remains concerning. Appropriate safeguards are in place and we recognise the need for adoption of the least worst option. ➢ Complaints closures times still require improvement. The reduction in the number of formal complaints as a result of the new system is positive. ➢ Important information is being realised as a result of our new structured judgement reviews in our mortality review process. **NHS Improvement Indicators** ➢ The Trust continues to meet the majority of national performance metrics. ➢ Inappropriate out of area bed placement reduction target is currently not being achieved. ➢ A notable reduction in improving access to psychological therapies (IAPT) proportion of people completing treatment and moving to recovery in-month, but remains slightly above target. ➢ Total bed days of Children and Younger People in adult inpatient wards increased from 0 to 14 and covered three individuals. **Locality** ➢ New service model for IAPT in Barnsley due to commence from 1 August 2018. Some staff transferring to Kirklees services. ➢ Focus on length of stay in mental health services across Barnsley. ➢ Pressure on inpatient wards remains high across all geographies. ➢ Occupancy in forensic learning disability wards being discussed with commissioners.

With all of us in mind.

	➢ High number of vacancies in Forensic Child & Adolescent Mental Health Services (CAMHs) and Learning Disability inpatient services. **Priority Programmes** ➢ Work has commenced to implement criteria led discharge across all inpatient units. ➢ SystmOne training sessions have taken place for medical and performance & innovation staff. ➢ First phase of data migration testing has been completed and went well. ➢ Discussions taking place with commissioner regarding older people's service transformation. **Finance** ➢ Net deficit of £464k in month which is a significant deterioration compared to April and May 2018. ➢ Cumulative deficit is now £959k. The run rate is adverse to the full year plan. ➢ Agency costs of £484k in month were 3% below the cap and a 10% reduction compared to May 2018. ➢ Net pay savings of £0.2m year-to-date. ➢ Out of area bed expenditure amounted to £349k. Cumulatively expenditure is now £1.1m which is 69% higher than the corresponding period for 2017/18. ➢ Year-to-date CIP delivery of £2.0m is £0.1m lower than plan. ➢ Cash balance of £19.8m was adversely impacted by delayed payments by two commissioners. ➢ Financial risk rating of 3 given the deficit margin. **Workforce** ➢ Sickness absence reduced to 4.4% in June 2018 – favourable to our internal target. ➢ Staff turnover is 11.6% year-to-date. ➢ Appraisal completion of Nand 6 and above stands at 72%.
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**
Private session:	Not applicable.

NHS
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Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

June 2018

With **all of us** in mind.

NHS
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Introduction

Please find the Trust's Integrated Performance Report (IPR) for June 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. During May 18, the Trust undertook work to review and refresh the summary dashboard for 2018/19 to ensure it is fit for purpose and aligns to the Trusts new objectives for 2018/19. All updates are now incorporated. This report includes matching each metric against the updated Trust objectives. It is recognised that for future development, stronger focus on outcomes would be beneficial.

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 and have been reviewed and refreshed for 2018/19.

KPI	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-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**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Year End Forecast**
Total number of children & young people in adult inpatient wards [5]	0	2	3	2	3	1	2	2	1	3	1	0	3	1
% service users followed up within 7 days of discharge	95%	93.3%	97.2%	96.1%	94.7%	98.2%	98.2%	97.2%	98.0%	95.8%	94.3%	99.2%	100%	4
% clients in settled accommodation	*60%*	81.8%	81.8%	80.8%	80.7%	80.4%	80.4%	80.1%	79.7%	79.1%	78.9%	78.5%	*79.0%*	4
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]	95%		87.5%			86.8%			87.8%			86.7%		95%
Out of area beds [2]	Q1 940, Q2 846, Q3 752, Q4 658	341	362	424	467	412	407	268	613	730	536	284	375	1
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA Community	Inpatient 90% Community 75%											79.8%	81.1%	4
Inpatient [9]												89.1%	90.6%	4
Smoking Cessation [8]												KPI Under Development		
Improve the quality and experience of care	**Target**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Year End Forecast**
Friends and Family Test - Mental Health	85%	89%	79%	85%	86%	86%	85%	85%	85%	87%	86%	75%	82%	85%
Friends and Family Test - Community	98%	95%	99%	99%	97%	98%	100%	97%	97%	99%	97%	100%	98%	98%
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) [4]	trend monitor	29	28	25	28	34	26	33	37	20	27	25	25	N/A
Safer staff fill rates	90%	112.6%	109%	111.8%	112.9%	115.7%	113.4%	117.1%	117.5%	115.7%	118%	120%	118%	100%
IG confidentiality breaches	<=8 Green, 9 -10 Amber,	6	10	6	5	12	7	7	10	4	8	11	14	
% people dying in a place of their choosing	80%			83%	91%	89%	88%	94%	84%	87%	83%	89%	*80%*	N/A
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic [7]	trend monitor		13.6%			15.1%			9.0%			15.1%		N/A
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [3]	trend monitor	Reporting Established from April 2018									36.3%	37.1%	33.2%	N/A
Improve the use of resources	**Target**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Year End Forecast**
Projected CQUIN Shortfall	£4.2m	£869k	£856k	£856k	£856k	£856k	£136k	£136k	£136k	£203k	-	£160k	£252k	£252k
Surplus/(Deficit)	In line with Plan	£204k	£226k	£6k	£158k	£235k	£551k	£635k	£1186K	£1139K	(£292k)	(£204k)	(£464k)	(£2626k)
Agency spend	In line with Plan	£457k	£446k	£435k	£515k	£531k	£430k	£465k	£563K	£555K	£444k	£538k	£484k	£5.3m
CIP delivery	£1074k	£2306k	£2950k	£3452k	£4117k	£4815k	£5442k	£6157k	£6816k	£7475k	£619k	£1308k	£1981k	£9.7m
Sickness absence	4.5%	4.8%	4.9%	4.9%	4.9%	5.0%	5.1%	5.2%	5.3%	5.3%	4.6%	4.5%	4.4%	4.9%
Aggression Management training	>=80%	76.6%	77.0%	77.6%	76.4%	79.0%	78.0%	77.9%	78.2%	79.3%	79.3%	81.7%	81.6%	80%
Moving and Handling training	>=80%	79.3%	79.3%	79.3%	80.7%	81.6%	81.9%	84.1%	85.4%	85.5%	85.2%	85.9%	85.6%	80%
Staff Turnover [6]	10%	10.3%	10.7%	11.7%	11.4%	12.1%	12.3%	12.4%	12.5%	12.6%	9.7%	8.5%	11.6%	11.0%

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

Notes:
1 - 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 introduced during 17/18 and counts first contact with service post referral. Under performance is generally due to waiting list issues. To mitigate this, the service have a management process in place for waiting lists across all our 4 community localities – generally, waits occur due to medium to long term absence within a specific locality discipline and as the member of staff returns to work the waits reduce. Specific issues are being addressed with locality commissioners where appropriate. The waiting lists are reviewed by leads regularly and allocated by clinical priority.
2 - Out of area beds - From April 18, in line with the national indicator this identifies the number of inappropriate out of area bed days during the reporting month - the national definition for out of area bed is: is a patient that is admitted to a unit that does not form part of the usual local network of services. This is for inappropriate admission to Adult Acute and PICU Mental Health Services only.
3 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date.
4 - 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.
5 - further detail regarding this indicator can be seen in the National Metrics section of this report.
6 - Introduced into the summary for reporting from 18/19.
7 - Introduced into the summary for reporting from 18/19. Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other
8 - Work has taken place to identify a suitable metric across all Trust smoking cessation services. The metric will identify the 4 week quit rate. It is anticipated that Q1 data will be available in August18.
9 - The figure shown is the proportion of eligible clients with a cardiometabolic assessment. This may not necessarily align to the CQUIN which focuses on the quality of the assessment.

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 2017 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 relates to our 16/17 agency expenditure performance and our financial risk.

Areas to Note:
Quality
• Safer staffing fill rates continue to be maintained but significant pressures remain in terms of recruitment and patient acuity
• The 3 admissions of under 18's to acute mental health wards remains concerning. Appropriate safeguards are in place and we recognise the need for adoption of the least worst option
• Complaints closures times still require improvement. The reduction in the number of formal complaints as a result of the new system is positive.
• Important information is being realised as a result of our new structured judgement reviews in our mortality review process

NHS Indicators
• The Trust continues to meet the majority of national performance metrics
• Inappropriate out of area bed placement reduction target is currently not being achieved
• A notable reduction in IAPT proportion of people completing treatment and moving to recovery in-month, but remains slightly above target
• Total bed days of Children and Younger People in adult inpatient wards increased from 0 to 14 and covered 3 individuals

Locality
• New service model for IAPT in Barnsley due to commence from August 1st. Some staff transferring to Kirklees services
• Focus on length of stay in mental health services across Barnsley
• Pressure on inpatient wards remains high across all geographies
• Occupancy in forensic learning disability wards being discussed with commissioners
• High number of vacancies in Forensic CAMHs and Learning Disability inpatient services

Priority Programmes
• Work has commenced to implement criteria led discharge across all inpatient units
• SystmOne training sessions have taken place for medical and performance & innovation staff
• First phase of data migration testing has been completed and went well
• Discussions taking place with commissioner regarding older people's service transformation

Finance
• Net deficit of £464k in month which is a significant deterioration compared to April and May
• Cumulative deficit is now £959k. The run rate is adverse to the full year plan
• Agency costs of £484k in month were 3% below the cap and a 10% reduction compared to May
• Net pay savings of £0.2m year-to-date
• Out of area bed expenditure amounted to £349k. Cumulatively expenditure is now £1.1m which is 69% higher than the corresponding period for 2017/18.
• Year-to-date CIP delivery of £2.0m is £0.1m lower than plan
• Cash balance of £19.8m was adversely impacted by delayed payments by two commissioners
• Financial risk rating of 3 given the deficit margin

Workforce
• Sickness absence reduced to 4.4% in June.
• Staff turnover is currently reported at 11.6%
• Appraisal completion of band 6 and above is currently 84%

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	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-18	Jun-18	Year End Forecast Position *
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	KT/SR/CH	TBC	Reporting Established from April 2018								36.6%	37.7%	33.2%	N/A
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%				28% 11/39	12.7% 8/63	12% 6/50	9.3% 4/43	29% 2/7	20% 2/10	21% 6/28	21% 2/7	1
	% 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	19.8% 43/217	18.2% 38/208	7.7% 13/168	16% 10/64	5% 3/57	10% 5/50	12% 11/88	4
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	72%	71%	71%		84%	84%	86%	86%	86%	75%	82%	4
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	98%	98%	99%	98%	98%	98%	98%	97%	100%	98%	4
Quality	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%	74%	75%	N/A	76%	N/A		75%	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%	60%	64%	N/A	67%	N/A		70%	N/A
	Number of compliments received	Improving Health	Caring	TB	N/A	Data not avail until Oct 16.		141	81	81	113	148	64	26	109	44	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	N/A	73	86	83	86	337				21	22	Due Aug 18	N/A
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	N/A	Reporting established from Oct 16		0	2	26				0	0		N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	Reporting established from Oct 16		0	1	1		2	1	0	0		
	% 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%	85.6%	85.0%	84.9%	86.3%	85.8%	86.2%	4
	Un-outcomed appointments [6]	Improving Health	Effective	KT/SR/CH	TBC		2.2%	2.9%	2.6%	4.3%	3.3%	2.5%	2.5%	5.4%	4.3%	4.1%	N/A
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=8	36	25	29	36	33	22	24	21	8	11	14	
	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%	1.6%	2.3%	2.7%	3.7%	2.7%	2.1%	2.6%	4
	Number of records with up to date risk assessment	Improving Care	Effective	KT/SR/CH	TBC	KPI under development											N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	3509	3405	3293	2946	2849	3065	2962	3441	1074	1084	1016	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	trend monitor					57	58	56	72	23	14	19	N/A
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	10	19	19	20	3	8	9	7	2	1	2	N/A
	Total number of patient safety incidents resulting in death harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	73	79	73	84	12	17	24	11	2	10	4	N/A
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	*17.7%*	16.8%	17.7%	Data not avail	18.70%	18.2%	24.3%	16.5%	20.5%	19.9%	20.6%	18.4%	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%					109%	111.1%	114%	116.8%	118%	120%	118%	4
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%					107%	94.1%	99%	98.4%	99.2%	100%	99.5%	4
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	N/A	98	95	78	86	82	92	71	98	30	29	29	N/A
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	0	1	4	3	2	2	1	2	2	0	0	1	3
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	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%	75%	80%	77%	76%	80%	61%	75%	4
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	162	158	136	95	139	139	150	181	40	40	44	N/A
	Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	Data not avail				345	424	442	589	173	211	143	N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	1	2	1	0	0	0	0	0	0	4
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	4
Quality	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%	78.4%			4

** 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.

5 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date.

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 - 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.

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.

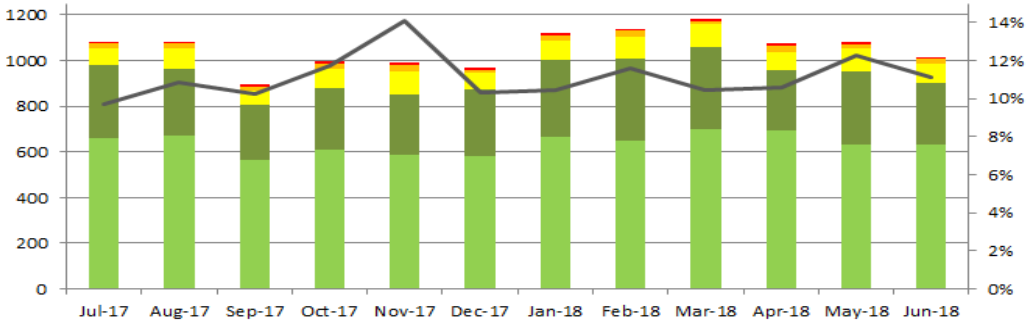
Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.

- The total number of all restraints incidents reported has decreased by 71 during the month to 134 and is below the mean number of restraints over the past 24 months which is 147.96. 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 inpatient 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 in-patient medicine omissions in Mental Health Trusts is just below 15%. At the end of quarter 1, SWYPFT average is 19.6%. Older Peoples services have made a concerted effort to improve their patient compliance as historically patient refusal was by far the biggest reason for medication omissions. Their combined Q1 rate is now 15.2% which is almost at the national average. Unfortunately working age adult services in the remains above the national average and their combined Q1 average is now 19.8%. Learning disability in-patient services have uncharacteristically been recording some medication omissions in the quarter. This is due to the low bed numbers, only have 6 beds and recorded 1 patient refusal for April and 1 absent from meds rounds for May. The two omissions record mathematically higher percentages but in reality only equate to 2 omissions in the quarter.
- Number of falls (inpatients) - Late 2017/18 saw a spike un the number of falls. The number of falls reported in April and May 18 had decreased, however June is showing a slight increase in month. On investigation, this relates to Calderdale older people wards who have seen an increase in agitated complex patients either having alterations or who are physically unwell. Wakefield BDU have also seen an increase in falls in the month due to an increase in patients with organic illness on Chantry ward, to mitigate along with the usual falls procedures, the service have increased the levels of within eyesight observations.
- 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.

Safety First

Summary of Incidents during 2017/18 and 2018/19

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



	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Red (should not be compared with SIs)	10	6	14	12	12	11	8	7	9	8	11	7
Amber	18	25	16	21	28	14	23	30	15	27	18	21
Yellow	77	87	62	84	100	75	86	95	100	79	104	85
Green	317	297	242	272	263	290	337	357	360	268	316	271
Green no harm	662	669	563	608	590	582	665	650	699	692	635	632
Total	1084	1084	897	997	993	972	1119	1139	1183	1074	1084	1016
Percentage of total that are Red/Amber/Yellow *	9.7%	10.9%	10.3%	11.7%	14.1%	10.3%	10.5%	11.6%	10.5%	10.6%	12.3%	11.1%

** A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety). The distribution of these incidents shows 89% are low or no harm incidents.*

Safety First cont…

Summary of Serious Incidents (SI) by category 2017/18 and 2018/19

	Q1 18/19	Q2 17/18	Q3 17/18	Q4 17/18	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May-18	Jun-18	Total
Administration/supply of medication from a clinical area	0	1	1	0	1	0	0	0	1	0	0	0	0	0	0	0	2
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Fire / Fire alarm related incidents	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Formal patient absent without leave	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Information disclosed in error	0	1	2	0	0	0	1	0	2	0	0	0	0	0	0	0	3
Self harm (actual harm) with suicidal intent	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	1
Suicide (incl apparent) - community team care - current episode	4	10	14	6	5	2	3	4	5	5	2	3	1	1	3	0	34
Suicide (incl apparent) - community team care - discharged	2	2	2	0	1	0	1	1	0	1	0	0	0	0	0	2	6
Suicide (incl apparent) - inpatient care - current episode	0	0	2	2	0	0	0	0	1	1	1	0	1	0	0	0	4
Allegation of violence or aggression	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	1
Physical violence (contact made) against staff by patient	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Physical violence (contact made) against other by patient	0	1	1	1	0	0	1	1	0	0	0	0	1	0	0	0	3
Pressure Ulcer - grade 3	1	1	3	1	1	0	0	1	1	1	1	0	0	0	0	1	6
Total	8	18	26	12	9	2	7	7	11	8	4	4	4	1	3	4	64

•Incident reporting levels have been checked and remain within the expected range.
• Degree of harm and severity are both subject to change as incidents are reviewed and outcomes are established.
• Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
• All serious incidents are investigated using Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
• Risk panel remains in operation and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report.
• No never events reported in June 18.

The information comes from a live system so is accurate at the time of reporting but is subject to changes following review by managers. This data set cannot be replicated at a future date as it will change.

The number of SIs in Q1 (8) has reduced substantially since 2017/18 Q4 (18) and Q3 (26), especially for suicides Q1 (6), Q4 (8) and Q3 (18). This reduction is welcomed and we will continue to monitor. We are unable to confirm if this is part of a longer-term downward trend in response to prevention initiatives, as the frequency of incidents is sensitive to multiple factors and regular fluctuations up and down. Year on year comparison, ideally over a 3-year rolling period, would be required to confirm a long-term trend.

The Bluelight alert process has been reviewed - see http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Bluelight-alerts.aspx

Assurance: 360 Assurance Internal audit report on Learning from Healthcare Deaths has been received giving Significant Assurance. Mortality review group workshop has been held and actions are being implemented.
Data quality: Following work with managers in the Autumn when the scope changed, we are now seeing improvements in reporting and quality of information in response to reported deaths.
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/
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 - currently being finalised
-Structured Judgement Reviews – 20 cases have been completed for reviews from 2017/18.
60% of reviews completed to date rated overall care as good or excellent
Structured Judgement Review (SJR) Themes
Risk assessment: 25% of cases reviewed were rated good or excellent
Allocation/Initial Review: 35% of cases reviewed were rated good or excellent
On-going Care: 60% of cases reviewed were rated good or excellent
Care During Admissions (where applicable): 62% of cases reviewed were rated good or excellent
Follow-up Management / Discharge: 62% of cases reviewed were rated good or excellent
50% of reviews completed to date rated the quality of the patient record as good or excellent overall care as good or excellent
The learning from healthcare deaths report includes examples of areas for improving practice identified by the reviewers, and also good practice examples.
Work to develop themes further continues as more reviews are completed.
Policy: The Learning from Healthcare Deaths policy will be completed when further national guidance is made available in consultation with Northern Alliance colleagues.

Since 2016 there has been a substantial increase in STEIS reported serious incidents in SWYPT, which require root cause analysis investigation. This placed significant pressure on our patient safety team resources, which led to delays in allocating investigations and an increase in the number of SI reports that were not completed within the 60-day time period. In response, we increased capacity within the patient safety team, commissioned external investigators and recruited staff from across the Trust with specialist knowledge and training in Root Cause Analysis. The management, coordination and supervision of these individuals has ensured that 1) the standard of the investigations remains of a high quality, 2) SIs are completed in a timely manner, 3) we are meeting the requirements of external agencies, and 4) staff have opportunities for personal development. This has led to a reduction of unallocated serious incidents and a reduction in SI reports rated as red from 15 in May 2017 to 7 in July 2018. Work is ongoing to improve the position further and updates will be included in future IPRs.

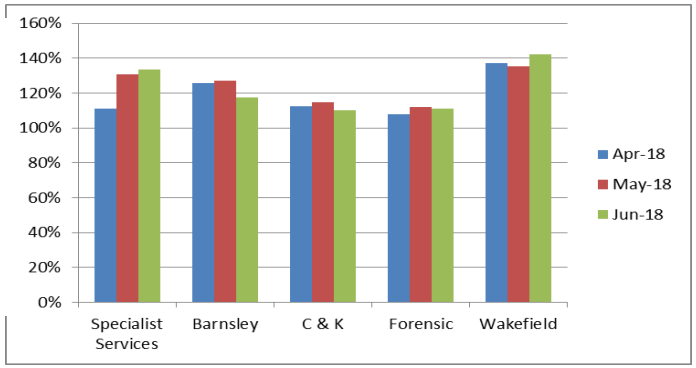
Safer Staffing

Overall Fill Rates: 118%
Registered fill rate: (day + night) 95.5%
Non Registered fill rate: (day + night) 137.4%

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

BDU Fill rates - April 18 - June 18

Overall Fill Rate (Area)	Month-Year		
Unit	Apr-18	May-18	Jun-18
Specialist Services	111%	131%	134%
Barnsley	126%	127%	117%
C & K	112%	115%	110%
Forensic	108%	112%	111%
Wakefield	137%	136%	142%
Overall	**118%**	**120%**	**118%**



Registered Staff: Days 92.7% (remained constant from May); Nights 106.4% (decrease of 0.6% on May)

Registered average fill rate: Days and nights 99.5% (decrease 0.5% on April)

Non Registered Staff: Days 134.1% (decrease of 2.0% on May); Nights 142.8% (decrease of 2.8% on May)

Non Registered average fill rate: Days and nights 137.4% (decrease of 1.1% on May)

Overall average fill rate all staff: 118.3% (decrease of 1.7% on May)

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

Safer Staffing cont…

Summary

For the tenth consecutive month, no ward fell below a 90% overall fill rate in June. Of the 31 inpatient areas listed 21 (67.2%) achieved greater than 100%. Indeed of these 21 areas, again 13 achieved greater than 120% fill rate.

Registered On Days (Trust Total 92.7%)

There has been an increase in the number of wards that have failed to achieve 80%, five wards in all (16%) compared to 2 (6.4%) in April. Within the Forensic BDU Chippendale increased by 7.6% to 75.6%, Appleton decreased by 0.9% to 70.1%, Waterton decreased by 18.7% to 79.4%. Within Barnsley Willow decreased by 6% to 76.5% and in C&K Enfield Down decreased by 5.2 % to 77.1%.

Registered On Nights (Trust Total 106.4%)

No ward has fallen below the 80% threshold. The number of wards who are achieving 100% and above fill rate on nights remained consistent on 74.2% (23 wards) for June.

Average Fill Rates for Barnsley BDU decreased by 10% to 117%. Calderdale and Kirklees BDU decreased by 5% to 110%. Forensic BDU were 111% a decrease of 1%. Wakefield BDU increased by 6% to 142%. Specialist services were 134% with an increase of 3%.

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.

Complaints Closed Within 40 Days

Work remains ongoing to streamline the complaints process, with the aim of improving responsiveness. For clarity, in future IPR reports we will report the number of complaints up to March 31st 2018, that remain open. This will allow us to monitor the reduction in the number of complaints overtime.
We will continue to report on the number of complaints closed within 40 days, for complaints received.

Information Governance

There were 14 confidentiality breaches during June involving information disclosed in error, lost or stolen paperwork, patient healthcare record issues.

No incidents were reported to the Information Commissioners Office (ICO).

Commissioning for Quality and Innovation (CQUIN)

CQUIN leads have been agreed for 2018/19. Services are now working towards the requirements for 18/19 and the first set of reports are due to be submitted at the end of quarter 1 (July 18).

A new set of indicators for the Barnsley alliance contract for 2018/19 have been negotiated and these include:
• NHS Staff Health and Wellbeing which aligns to the requirements across the other Trust contracts.
• Improving the assessment of wounds
• Personalised Care / support planning
The following indicators are applicable to the Intermediate Care pathway:
• Patient self-administering of medication
• Patients at risk of readmission
• #endpjparalysis
Work is taking place locally to review and create action plans relating to this new set of indicators.

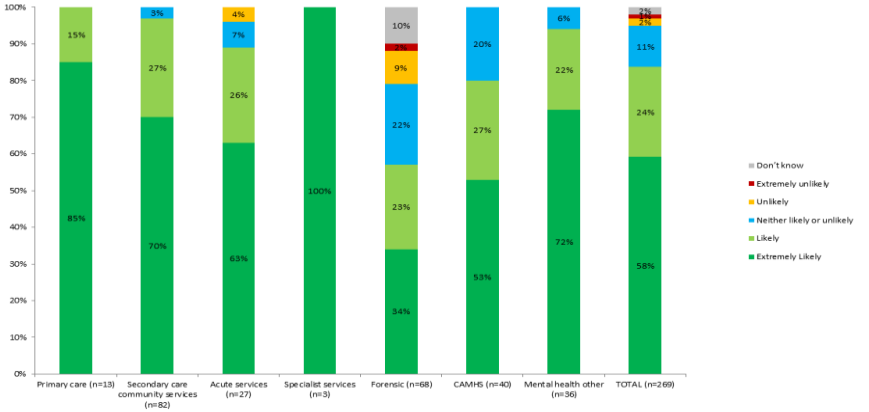
All CQUINs for 2018/19 have a RAG rating of green with the exception of:
• NHS Staff Health and Wellbeing – risk in achievement linked to the improvement of staff health and wellbeing. To achieve would mean that the Trust would need to be in the top 6 of 200+ trusts nationally to achieve the required threshold.
• Cardiometabolic assessment and treatment for patients with psychoses - The early intervention in psychosis element of this indicator has been rated as amber until the results of the 17/18 have been finalised.
The total CQUIN value for 2018/19 is £4.4m. The Trust currently has a risk of £262k shortfall for 2018/19. CQUIN leads are working to mitigate this risk as far as possible.

Patient Experience

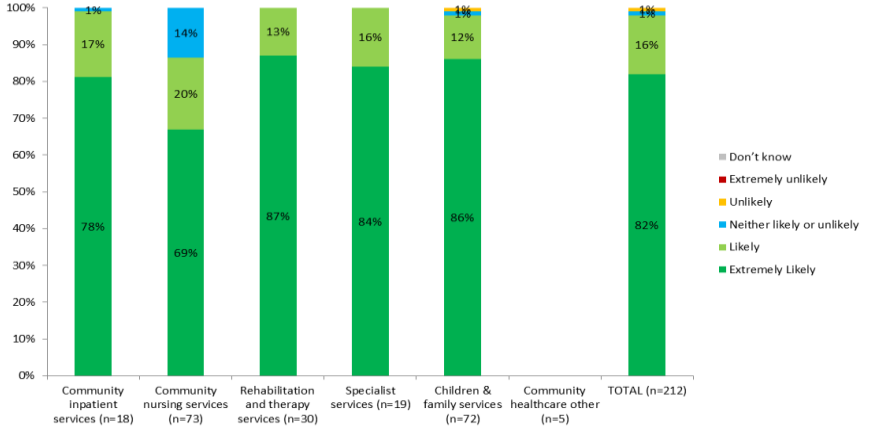
Friends and family test shows

- Community Services – 98% would recommend community services.
- Mental Health Services – 82% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 34% in forensic services and 100% in specialist mental health services
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



The NHS Friends and Family Test (FFT) question and the timing requirements are currently being reviewed by NHS England. Any amendments to FFT and new guidance are expected in April 2019.
The Trust has procured a new real time patient experience system, 'Meridian Optimum'. Planning and preparation is currently underway prior to implementation. Once the new system has been implemented, the QIAT will be providing training to staff. Following implementation the QIAT Project leads will be working with teams on the governance of the new system.

Care Quality Commission (CQC)

CQC update:
The Trust was subject to a well-led inspection by the Care Quality Commission (CQC) in March & April 2018. As a learning organisation, the Trust's values are at the heart of everything it does, and the CQC visit and its independent view of services was welcomed.

Draft reports were provided to the Trust for factual accuracy checking which was undertaken by corporate support and operational teams. The Trust was not required to take an urgent action. The number of regulatory breaches reduced from 22 to 18 as a result of this process.

The Trust has received its final reports, which consist of six core service reports and one overall quality report, which were published by the CQC early July.

Key findings from the reports highlight our areas of strength and improvement, e.g.
- The improvements seen in our community learning disability services
- That staff felt supported, valued and were proud of the work they did
- Our open culture with good reporting of incidents, thorough investigations and learning when things go wrong
- Our clear vision, values and strategy that are person-centred and focused on sustainability
- The good learning from deaths processes in place, with learning events following all death investigations
- Our strong relationships with partners, investing in relationships to ensure sustainable care
- Our strong, approachable and visible leadership
- Our established and experienced Board

Care Quality Commission (CQC) cont…

The CQC have also provided a fair representation of the areas where we are facing significant challenges:
• Our services are under pressure, in particular our acute and community mental health services and our child and adolescent mental health services (CAMHS)
• We still have long waits in some of our services
• We need to improve how we measure service user and carer experience
• We need to address specific issues, such as:
• Our approach to nurse call systems across our inpatient areas
• On-call arrangements in CAMHS
• Restrictive practices
• Our pharmacy strategy

The overall rating for the Trust is requires improvement, with 11 of our 14 core services are rated Good, and all services rated Good or Outstanding for being caring

The SAFE domain is the area where we have seen most change and where immediate attention has been focussed.

Services are currently taking immediate actions in areas of high risk and action plans are in development.

Next steps
• Continue to take immediate action against the regulatory breaches. Priority for action is the acute wards and PICU where care is deemed by the CQC as not safe. Implement the plans for 'should do' actions
• Submission of action against regulatory breaches to CQC – 30th July 2018
• Develop an overarching action plan (Quality Improvement & Assurance Team/Business Delivery Units/support services), as an internal working document to include all CQC actions (regulatory breaches, must do's and should do's) for Operational Management Group/ Executive Management Team sign off.
• Integrate CQC improvement actions into Trust work streams/agree new work streams where required
• Instigate formal monitoring of action plans in BDUs and in corporate teams .
• Agree formal reports and frequency of these to Trust Board and relevant committees.

Safeguarding

Following the recent Office for Standards in Education (Ofsted) inspection in Wakefield, children's social care services have been rated as inadequate across all areas. The report highlights that some children may be at risk and urgent action is being taken to address this. The Trust continues to work in partnership with the local authority to support the implementation of the improvement plan. The rating may trigger a 'Children Looked-after and Safeguarding (CLAS) inspection' across health providers in Wakefield by the CQC. Please see following link to the briefing.

OFSTED_Briefing_July_2018

Infection Prevention Control (IPC)

• Progress on the Infection Prevention and Control (IPC) Annual programme 2018-19, has been good, all areas in Q1 have been completed.
• Surveillance: there has been no MRSA Bacteraemia, Clostridium difficile, or any other alert organisms, up to time of the report (in the first quarter). Barnsley BDU has a locally agreed C difficile Toxin Positive Target of 6.
• No outbreaks identified.
• Mandatory training figures are healthy: Hand Hygiene-Trust wide Total – 90%; Infection Prevention and Control- Trust wide Total – 86%;
• Policies and procedures are up to date.
• The Trusts CQC inspection report has been published and there are areas for improvement for the infection prevention and control team to support. A review of the findings will be undertaken and action going forward implement.
• There is still reduced capacity within the team, (there is 1 IPC nurse vacant), unfortunately the recruit expected for 30th April 2018 has given back word. The team have reviewed the current process and put contingency plans in place where appropriate.

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	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-18	Jun-18	Q1 18/19	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%	98.3%	96.8%	95.0%	97.4%	97.1%	97.3%	97.2%	97.1%	4	
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	SR	99%	99.6%	100%	100%	100%	99.7%	100%	100%	100%	100%	100%	100%	100%	4	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	SR/CH	95%	96.9%	99.3%	99.2%		98.5%	96.6%	96.9%	99.6%	*95.5%*	98.3%	98.8%	97.6%	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%	97.6%	95.5%	96.9%	96.7%	94.3%	99.2%	100%	97.7%	4	
Data Quality Maturity Index [4]	Improving Health	Responsive	SR/CH	95%	Reporting from Nov 17					98%	98.1%						4	
Out of area bed days [5]	Improving Care	Responsive	SR/CH	Q1 940, Q2 846, Q3 752, Q4 658	Reporting from April 17.				885	1127	1286	1608	536	284	375	1195	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%	50.1%	49.2%	53.8%	54.0%	52.9%	57.2%	*51.1%*	*53.8%*	3	
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	SR/CH	75%	76.1%	83.6%	88.9%	86.0%	81.9%	81.1%	89.8%	90.6%	91.6%	88.0%	*93.9%*	*91.4%*	4	
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	SR/CH	95%	98.9%	99.3%	97.9%	99.9%	99.5%	99.4%	99.6%	100%	100%	98.7%	*100%*	*99%*	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%	89.2%	84.4%	89.5%	89.8%	93.5%	81.0%	70.0%	81.7%	4	
% clients in settled accommodation	Improving Health	Responsive	SR/CH	*60%*	Reporting developed from Sept 16		82.7%	82.9%	82.2%	80.8%	80.2%	79.1%	78.9%	78.5%	*79.0%*	*79.0%*	4	
% clients in employment [6]	Improving Health	Responsive	SR/CH	*10%*	Reporting developed from Sept 16		8.3%	8.8%	9.0%	8.7%	8.6%	9.1%	9.0%	*8.7%*	*8.6%*	*8.6%*	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 June 19				2	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-18	Jun-18	Q1 18/19	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	4	108	62	96	2	0	14	16	2	
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	SR/CH	*TBC*	4	1	4	3	2	4	5	4	1	0	3	4	2	
Number of detentions under the Mental Health Act	Improving Care	Safe	SR/CH	*Trend Monitor*	167	174	156	168	212	221	186	180	212				N/A	
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	SR/CH	*Trend Monitor*	15.0%	10.3%	10.9%	19.6%	10.8%	13.6%	15.1%	9.0%	15.1%				N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-18	Jun-18	Q1 18/19	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%	98.7%	97.1%	98.4%	98.1%	97.4%	97.7%	*97.5%*	*97.5%*	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%	99.7%	99.8%	99.8%	99.8%	99.8%	99.9%	*99.9%*	*99.9%*	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%	89.3%	90.3%	90.8%	90.6%	90.7%	90.5%	*90.1%*	*90.1%*	4	

** See key included in glossary.*
Figures in italics are provisional and may be subject to change.
1 - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data.
2 - Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other
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 - The figure for 17/18 reflected the total number of out of area bed days in the Trust, for 18/19 this has been aligned to the national indicator and therefore only shows the number of bed days for those clients whose out of area placement was inappropriate and they are from one of our commissioning CCGs. Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021. Sustainability and transformation partnership (STP) mental health leads, supported by regional teams, are working with their clinical commissioning groups and mental health providers during this period to develop both STP and provider level baselines and trajectories. The January 2018 submission was taken as an agreed baseline position.
6. Clients in Employment - this shows of the clients aged 18-69 at the reporting period end who are on CPA how many have had an Employment and Accommodation form completed where the selected option for employment is '01 - Employed'

Areas of concern/to note:

- The Trust continues to perform well against the vast majority of NHS Improvement metrics
- After a slight dip in performance against target in April, the percentage of service users followed up within 7 days of discharge remains above target in June and for quarter 1.
- Given the hard work and focus of our staff, we continue to meet the target for proportion of people completing treatment who move to recovery within Improving Access to Psychological Therapies (IAPT), although this continues to be a challenge.
- During June 2018, 3 children or younger people aged under 18 years were placed in an adult inpatient ward. this related to one 17 year old in Wakefield, one 17 year old in Barnsley and one 16 year old in Kirklees. All 3 patients were admitted and discharged during the month and totalled 14 occupied bed days - each admission ranging between 4 and 6 days. Total bed days and number of children and younger people under 18 in adult inpatient wards forecast for year end has been rated as a '2 - Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame' - the rationale for this is due to the fact that this is outside control of the Trust. When this does occur the Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. The Trust has 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 Trust's operational management group have recently signed off a new standard operating procedure for admitting young people to adult wards which has now been put into operation.
- As identified above the Trust has submitted a reduction trajectory for the use of out of area bed placements. This trajectory has been agreed with commissioners and requires a 30% reduction in inappropriate admissions during the year. There has been a reduction in quarter one however this target is currently not being met with 1195 bed days in Q1 against a trajectory of 940. The total number of out of area bed days for Q1 including clients from outside of the Trust's CCGs is 1267 days.
- The proportion of admissions under the mental health act has been increasing steadily over the last few years. The national mean in 2016/17 was 36% (median 34%) but the range (excluding outliers was between about 10% and 68%). Looking at national figures since 2013/14 there seemed to be correlation between reducing bed numbers and increased MHA admissions. This might suggest the raw number of admissions under the act is was not increasing, but as bed numbers reduce and admission rates fall, the acuity of people being admitted increases so the proportion of admissions that are detentions will rise, impacting on overall length of stay and turnover of beds. Locally there was a significant increase in mental health act admissions last year when there was no significant change in bed numbers. Work continues to monitor and analyse the data and national figures are expected to be available from September.
- % clients in employment- the Trust is involved in a West Yorkshire and Harrogate Health & Care Partnership wave 1 three-year funding initiative, led by Bradford District Care, to promote, establish and implement an Individual Placement Support (IPS) scheme. IPS is an evidence based vocational scheme to support people with mental health problems to gain and keep paid employment. Work is currently ongoing in Calderdale to expand the opportunities we can offer people under this scheme

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

Barnsley BDU:

Mental Health

• The Improving Access to Psychological Therapies (IAPT) bid has been successful and we are in a consultation process with staff ending on 29.7.18. The Trust will then enter a mobilisation phase for the new service model. Appropriate communication with and support for staff is in place. The service has sustained its improved performance against required key performance indicators. There has been a slight increase in did not attend rates but this is still in target range.

• Memory Service prevalence rates remain an issue and work has been undertaken to understand and remedy this going forward. The figure as it stands does not accurately reflect required performance. During the pilot of the new Memory Assessment and Support Services specification (2015/2016) the nationally set prevalence rate for persons with dementia in Barnsley was 3007. This has subsequently been recalculated nationally on 2 separate occasions and now is accepted to be 2783 for persons aged 65 +. In order to maintain continuity from the pilot and beyond our figures continue to be set using the old prevalence rate of 3007 hence the 68.90 %. Our current NHS England recorded rate based on GP quality outcomes framework (QoF) register reporting is 71.5% which is accurate with our own database which continues to be reconciled with primary care on a bi-monthly basis.

• Performance around care programme approach (CPA) reviews remains below target but has improved, the general manager is working at team level with action plans to address specific issues – tracked through the business delivery unit business meeting. There are added challenges with the disaggregation of social work caseloads and caseload transfers which are now contributing to the under-performance.

• Food safety training figures in acute remain below required standards and are being addressed through skill-mixing on the wards and a stricter interpretation of eligibility of staff for different levels of training. There has been a delay in adjustment of individual training eligibilities, once adjusted the data should reflect concordance with required standards.

• Average length of stay remains in excess of local target levels and has been identified as part of the trustwide programme of improvement in addressing demand and capacity in acute services.

• Planning and implementation continues around the required changes to mental health community services required in the context of the agreed the dissolution of the S75 agreement between the Trust and Barnsley Metropolitan Borough Council planned for August 2018. Human resource, finance, performance and caseload and clinical management issues are being addressed. Consultation with affected Trust staff has concluded regarding the consequent reduction of enhanced teams from three to two and staff are now occupying their new teams. Work is ongoing to understand the impact of the changes in terms of the single operating procedure and coping with demand and capacity and ensuring operational effectiveness going forward.

• Work is ongoing with the clinical commissioning group (CCG) to address the waiting lists for psychology in the community service line. Meetings have taken place regarding the revised business case proposal to address the 'back-waiters' in the core pathway. The proposal was favourably received and has been taken back into the internal governance process of the CCG for approval.

General Community

• Intermediate Care - development being undertaken on key performance indicators (KPI) in the service specification:

  o New developmental KPI for this year is the concept of red day/ green day. This is a concept that was rolled out in general acute hospital settings to assist in the identification of potential wasted time in a patient's journey.

  o The service has rolled out training on the use of the concept of red day/ green day and set up systems to capture the data to report against the KPI, staff in the community setting have embraced this concept.

  o The report enables staff to have an increased awareness of the reasons for not being able to support patients on their rehab journey. It highlights some areas where there may be systems and process issues than can be improved to reduce the amount of red days for patients, which in turn leads to a more productive pathway journey and contributes to improvement of patient outcomes.

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

Calderdale & Kirklees BDU:

Key Issues
• Adult acute ward pressures remained high on all adult wards.
• 7 day follow up and gatekeeping in Kirklees and Calderdale achieved 100%
• Delayed Transfers of Care (DTOC) increased better care fund (IBCF). Monthly figures continue to be scrutinised at Calderdale CCG level as a reduction target has been set against IBCF investment. SWYPT figures improved overall and cllinical commissioning group (CCG) and system performance is better than target set by NHS England.
• Out of area (OOA) improved on May figure with periods of no clients out of area. Significant focus from BDU leaders in community and inpatient teams to focus on admission prevention and flow. Use of older adult beds and social care beds in both areas to create flow and capacity.
• Length of stay increased however a number of longer staying patients were discharged in the month.
• Older adult consultant vacancies all recruited to and starting in post by end of September.
Strengths
• Formal CPA reviews above 95%
• Strong performance on mandatory training.
• Sickness levels in older adult and community service lines below 4.5%. Overall business delivery unit is 4.4%. Improvement in hotspots noted.
• Improving Access to Psychological Therapies (IAPT) performance in spite of underfunded workforce and gaps in workforce. Now we are aware of the Barnsley contract bid we have identified staff to move to Kirklees IAPT to start to fill in workforce gaps.

Challenges
• Recruitment is underway in adult community consultant roles but gaps will remain for trainee posts until rotation in August. Alternative options such as advanced nurse practitioners/prescribers are being explored in the BDU.
• Occupancy levels (high above 95%) continue to be monitored closely.

Areas of Focus
• Admissions and discharge flow in acute adults
• Reduction of sickness in hotspots.
• Continue to improve performance in service area hotspots.
• Recruitment to posts in community especially Kirklees IAPT and Early Intervention in Psychosis (EIP).

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

Forensic BDU:

Medium and Low Secure
• Forensic outreach service learning disability – currently awaiting final confirmation of the pump priming figure. The money is currently sat with Leeds CCG. Implementation plan being delivered.
• Recent West Yorkshire steering group. NHS England have scoped out the work that requires attention. Commitment at the meeting to the development of a business case which would support a lead provider model moving forward.
• NHS England have signalled an intention to discuss under occupancy with us particularly in relation to learning disability wards in medium secure.
• Focus on reducing sickness continues with a small reduction in overall sickness noted.
• Mandatory training figures are improving.

Forensic Child and Adolescent Mental Health Services
• High number of vacancies leading to service pressures. Recruitment in place.
• Framework for integrated care project (a more psychologically/multi disciplinary team way of working with young people in custody known as "Secure Stairs") is now being implemented across Adel Beck and HMP (Her Majesty's Prison)/YOI (Youth Offending Institute) Wetherby.
• Funding of the Wakefield community team is reduced following transformation. Work is ongoing to finalise the budget. At this stage there is not thought to be any direct impact on staff.
• Sickness levels are reducing.
• Secure estate has seen a significant rise in admissions into the prison service caused by rationalisation of the estate and an increase in violent crime mainly in the south (this relates to approximatley between 40 to 50 admissions). That has led to some pressure on the workload.
• Implementation of Secure Stairs has commenced in Adel Beck and Wetherby.

Specialist BDU:

Specialist services
• Ongoing difficulties are being experienced across specialist services with respect to medical recruitment and retention. A total of 8 agency medics are currently being deployed. Efforts to recruit are ongoing (and supported through the Medical Directorate) with a number of recruitment incentives now being considered.

Child and Adolescent Mental Health Services (CAMHs)
• Waits with regard to Autistic Spectrum Condition (ASC) diagnostic assessment continue to be a focus of attention. In Wakefield commitment has been made to an improvement plan by key agencies to reduce the waiting time for ASC assessment to meet NICE Guidelines (assessment to begin within 3 months). The current trajectory indicates achievement by August 2018 - with the exception of the 14+ pathway. With regards to this SWYPFT-led pathway a sustainable recovery plan will being agreed with the CCG by the end of September 2018.
• In Kirklees a strengthened pathway is on target to ensure waiting times have been reduced to less than 12 months by September 2018. Again this plan has been agreed with the CCG.
• In Calderdale data identify waiting times for ASC assessment to be increasing (longest wait - 36 months) Calderdale CCG has led on development of a new diagnostic assessment pathway and is currently considering options for investment in a waiting list initiative.

Learning Disability
• Horizon continues to experience a high level of vacancies – principally qualified staff. A recruitment and retention workshop has been arranged with respect to Horizon. This will be attended by service managers/lead clinicians and support service colleagues.
• Capital programme work has commenced on Horizon and is scheduled for completion October 2018. Until that time only the 6 block purchase beds will be available.
• The first meeting of the SWYPFT-hosted Yorkshire and Humber Operational Delivery Network for learning disability and autism was held on 3 July 2018. Priority workstreams are being identified and the appointment of a network clinical lead is being progressed.

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

Wakefield BDU:

• The acute service line continues to experience high demand and staffing pressures leading to ongoing bank and agency expenditure. Use of out of area (OOA) beds (acute and PICU) for Wakefield service users has continued to present a challenge although intensive work is ongoing to explore all possible alternatives at the point of admission, and to reduce OOA episode duration once commenced. This usage has not increased for this month from last, but continues to have an adverse impact financially and on the quality of service user and carer experience.
• Average length of stay remains in excess of local targets and has been identified as part of the trustwide programme of improvement in addressing demand and capacity in acute services.
• Work to develop and refocus the Intensive home based treatment team offer is ongoing and recruitment to additional posts now completed, informed and focussed by the action plan from the core fidelity audit undertaken across Wakefield and Barnsley.
• Care programme approach reviews for Quarter 1 are at 100%.
• In the acute wards the 12 month housing coordinator pilot delivered in partnership with Wakefield District Housing is already achieving positive outcomes for service users at the three month evaluation stage. The project is focussed on prevention and early intervention by working closely with service users from the point of admission, identifying and addressing any housing related issues which could be barriers to discharge. It is also looking at wider determinants of health, such as physical wellbeing, lifestyle and finance - linking people in to Wakefield District Housing (WDH) Wellbeing, Care-link and Cash Wise Teams, encouraging and developing robust life and budgeting skills and helping to build confidence and personal resilience to achieve tenancy sustainability. The pilot has supported 23 service users so far, 17 of whom have been have been successful in gaining alternative accommodation with WDH and other housing providers together with tenancy support where needed.

Communications, Engagement and Involvement

• Staff listening events: Third and fourth events held in June
• Kirklees improving access to psychological therapies (IAPT) website: A new standalone website has been launched
• Volunteering: Volunteer celebration event held during National Volunteers Week
• Intranet: Ongoing technical issues, some features still not working. It is captured on risk register, given high reliance for human resource/performance and information processes
• New Trust website: Fully redeveloped site in pre-launch phase. Site includes eight separate microsites
• EASI cup: Full communications and public relations support, including extensive media coverage

This is the July update to the integrated performance report for activity conducted on the Trust priorities for 2018/19.

Where a priority programme is already reported in another section of the IPR, for example patient safety, then an update will not be repeated in this priority page. Not all the priorities that are reported in the IPR are updated monthly - some are updated bi-monthly, as determined by the inherent degree of cost, risk and complexity present.

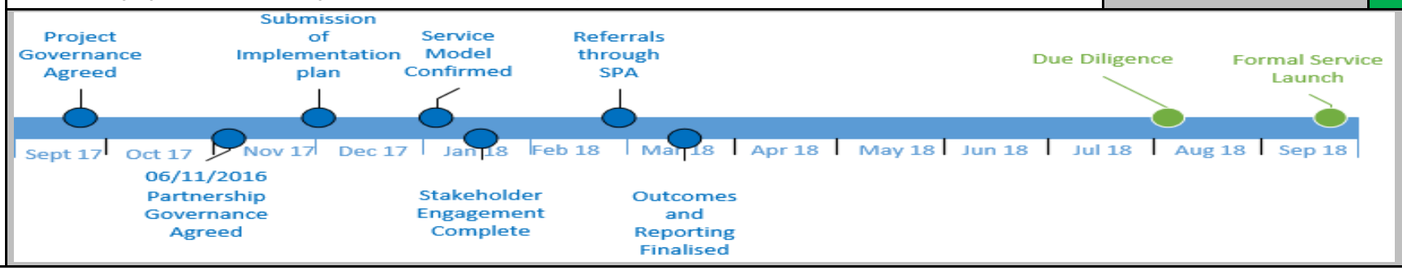
Given that the majority of priorities are new for 2018/19 then scoping, establishment of governance and resource allocation is still ongoing for many. However, a summary of updates for July includes:

Flow and out of area beds:
• Bed pressures remain in the system and the long term trend of high out of area placements has continued.
• All BDUs are part of the implementation project team for this priority.
• Work has now commenced to implement criteria led discharge across all inpatient units. Wakefield BDU is first in the planned implementation which will be rolled out Trust-wide towards the end of 2018.
• Personality Disorder (PD) pathway modelling, co-design stage of the integrated change framework is scheduled through Summer 2018 with implementation planned from Autumn onwards.
• A detailed plan is in place for activity to reduce admissions. Calderdale and Kirklees are currently trialling trusted assessor processes to speed up the interface between team and changed thresholds to access intensive home based treatment (IHBT), so people with increasing needs can access this service sooner.

Clinical Record System
• Progress in this priority is continuing and to plan
• SystmOne training sessions have been conducted for medical staff/representatives and for our performance and information (P&I) staff.
• All forensic service process maps, except for a few, have been signed off by the clinical safety design group.
• The inpatients process mapping focus group has agreed a priority set of SystmOne functionality to be applied across all acute inpatient wards.
• An approach and priority for recreating RiO forms in SystmOne has commenced.
• Resources required to configure the system to an acceptably 'safe' level for go live has been bolstered.
• The first phase of data migration testing by the Trust was completed and went well. It is anticipated that future testing may be reduced as a result.

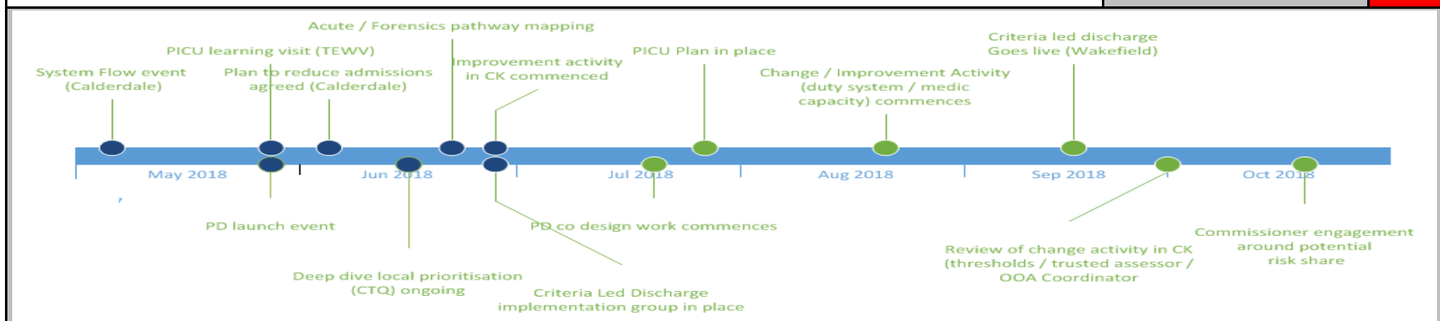
Older People's Services
• Following EMT decision that this priority should move into conversations with commissioners about the proposed model meetings have commenced and more information has been requested by commissioners about areas including: the case for change; evidence of engagement activity conducted; financial and activity data
• Learning has taken place with Lancashire Care Trust who went through a similar journey of transforming their services in recent years. Findings from the conversations are being factored into the business case.

Priority	Scope	Narrative Update	Area	RAG
South Yorkshire Projects: Stroke Service Review	Work with our South Yorkshire partners to deliver shared objectives as described through the integrated care systems planes. This includes work on: • Stroke service review	• An initial detailed implementation plan for integrated stroke pathways has been established in joint agreement with Barnsley Hospital NHS Foundation Trust (BHNFT) and shared with commissioners. • Project governance is being established with the first meeting on 31st July	Progress Against Plan	
		There is a risk that the scope of the project will be changed if BHNFT are successful with a bid for capital funding which will enable stroke rehab to be co-located at the acute Trust site.	Management of Risk	
		Implementation Plan is in development		
South Yorkshire Projects: Neurological rehabilitation	Work with our South Yorkshire partners to deliver shared objectives as described through the integrated care systems planes. This includes work on: • Neurological rehabilitation	• The governance route for this priority is via the Trusts Operational Management Group (OMG). • Reporting is bi-monthly on the IPR with the next update due in the August IPR. The last update included: • Barnsley Clinical Commissioning Group (CCG) has informed SWYPFT that from 1 October 2018 it will be reducing the number of Neuro Rehabilitation Unit (NRU) beds it commissions from the current twelve to eight.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Implementation Plan is in development		

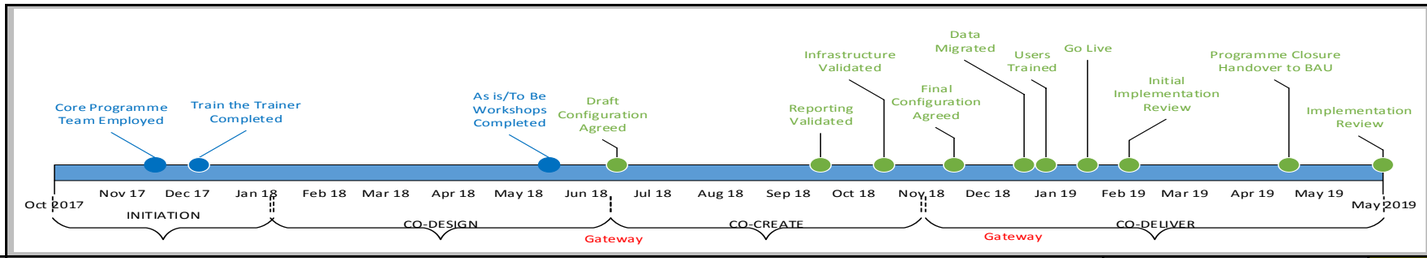
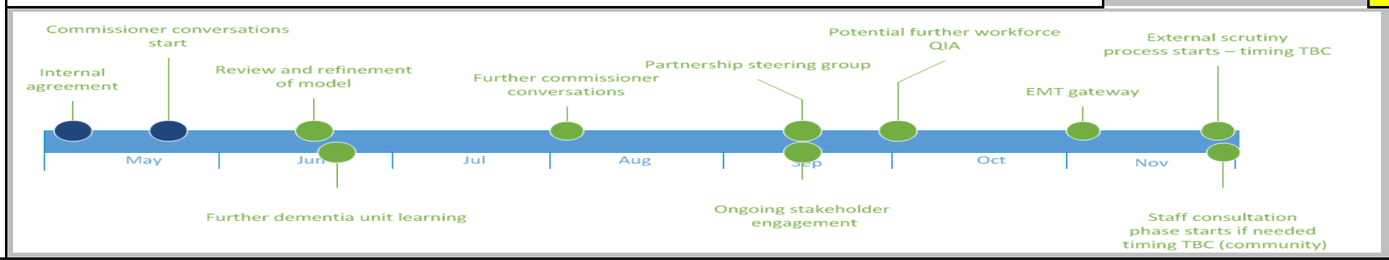
South Yorkshire Projects: Autism and ADHD	Work with our South Yorkshire partners to deliver shared objectives as described through the integrated care systems planes. This includes work on: • Autism and ADHD	• The governance route for this priority is via the Transformation Board. • Reporting is bi-monthly on the IPR with the next update due in the August IPR. The last update included: • An initial meeting has been arranged to help scope the priority prior to developing an implementation plan and determining objectives and resource implications.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Implementation Plan is in development		
New Business	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Forensics: work with NHS and private sector partners in the region to develop and deliver a co-ordinated approach to forensic care.	SWYPFT are developing a business case to bid to become the lead provider for Forensic services across West Yorkshire. Work has commenced on a business case for this with weekly meetings in place between services and Business Development to undertake this work for September.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Business case in development		
West Yorkshire Projects: Community Forensics CAMHS	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Community Forensic CAMHS	• Governance through the forensic children and adolescent mental health services (FCAMHS) Partnership Board and FCAMHS Operational Meetings is established. • The contract variation for this service is in place. Partner sub-contracts have been circulated to them for sign-off. • Due diligence continues by the lead provider for all partners in the contract (Humber, Tees, Esk and Wear Valleys (TEWV) and Sheffield Children's). • Acceptance of referrals through the Single Point of Access (SPA) continues and referral numbers are being collated. • Monthly Key performance indicators (KPIs) reporting on performance to NHS England (NHS E) has commenced. • Graded introduction/communication of the service to agencies across the region continues. • A website domain has been purchased and the Yorkshire and Humberside FCAMHS site is in final stages of completion and leaflets for the service are produced and in use across the region. • Initial planning has commenced with regards to the formal service launch. • Engagement with the National Clinical Network has commenced. • First meeting conducted regarding the national evaluation through the Anna Freud Centre. • All posts in Wakefield, TEWV and SPA have now been filled and remaining vacancies across the region are out to advert.	Progress Against Plan	
		• There are currently no high level risks identified in this project. • Risk sharing agreements are being developed for the partnership	Management of Risk	
				

West Yorkshire Projects: Forensic Community Mental Health	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Forensic community Mental Health	In February 2018, NHSE approached SWYPFT regarding an opportunity to be one of three wave 1 trial sites for a specialist community forensic team. A bid was duly prepared for this opportunity and submitted. We have been informed that our bid was not successful and that SWYPFT have not been chosen as one of the three specialist community forensic team wave 1 trial sites. Following initial verbal feedback on the bid our forensic services team have been invited to take part in a learning network with those from the successful wave 1 specialist community forensic team sites and further formal feedback on the bid has been requested. Wave 2 will be open for applications in September/October this year.	Progress Against Plan	N/A
		Not applicable	Management of Risk	N/A
		Not applicable		
West Yorkshire Projects: Forensic Community LD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Forensic community LD	• SWYPFT submitted a proposal to NHS England (NHSE) for provision of a Community Forensic Learning Disability Service to support individuals with Learning Disability and autism who display offending behaviour more effectively within the community, safely managing risk and avoiding contact with the criminal justice system or admission to secure hospital where possible. • SWYPFT were asked to provide a proposal for provision of a Community Forensic Learning Disability Service to the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) which was submitted to NHSE in September 2017. • Following this submission NHSE have invited all Trusts who expressed an interest in this provision to work together to ensure consistency of new service model. SWYPFT was asked to develop a proposal for WY&HHCP, building on our original bid of September 2017. • NHSE have invited bids for £50k initial implementation funding for this service, which SWYPFT have submitted in March 2018. • We are currently awaiting confirmation of funding.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		An implementation plan will be developed once a successful bid is approved		
West Yorkshire Projects: Improving Autism and ADHD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the areas of: • Improving autism and ADHD	SWYPFT is to be lead provider for the adult autism and ADHD pathways across the West Yorkshire Mental Health collaborative. Initial meetings have been arranged to inform the development of an implementation plan of key milestones for this priority.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Development of an implementation plan of key milestones is yet to be identified		
West Yorkshire Projects: Learning Disability ODN	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Learning Disability Organisational Development Network (ODN)	SWYPFT are taking a lead role through the Operational Delivery Network (ODN) and Transforming Care Partnership on improving services for people with a learning disability and autism across Yorkshire and Humberside from April 2018. • Mobilisation of the ODN and initial scoping for the network and drafting of a plan for the network has commenced • An initial meeting of other ODN providers is planned for 3rd July focussing on how we will appoint clinical leadership for this priority. • Work on agreeing and documenting the scope for this new priority and determining the boundaries of the work involved, governance arrangements and resource implications continues. • Implementation of this priority is being supported by the integrated change team.	Progress Against Plan	
		No risks have currently been identified at this time.	Management of Risk	
		An implementation plan is in development.		

West Yorkshire Projects: Inpatient CAMHS	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners contributing to the following areas of work across WY&HHCP: • Inpatient CAMHS	• Reporting for this priority is bi-monthly on the IPR with the next update due in August. The last IPR included the following updates: • 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. • The project is two-year pilot • 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 Projects: Eating Disorders	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners contributing to the following areas of work across WY&HHCP: • Eating Disorders	• 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. • Reporting for this priority is bi-monthly on the IPR with the next update due in August. The last IPR included the following updates: • The Eating Disorders West Yorkshire and Harrogate Network has SWYPFT as a partner as part of the WY&HHCP. • Funding has been secured though the new models of care (NMoC) workstream. • SWYPFT are active on the new care models programme board and steering group.	Progress Against Plan	
		Any implementation risks are with Leeds and do not transfer to SWYPFT	Management of Risk	
		Implementation plan in development		

Flow and out of area beds	Stop people under the care of SWYPFT being placed out of area and ensure everyone is as near to their own home as possible. Work with others across West Yorkshire and Harrogate to help stop all of us placing people out of area. Implement Personality disorder pathway.	• Bed pressures remain in the system and the long term trend of high out of area (OOA) placements has continued through June. • Work has now commenced to implement criteria led discharge across inpatient units. Wakefield Business Delivery Unit (BDU) is first in the planned implementation and expect to go live with the new system in September 2018. All BDUs are part of the implementation project team and criteria led discharge will be rolled out Trust-wide towards the end of 2018. • PD pathway modelling (co-design) is scheduled through Summer 2018 with implementation planned from Autumn onwards. • Critical to Quality (CTQ) activity has continued and is focussing on local priorities. • A detailed plan is in place for activity to reduce admissions. Calderdale and Kirklees are currently trialling trusted assessor processes to speed up the interface between team and changed thresholds to access IHBT, so people with increasing needs can access this service sooner.	Progress Against Plan	
		Current risk is that we continue send people out of area, which has an adverse impact on their care. This risk remains off project trajectory with ongoing pressures across the system.	Management of Risk	
				
Workforce Productivity	Develop and deliver clinical support worker strategy. Develop new roles to improve rostering, reduce agency spend and enhance skill mix. Develop and deliver a retention strategy.	• An initial meeting to agree the scope for this priority has been held with our Director of Delivery and our Director of Human Resources, Organisational Development and Estates. • A TAG group for workforce productivity to be set up. • The Retention Strategy for the Trust has been written and signed off at EMT, Board and with NHS Improvement (NHSI) as external support. • Our workforce planning lead is the lead identified for implementation of the recruitment and retention strategy. • The integrated change team is supporting this work. • Future monthly steering group and task groups meetings are being arranged. • A draft action plan is now in development for the implementation of the recruitment and retention strategy and a project team in place. • Current focus is to ensure that activity required in the action plan is well defined and that there are action owners in place for each strand of activity.	Progress Against Plan	
		A risk review will take place in July and initial risks will be identified on the next update to the IPR.	Management of Risk	
		Implementation Plan is in development.		

Clinical record system	Plan and deliver a new clinical record system which supports high quality care	• SystmOne training sessions (getting started module) were held for medics and for Performance and Information, and positive feedback received, as part of evaluating the quality of the training. The attendees also trialled (and passed) the competence check that all SystmOne users will have to complete before they are given access on their smartcard. • The practice governance coach for forensics presented the forensics process maps to the clinical safety design group. The group signed off the maps. • The inpatients process mapping focus group met for a second time and agreed on a priority set of SystmOne functionality to be applied across all acute inpatient wards. In attendance were the CRS programme system analysts, and practice governance coaches for Wakefield, Barnsley, Calderdale and Kirklees Acute Services. • A meeting was held on Friday 29th June to agree the approach and priority for re creating RiO forms in SystmOne. There was representation from the SystmOne for MH design reference group, P&I, information management and technology (IM&T) and the programme team. The approach for completing this work was agreed. • The estimated resource required to configure the system to an acceptably 'safe' level (that is the minimum 'system safe' level of functionality in the proposed SystmOne system that is currently present in RiO) for go live has been scoped . A shortfall was identified. Discussions have taken place with IM&T resulting in the agreement that resource will be provided by IM&T as follows. - Two 'person' days per week from w/c 26th June to end July 2018 - Equivalent of 1 Full time equivalent (FTE) from start of August to end of December 2018 This will have the added benefit of improving the SystmOne skillset of IM&T as we move from go live to business as usual (BAU). • The first phase of data migration testing by the Trust was completed on Friday 29th June. The Trust and the suppliers of SystmOne (TPP) will now revisit the latest TPP schedule with a view to reducing the length of future testing phases to increase contingency used during the initial data production.	Progress Against Plan	
		Risks Identified: • 1251 CUTOVER: during the transition (cut over) period before go live if there is no electronic clinical record system to use, there will be a risk of a delay and inconvenience to patients, services and staff. • 1285 DATA MIGRATION: Delays to 1A impact on overall plan. Data Migration Timetable has slipped due to adaptor build issues (TPP), this has a potential to impact on Go Live if subsequent phases cannot be bought back in line with revised plan. In terms of impact on overall plan the Trust has used 4/6 weeks contingency currently built in plan. • 1305 CONFIGURATION: Insufficient time for system analysis Insufficient time for system analysts to create required configuration from co-design workshop outputs. • 1293 INFRASTRUCTURE: Lack of funding within the programme budget to fund any work required to achieve deliverables Following the assessment of the infrastructure to meet the suppliers warranted environment specification (WES), there may be insufficient funding available to comply. • 1223 CHANGE MANAGEMENT: Staff not engaging. In the event of staff not engaging there will be a risk of not capturing all processes/ways of working which will result in incorrect configuration of SystmOne for Mental Health. • 1224 TRAINING: Staff are not trained. 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. • 1316 TESTING: Impossible to replicate live environment prior to system go-live. It is not possible to replicate the live environment in full prior to the cutover period between the 7th and 21st January. During this final testing it might reveal poor technical performance, system user authentication issues, technical unit limits being exceeded, inadequate clinical data availability and reporting. 1281 REPORTING: It is currently unclear what data that will be migrated from RiO. It is currently unclear whether data that will be migrated from RiO to SystmOne will be suitable for use for reporting. If not suitable, reporting will need to "stitch together" RiO and SystmOne data.	Management of Risk	

<table>
<tr><td rowspan="3">Older Peoples Services Transformation</td><td rowspan="3">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.</td><td colspan="3"> 
</td></tr>
<tr><td>• Further conversations have now been held with commissioners and additional information has been requested including a more detailed case for change, evidence of engagement activity carried out to date, and the financial and activity underpinnings that led to the preferred options being reached, plus financial and activity requirements that support the need for reinvestment by each locality. Work is being undertaken to pull this information together.
• Meeting are also to be held with commissioning groups through July and August and the Kirklees commissioner is pulling together a wider external steering group.
• Learning has taken place with Lancashire Care Trust who went through a similar journey of transforming their services in recent years. Findings from the conversations are being factored into the business case.</td><td>Progress Against Plan</td><td></td></tr>
<tr><td>• We will need to receive wide external support from partners to take the inpatient options being considered through an external consultation process.
• The ongoing risk of slippage in the project timescale due to limited capacity across the project and across the BDUs remains, the project will need to ensure it is well resourced when moving on beyond commissioner conversations.</td><td>Management of Risk</td><td></td></tr>
<tr><td colspan="3"> 
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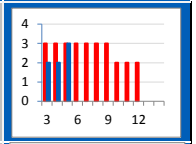
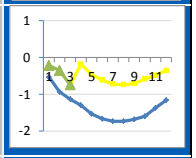
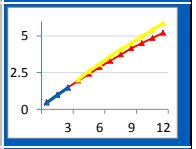
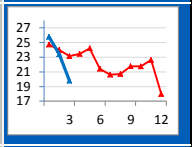
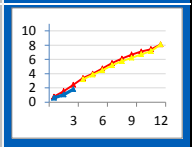
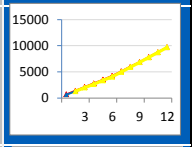
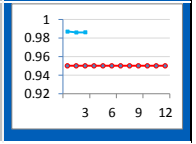
RAG Ratings	
	On Target to deliver within agreed timescales/project tolerances
	On Trajectory but concerns on ability/confident to deliver actions within agreed timescales/project tolerances
	Off Trajectory and concerns on ability/capacity to deliver actions within agreed timescales/project tolerances
	Actions will not be delivered within agreed timescales/project tolerances
	Action Complete

Overall Financial Performance 2018/19

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	3	3	Given the fact the Trust's I&E margin is a deficit in excess of 1% it scores a risk rating of 4. This means the overall risk rating can only be 3, which is a deterioration compared to 2017/18 and May.	
2	Normalised Surplus (inc STF)	(£1m)	(£2.6m)	A disappointing deficit in June of £464k pre Provider Sustainability Fund (PSF) was incurred. The year-to-date deficit is now close to £1m, which whilst favourable to plan is a concern given the run rate.	
3	Agency Cap	£1.5m	£5.8m	Agency expenditure was £0.5m in June, which is fairly consistent with recent months. Year-to-date costs are £1.5m which is 3% higher than the same period last year. Current year-end projection is to exceed our agency cap by £0.6m (12%).	
4	Cash	£19.8m	£18m	The Trust cash position is £3.4m below plan in June due to delayed payments from two commissioners. These were paid on July 2nd.	
5	Capital	£1.8m	£8.1m	Capital expenditure is £0.6m lower than plan to date, largely due to the timing of some IT schemes. All schemes are being progressed and are expected to be delivered by the year-end.	
6	Delivery of CIP	£2m	£9.7m	Year to date CIP delivery is £0.1m behind plan (5%). At June 2018 the forecast position assumes delivery of the potential upside scenarios (£1.3m).	
7	Better Payment	99%		This performance is based upon a combined NHS / Non NHS value.	

Red	Variance from plan greater than 15%
Amber	Variance from plan ranging from 5% to 15%
Green	In line, or greater than plan

Plan
Actual
Forecast

Contracting - Trust Board

Contracting Issues - General

The contract variation with NHSE for Forensic Services remains to be agreed.

Commissioning for Quality and Innovation (CQUIN)

Q4 17/18 final position was confirmed at £2,031k against a target of £2,067k, following publication of national results of Centre for Quality Improvement audit for early intervention in psychosis in June.
Q1 18/19 No delivery problems anticipated

Contracting Issues - Barnsley

Key strategic work areas in Barnsley continue across Intermediate care, Respiratory, Musculoskeletal and Stroke services. SWYPFT has been awarded the new contract for Improving Access to Psychological Therapies (IAPT) services to commence 1 August 2018. Barnsley clinical commissioning group (CCG) has confirmed investment to increase capacity for the Police to access advice from mental health practitioners to inform section 136 admissions to meet requirements set out in the Police and Crime Act. Barnsley CCG has confirmed the intention for additional investment within Adult attention deficit hyperactivity disorder (ADHD) / autistic spectrum disorder (ASD) services.

Contracting Issues - Calderdale

An enhanced ASD service for adults commenced from 1 April 2018. Key ongoing work streams include the mobilisation and implementation of the expansion of IAPT services to long term conditions and continued implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Development of the THRIVE model of delivery for child and adolescent mental health (CAMH) services in Calderdale continues between commissioners and providers. Ongoing in year priorities include early intervention in psychosis services, mental health liaison, 24/7 intensive home based treatment services and out of area placements.

Contracting Issues - Kirklees

The current priority areas of work related to Kirklees CCGs' contracts include IAPT services and expansion to core IAPT services and long term conditions, expansion of early intervention in psychosis services and continued implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Work has commenced on clearance of Adult ASD backlogs.

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.

Contracting Issues - Forensics

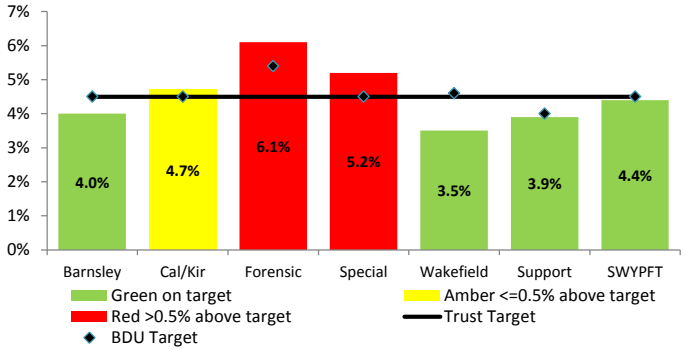
Following successful award of the lead provider role for the Yorkshire & Humber delivery of community forensic CAMHs services work continues on implementation. Implementation of secure stairs within the forensics secure estate is ongoing.

Contracting Issues - Other

SWYPFT is leading the implementation of the Operational Delivery Network for Yorkshire and Humber for learning disability and autism following successful tender award.

Human Resources Performance Dashboard - June 2018

Sickness Absence

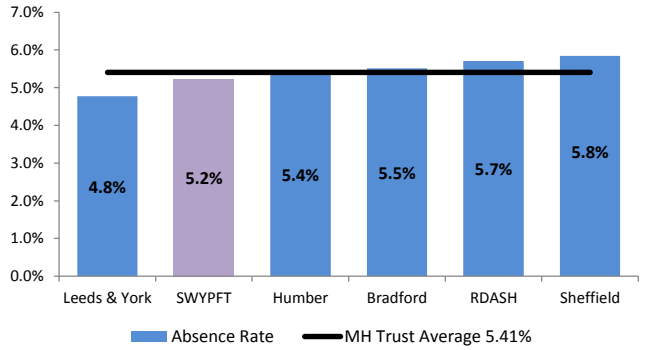


Current Absence Position and Change from Previous Month - June 2018

	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	3.7%	4.4%	6.0%	4.4%	4.6%	4.6%	4.4%
Change	↓	↓	↔	↓	↑	↑	↔

The Trust YTD absence levels in June 2018 (chart above) were below target at 4.4%

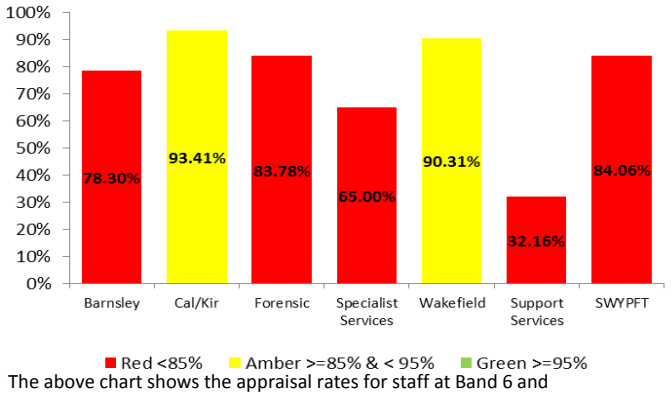
The YTD cost of sickness absence is £1,303,099. The Trust was below its target so has saved -£20,591.



The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2017 to March 2018.

During this time the Trust's absence rate was 5.23% which is below the regional average of 5.41%.

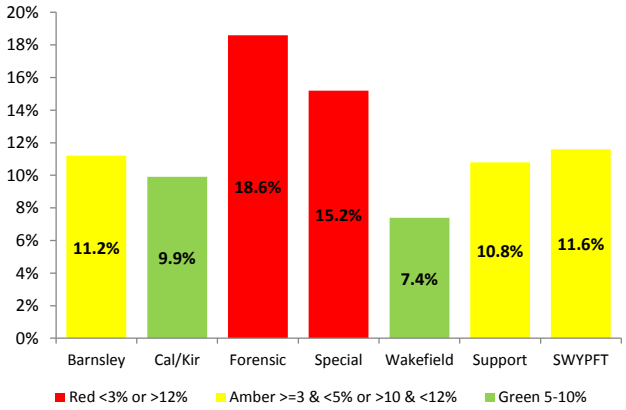
Appraisals - Band 6 and Above



The above chart shows the appraisal rates for staff at Band 6 and above to the end of June 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 in each financial year.

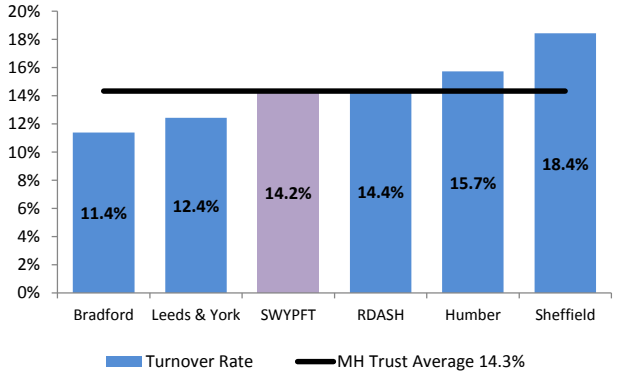
Turnover and Stability Rate Benchmark



This chart shows the YTD turnover levels up to the end of June 2018.

Turnover figures may look out of line with the average across the Trust but this is because of the small amount of data; the figures will level out over the new reporting year.

*The turnover data excludes recently TUPE'd services

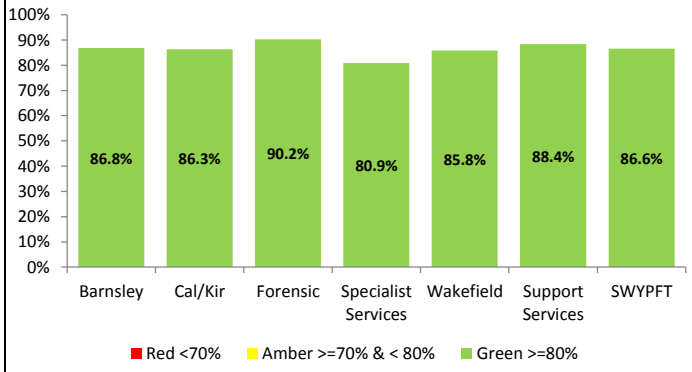


This chart shows turnover rates in MH Trusts in the region for the 12 months ending in April 2018. The turnover rate shows the percentage of staff leaving the organisation during the period.

This is calculated as: leavers/average headcount.

SWYPFT figures exclude decommissioned service changes.

Fire Training Attendance



The chart shows the 12 month rolling year figure for fire lectures to the end of June 2018. The Trust continues to achieve the 80% target across all BDUs.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.8%	4.9%	4.9%	5.0%	5.0%	5.1%	5.2%	5.3%	5.3%	4.5%	4.4%	4.4%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	5.0%	5.2%	5.0%	5.2%	5.6%	5.8%	6.2%	6.0%	4.9%	4.4%	4.4%	4.4%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	80.9%	89.0%	91.0%	92.7%	97.6%	98.1%	97.9%	97.8%	97.8%	7.3%	26.1%	84.0%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	31.1%	46.2%	75.8%	82.7%	95.5%	95.7%	95.9%	95.9%	96.0%	0.8%	2.8%	9.4%
Aggression Management	Improving Care	Well Led	AD	>=80%	76.6%	77.0%	77.6%	76.4%	79.0%	78.0%	77.9%	78.2%	79.3%	79.3%	81.7%	81.6%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	73.1%	71.9%	73.4%	72.8%	75.4%	76.6%	77.0%	78.5%	81.4%	82.3%	84.0%	84.5%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	74.6%	77.3%	79.2%	80.7%	82.3%	82.5%	83.8%	85.3%	85.1%	85.6%	85.5%	85.8%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	86.6%	87.1%	85.7%	85.4%	87.0%	86.9%	88.3%	88.9%	88.5%	89.0%	89.8%	89.7%
Fire Safety	Improving Care	Well Led	AD	>=80%	81.8%	82.6%	82.8%	82.8%	83.3%	82.4%	83.8%	84.6%	85.4%	85.3%	86.8%	86.6%
Food Safety	Improving Care	Well Led	AD	>=80%	79.1%	79.2%	77.0%	76.2%	78.4%	78.6%	79.3%	77.8%	77.2%	76.2%	77.2%	77.5%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	83.7%	83.6%	82.3%	81.8%	83.2%	83.2%	85.0%	86.5%	86.8%	87.0%	87.3%	87.3%
Information Governance	Improving Care	Well Led	AD	>=95%	90.4%	89.1%	88.3%	86.2%	85.9%	83.8%	89.2%	95.7%	96.5%	92.4%	92.7%	92.1%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	79.3%	79.3%	79.3%	80.7%	81.6%	81.9%	84.1%	85.4%	85.5%	85.2%	85.9%	85.6%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	82.5%	86.1%	87.6%	88.9%	90.3%	91.1%	91.0%	91.1%	90.7%	91.1%	91.4%	91.3%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	75.0%	80.3%	81.6%	83.4%	84.7%	86.6%	86.4%	86.0%	84.7%	85.7%	86.8%	86.5%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%		61.0%			64.7%			86.5%			78.4%	
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	86.2%	86.0%	86.3%	86.3%	87.4%	87.8%	89.0%	89.8%	89.9%	90.0%	91.0%	91.3%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	84.3%	84.7%	84.8%	84.1%	85.4%	85.1%	86.7%	87.5%	87.8%	88.4%	88.6%	89.4%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	93.2%	94.2%	94.2%	92.9%	93.4%	93.3%	93.8%	94.3%	93.4%	94.4%	95.1%	94.9%
Bank Cost	Improving Resources	Well Led	AD	-	£576k	£518k	£614k	£545k	£534k	£534k	£604k	£655k	£907k	£557k	£603k	£768k
Agency Cost	Improving Resources	Effective	AD	-	£457k	£446k	£435k	£515k	£531k	£430k	£465k	£563k	£555k	£444k	£538k	£484k
Overtime Costs	Improving Resources	Effective	AD	-	£9k	£12k	£12k	£7k	£10k	£8k	£11k	£13k	£6k	£8k	£13k	£5k
Additional Hours Costs	Improving Resources	Effective	AD	-	£44k	£38k	£45k	£44k	£50k	£39k	£34k	£24k	£23k	£29k	£15k	£23k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£493k	£527k	£499k	£547k	£550k	£594k	£633k	£532k	£483k	£430k	£443k	£417k
Business Miles	Improving Resources	Effective	AD	-	299k	267k	283k	291k	265k	305k	271k	275k	230k	274k	264k	259k

1 - this does not include data for medical staffing.

Workforce - Performance Wall cont…

Notes:
Mandatory Training
Green Compliance Status:
• Aggression Management – 81.6% no significant change in compliance from last month.
The Aggression Management/Physical Interventions Clinical Level 2 is at 89.2% compliance.
• Cardio Pulmonary Resuscitation – 84.5% no significant change in compliance from last month.
• Clinical Risk – 85.8% no significant change in compliance from last month.
• Equality and Diversity – 89.7% 1% increase on last month.
• Fire Safety – 86.7% no significant change on last month. The 95% compliance requirement for ward based staff is monitored at service level and no particular 'hot spots' were highlighted this month.
• Infection Control and Hand Hygiene – 87.3% no significant change in compliance from last month.
• Mental Health Act – 86.5% no significant change in compliance from last month.
• Mental Capacity Act – 91.3% no significant change in compliance from last month.
• Moving and Handling – 85.6% no significant change in compliance from last month.
• Safeguarding Adults – 91.3% no significant change in compliance from last month.
• Safeguarding Children – 89.43% 0.8% increase on last month.
• Sainsbury's Tool – 94.9% no significant change in compliance from last month.

Amber Compliance Status:
• Data Security Awareness Level 1 (formally IG) – 92.1% no significant change on last month.
• Food Safety – 77.5% no significant change on last month. The review of Food Safety training continues with regard to reviewing staff groups that require mandatory Food Safety training according to their role.

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

It should be noted that the next report will include the lower levels of mandatory training contained within each subject, in line with how the Care Quality Commission have requested information.

Sickness
• The Trust sickness has shown a positive downward trend since April and the year to date sickness rate is currently 4.4%. Whilst we would expect to see a lower sickness rate in April and May these are both lower than the figures for the same time last year.
• Wakefield BDU has had an increase in sickness during the month but remains the BDU with the lowest year to date sickness level in the Trust at 3.5%. Barnsley BDU and Corporate Services are also below target levels with Calderdale and Kirklees BDU only slightly above. Specialist Services has seen a drop in month sickness levels to 4.4% and so has reduced the year to date position to 5.2% but still remain above the target level. Forensic has the same sickness rate as at the same time last year and remains above target.
• 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.
• 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 healthy 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

Workforce Racial Equality Standard (WRES)

• The WRES data is collected on an annual basis and submitted to the NHS England by the end of September 2018.
• In addition the WRES uses the annual staff survey
• The WRES submission will be presented to the Trust Board on the 25th September 2018 for sign off prior to sending to NHS England
• WRES action plan is agreed through the Equality and Inclusion Forum

Guardian of Safe Working Report

Number of doctors in training (total):	51
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

Distribution of Trainee Doctors within SWYPFT

Poor recruitment to core training posts in Psychiatry has led to a number of gaps with 1 out of the 7 Wakefield posts vacant, 5 out of 10 posts on the Calderdale and Kirklees Core Training Scheme and although none of the 4 CT posts in Barnsley were vacant there was an FY2 vacancy and Specialty Doctor vacancies which affects this rota..

Exception reports (with regard to working hours)

There have only been a few ERs completed in SWYT since the introduction of the new contract and only one during this period. This related to a higher trainee being asked to act down to cover a vacant 1st on-call shift.

Fines

There have been none within this reporting period.

Work schedule reviews

There were no reviews required.

Rota gaps and cover arrangements

Gaps by rota January/February/March '18

Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	52 (29%)	22 (42%)	5 (10%)	25 (48%)	0
Calderdale 1st	37 (20%)	23 (62%)	9 (24%)	4 (11%)	1 (3%)
Kirklees 1st	17 (19%)	17 (100%)	0	0	0
Wakefield 1st	2 (1%)	2 (100%)	0	0	0
Total 1st	108 (17%)	64 (59%)	14 (13%)	29 (27%)	1 (1%)
Wakefield 2nd	7 (8%)	0	0	7 (100%)	0

Costs of Rota Cover January/February/March '18

1st On-Call Rotas	Shifts (Hours) Covered by Medical Bank	Cost of Medical Bank Shifts	Shifts (Hours) Covered by Agency	Cost of Agency Shifts	Total Cost
Barnsley	22 (167)*	£5880	5 (52)	£2598.40	
Calderdale	23 (184)	£6440	9 (81.75)	£3612.80	
Kirklees	17 (312)	£10920	0	0	
Wakefield	2 (24.5)	£857.50	0	0	
Total	64 (687.5)	£24097.50	14 (133.75)	£6211.20	£30308.70

*The majority of shifts in Barnsley (25) and some shifts in Calderdale (10) were covered by Specialty Doctors who were paid according to their individual terms and conditions.

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 tables detail 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 this quarter, there was only 1 shift unfilled compared with 4 shifts in the last quarter, where it was not possible to obtain junior doctor cover.

Issues and Actions

Recruitment – vacancies remain an ongoing national issue. There are a number of initiatives that the trust is involved through The Royal College (MTI - Medical Training Initiative) and Health Education England (WAST - Widening Access to Specialist Training) and a pilot Physician Associate role to address this.

Management of rota gaps – The process for managing rota gaps appears to be improving. The Medical Bank appears to have had 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. It is positive that only one shift was un-covered.

Junior Doctors' Forum – This continues to meet quarterly, offering a forum form trainees to raise concerns about their working lives and to consider options to improve the training experience. A number of issues about the Induction process were raised at the last meeting which the Guardian and AMD for Postgraduate Medical Education are trying to address.

Education and support – The Guardian will continue to work closely with the new Assistant Medical Director for Postgraduate Medical Education to improve systems to support clinical supervisors and monitor the educational aspects of the new contract and through induction sessions for new trainees on the use of Exception Reporting.

IT system – a decision was made to move from DRS to Allocate from April 2018. This seems to have proceeded smoothly but with only 1 ER since then it is hard to comment further at this stage.

Publication Summary

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

NHS England
Learning from deaths: guidance for NHS trusts on working with bereaved families and carers
This guidance advises trusts on how they should support, communicate and engage with families following a death of someone in their care. It sets out different stages following a death and calls on trusts to involve families throughout by providing bereavement support, signposting families to advice and advocacy support along with examples of how trusts are working with families and good practice guidance on specific subjects.

Click here for link to guidance

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

National Health Service Pay Review Body: thirty-first report 2018, Department of Health and Social Care

NHS Improvement provider bulletin: 27 June 2018:
• Patient Safety Alert: resources to support safer modification of food and drink
• Stop the Pressure: definition and measurement framework and national curriculum for pressure ulcer prevention
• New learning disability improvement standards
• Getting It Right First Time (GIRFT): cranial neurosurgery report
• Improvement 2018: leading for improvement
• Webinar: Evaluating your Freedom To Speak Up (FTSU) arrangements
• Updates from NHSI partners

Statistics on smoking, England: 2018

Female genital mutilation: April 2017-March 2018, annual report, experimental statistics report

NHS Improvement provider bulletin: 4 July 2018
• Deliver same-day care with help from new ambulatory emergency care (AEC) guides
• Three new safe staffing improvement resources
• Criteria-led discharge in practice
• Community and education and training standards published
• Webinar: Model Hospital masterclass — understanding the nursing and midwifery compartment
•Updates from NHSI partners

NHS Improvement provider bulletin: 11 July 2018
•Measles exposures and infections: recommended actions
•Manage bed capacity more effectively with the long-stays dashboard
•Update on the Single Oversight Framework (SOF)
•2016/17 medical workforce data now live on Model Hospital
•Well-led for the future: development for NHS board members and non-executive directors
•Updates from NHSI partners

Monthly hospital activity data: May 2018

Provisional monthly hospital episode statistics for admitted patient care, outpatient and accident a

Psychological therapies: reports on the use of IAPT services, England: April 2018

Publication Summary

Mental health services monthly statistics: final April, provisional May 2018

Community services statistics for children, young people and adults: March 2018

Direct access audiology waiting times: May 2018

Diagnostic imaging dataset: March 2018

Learning disability services monthly statistics, provisional statistics (assuring transformation: June 2018; mental health statistical dataset: April 2018, final)

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 3
(2018 / 19)

Appendix 1

With **all of us** in mind.

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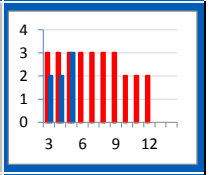
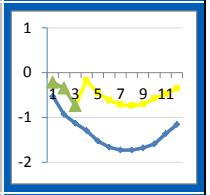
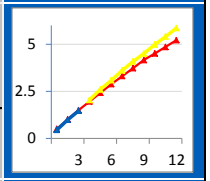
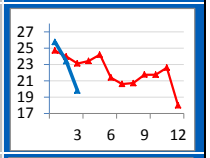
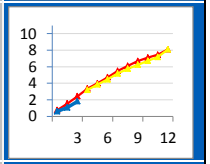
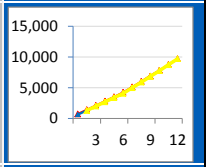
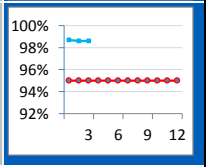
Contents

1.0 Executive Summary / Key Performance Indicators

Performance Indicator		Year To Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	3	3	Given the fact the Trust's I&E margin is a deficit in excess of 1% it scores a risk rating of 4. This means the overall risk rating can only be 3, which is a deterioration compared to 2017/18 and May.	
2	Normalised Deficit (excl PSF)	(£1m)	(£2.6m)	A disappointing deficit in June of £464k pre Provider Sustainability Fund (PSF) was incurred. The year-to-date deficit is now close to £1m, which whilst favourable to plan is a concern given the run rate.	
3	Agency Cap	£1.5m	£5.8m	Agency expenditure was £0.5m in June, which is fairly consistent with recent months. Year-to-date costs are £1.5m which is 3% higher than the same period last year. Current year-end projection is to exceed our agency cap by £0.6m (12%).	
4	Cash	£19.8m	£18m	The Trust cash position is £3.4m below plan in June due to delayed payments from two commissioners. These were paid on July 2nd.	
5	Capital	£1.8m	£8.1m	Capital expenditure is £0.6m lower than plan to date, largely due to the timing of some IT schemes. All schemes are being progressed and are expected to be delivered by the year-end.	
6	Delivery of CIP	£2m	£9.7m	Year to date CIP delivery is £0.1m behind plan (5%). At June 2018 the forecast position assumes delivery of the potential upside scenarios (£1.3m).	
7	Better Payment	99%		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.

			Actual Performance		Plan - Month 3	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	1.7	3	1.3	3
	20%	Liquidity (Days)	22.0	1	20.8	1
Financial Efficiency	20%	I & E Margin	-1.4%	4	-2.1%	4
Financial Controls	20%	Distance from Financial Plan	0.7%	1	0.0%	1
	20%	Agency Spend	-2.2%	1	0.0%	1
Weighted Average - Financial Sustainability Risk Rating				3		3

Impact

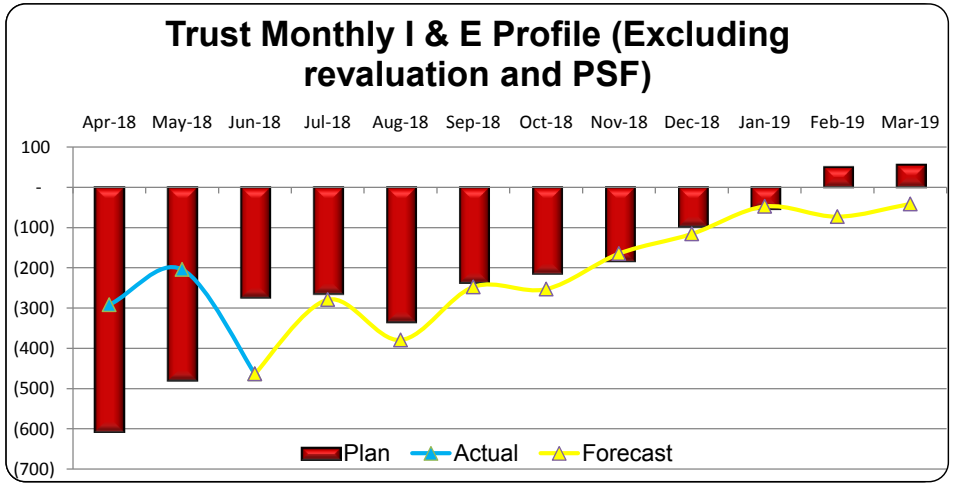
The current finance risk rating is 3. The Trust's I & E Margin exceeds a deficit of 1% at month 3, achieving a risk rating of 4 (this is in line with the planned position). As a result of the I&E Margin metric achieving 4 this means that the maximum threshold of 3 is applied to the financial sustainability risk rating this month.

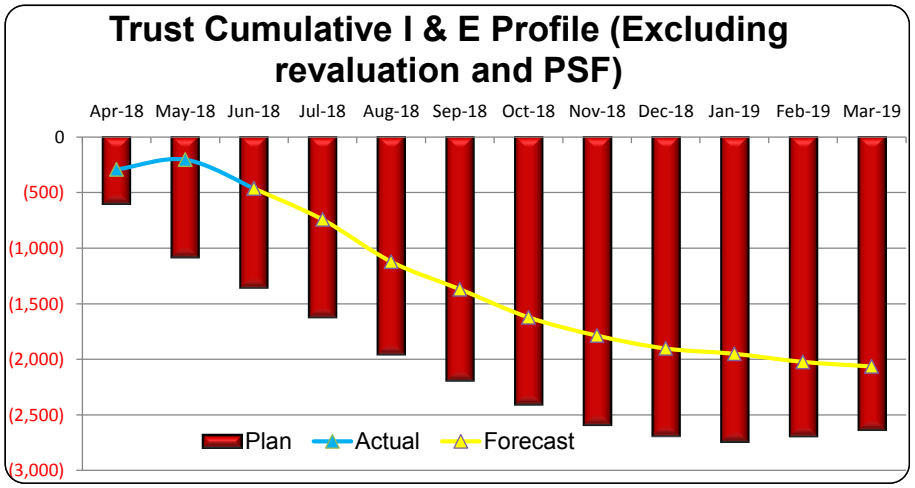
Definitions

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 £5.2m has been set for the Trust in 2018 / 2019. This metric compares performance against this cap.

2.0 Income & Expenditure Position 2018 / 2019

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**
				16,888	16,853	(34)	Clinical Revenue	50,226	50,169	(57)	200,153	200,220	68
				16,888	**16,853**	**(34)**	**Total Clinical Revenue**	**50,226**	**50,169**	**(57)**	**200,153**	**200,220**	**68**
				1,087	1,115	28	Other Operating Revenue	3,239	3,362	123	12,538	12,437	(101)
				17,975	**17,968**	**(7)**	**Total Revenue**	**53,465**	**53,532**	**66**	**212,691**	**212,657**	**(34)**
4,072	4,058	(14)	0.3%	(13,767)	(13,900)	(133)	Pay Costs	(41,476)	(41,300)	177	(164,994)	(165,055)	(61)
				(3,619)	(3,706)	(88)	Non Pay Costs	(10,596)	(10,731)	(135)	(41,214)	(41,028)	186
				(81)	(50)	31	Provisions	(405)	(131)	274	243	154	(89)
4,072	**4,058**	**(14)**	**0.3%**	**(17,467)**	**(17,657)**	**(190)**	**Total Operating Expenses**	**(52,477)**	**(52,161)**	**316**	**(205,965)**	**(205,928)**	**36**
4,072	**4,058**	**(14)**	**0.3%**	**508**	**311**	**(196)**	**EBITDA**	**988**	**1,370**	**382**	**6,726**	**6,729**	**3**
				(474)	(474)	0	Depreciation	(1,422)	(1,422)	0	(5,671)	(5,672)	(1)
				(310)	(310)	0	PDC Paid	(931)	(930)	1	(3,726)	(3,725)	1
				4	9	5	Interest Received	11	22	11	45	43	(2)
4,072	**4,058**	**(14)**	**0.3%**	**(273)**	**(464)**	**(191)**	**Normalised Surplus / (Deficit) Excl PSF**	**(1,354)**	**(959)**	**394**	**(2,626)**	**(2,626)**	**0**
				73	73	0	PSF (Provider Sustainability Fund)	221	221	0	1,470	1,470	0
4,072	**4,058**	**(14)**	**0.3%**	**(200)**	**(391)**	**(191)**	**Normalised Surplus / (Deficit) Incl PSF**	**(1,133)**	**(738)**	**394**	**(1,156)**	**(1,156)**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,072	**4,058**	**(14)**	**0.3%**	**(200)**	**(391)**	**(191)**	**Surplus / (Deficit)**	**(1,133)**	**(738)**	**394**	**(1,156)**	**(1,156)**	**0**





Income & Expenditure Position 2018 / 2019

Financial performance in June is a sizeable deficit. The run rate is adverse to what needs to be achieved and action is required in order to secure the year end control total position.

Month 3

The June position is a pre PSF deficit of £464k and a post PSF deficit of £391k, this is £191k behind plan. The normalised year-to-date position is a pre PSF deficit of £959k, which whilst favourable to the Q1 plan demonstrates a run rate which is significantly adverse to what its required to achieve our year-end control total of £2.6m deficit.

Both pay and non-pay costs were overspent in June. Out of area bed costs remain high and were only partly offset by savings in other non-pay areas. The net effect of temporary staffing costs covering vacancies was an overspend of £133k.

Income

At month 3 income is £34k ahead of plan, a full breakdown of Income is shown on page 7.

2018/19 CQUIN income totals £4.3m, a risk of £0.3m has been identified and actions are being taken to try to reduce this risk.

Pay Expenditure

As stated earlier pay costs were £133k overspent in June. This is the first monthly overspend on pay in well over a year. Cumulatively pay costs remain £0.2m favourable to plan. Further details on pay expenditure are provided on page 8.

Whilst the Trust has continued to run with a number of vacancies the costs associated with temporary staffing used to meet clinical and service requirements have exceeded any saving. In particular bank costs have increased in month and this is closely linked to cost pressures being experienced on inpatient wards. Due to this a further focus has been provided at page 10.

Non Pay Expenditure

Non pay overspent by £88k in June. Whilst out of area bed spend has stabilised it remains significantly higher than historical averages and budget. Actual spend was £349k in-month and is £1.1m cummulatively. The year-to-date spend represents over 60% of the full year budget. Drugs costs remains a pressure although a number of savings linked to pricing and usage have been identified and are being validated.

Forecast

The Trust is still forecasting to achieve its year-end control total of £2.6m deficit, but given the fact a number of the risks identified at the beginning of the year and the current run rate this is at risk. Based on known risks and other information additional savings of £1.5m are required to enable achievement of the control total.

Income Information

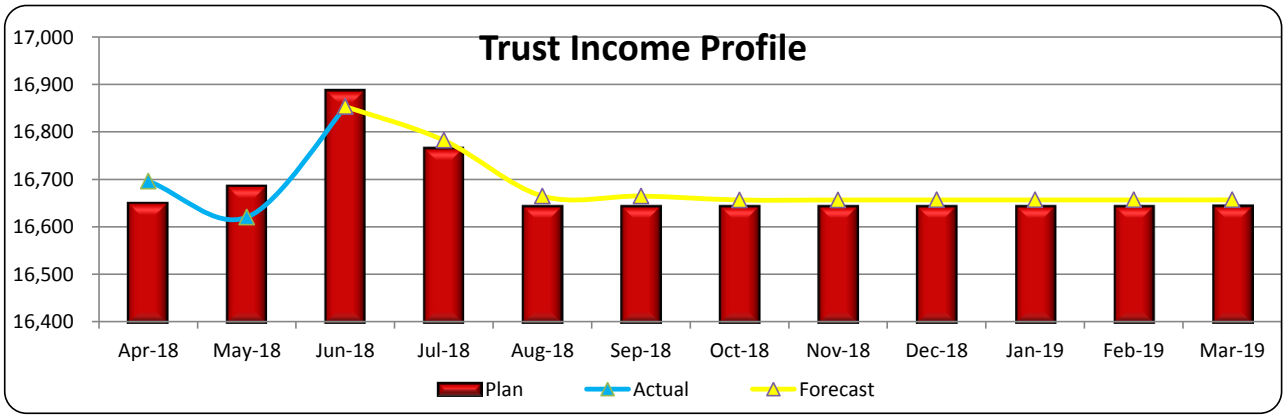
The table below summarises the year to date and forecast income by commissioner group. This is identified as clinical revenue within the Trust income and expenditure position (page 5). The majority of Trust income is secured through block contracts and therefore there has traditionally been little variation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

There is an increase in planned and actual income in month 3 as seen in the graph below. This is due to an expected contract variation with commissioners for reimbursement of property costs. The increased expenditure has also been included in non pay from month 3. This has been included prior to final contract signature to ensure that both income and expenditure are not misstated. It is expected that this process will be finalised in month.

The annual budget and forecast have also been updated in June 2018 following the announcement of retained IAPT services in Barnsley. This was previously flagged within the Trust risk and opportunity assessment.

There is a potential risk of unachieved CQUIN which has not been included in the forecast but has been presented through the Trust risk and upsides assessment.

Commissioner	Year to Date			Variance Headlines			Forecast			Variance Headlines		
	Budget £k	Actual £k	Variance £k	CQUIN £k	Other £k	Total £k	Budget £k	Actual £k	Variance £k	CQUIN £k	Other £k	Total £k
CCG	24,263	24,144	(119)	0	(119)	(119)	143,957	143,957	(0)	0	(0)	(0)
Specialist Commissioner	3,893	3,893	0	0	0	0	23,356	23,356	0	0	0	0
Alliance	2,158	2,158	0	0	0	0	14,478	14,478	0	0	0	0
Local Authority	843	843	(0)		(0)	(0)	5,060	5,000	(60)		(60)	(60)
Partnerships	1,154	1,154	0	0	0	0	6,922	6,922	0	0	0	0
Other	17,915	17,977	62	0	62	62	6,381	6,509	128	0	128	128
Total	**50,226**	**50,169**	**(57)**	**0**	**(57)**	**(57)**	**200,153**	**200,220**	**68**	**0**	**68**	**68**



CQUIN Risk - Summary	YTD	Forecast
Wellbeing Improvement	38	151
Ill Health by Risky behaviour	25	101
Total	**63**	**252**

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 in excess of 75% of total Trust expenditure.

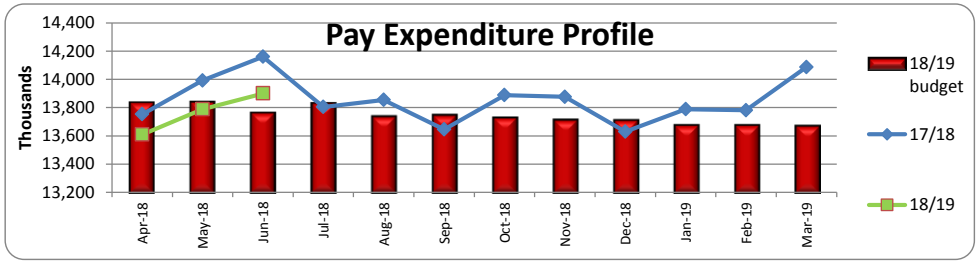
The Trust workforce strategy was approved by Trust board during 2017 / 2018 with the strategic workforce plan approved in March 2018.

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-18 £k	May-18 £k	Jun-18 £k	Jul-18 £k	Aug-18 £k	Sep-18 £k	Oct-18 £k	Nov-18 £k	Dec-18 £k	Jan-19 £k	Feb-19 £k	Mar-19 £k	Total £k
Substantive	12,595	12,598	12,593										**37,786**
Bank & Locum	571	652	824										**2,047**
Agency	444	538	484										**1,466**
Total	**13,610**	**13,789**	**13,901**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41,300**
17/18	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**
Bank as %	4.2%	4.7%	5.9%										5.0%
Agency as %	3.3%	3.9%	3.5%										3.6%

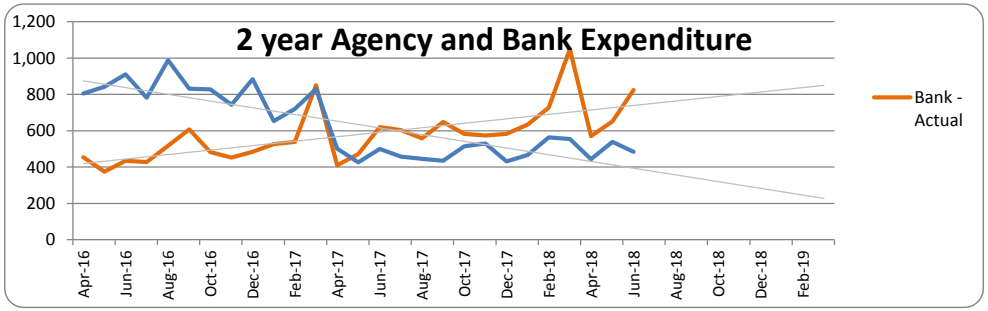
Year to Date expenditure - by staff group

	Substantive £k	Temp £k	Agency £k	Total £k
Medical	4,454	119	808	5,381
Nursing Registered	12,984	627	134	13,746
Nursing Unregistered	4,117	1,000	344	5,461
Other	10,055	154	181	10,389
Admin	6,161	162	0	6,323
Total	**37,771**	**2,062**	**1,466**	**41,300**



June WTE Analysis

	Budgeted	Contracted	Bank	Agency	Variance
Medical	210	165	2	19	(24)
Qualified Nursing	1,376	1,240	67	9	(60)
Unqualified Nursing	637	607	151	38	160
Other Clinical	847	764	8	10	(65)
A & C	805	733	27	0	(45)
Other	313	292	10	1	(9)
Staff Vacancy Factor	(115)	0	0	0	115
Total	**4,072**	**3,803**	**265**	**77**	**73**



Key Messages

Bank and locum costs have continued to increase in June 2018 and are higher than the average monthly spend for 2017 / 2018 (£622k). It is important to note that there was an increase also in June 2018 which relates to bank holiday payments (worked during May each year). This continues to be triangulated with substantive and agency costs and how the Trust provides a workforce solution to meet the demands placed on services. A key area of workforce spend is on inpatient wards, and this is typically overspending. As such a specific focus is provided on page 10.

Substantive pay levels are at a consistent level across quarter 1. It has been confirmed that the Agenda For Change pay award will be actioned in July 2018. This is currently not included within forecasted levels of spend as per national guidance. It is fully anticipated that specific funding will be makde directly available to providers to cover the extent of the pay award.

2.1 Agency Expenditure Focus

The NHS Improvement agency cap for 2018/19 is £5.2m

The forecast expenditure breaches cap by £0.6m

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

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

Good progress was made in 2017/18 in terms of significantly reducing agency usage and costs from the £9.8m incurred in 2016/17. Costs now seem to have plateaued at £450k-£550k per month. The maximum agency cap established by NHSI for 2018/19 is £5.2m which is £0.6m lower than the cap for last year.

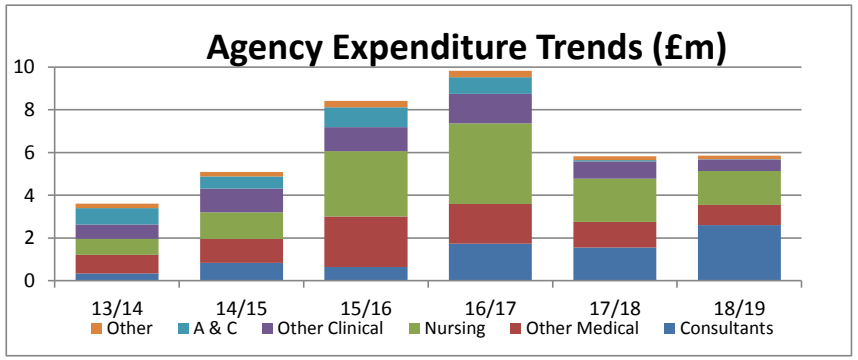
The NHS Improvement cap has been profiled to reduce spend across the year as actions have their desired impact. The cap profile reduces from £500k per month in April 2018 to £359k per month in March 2019. Actual expenditure needs to reduce to remain under this cap.

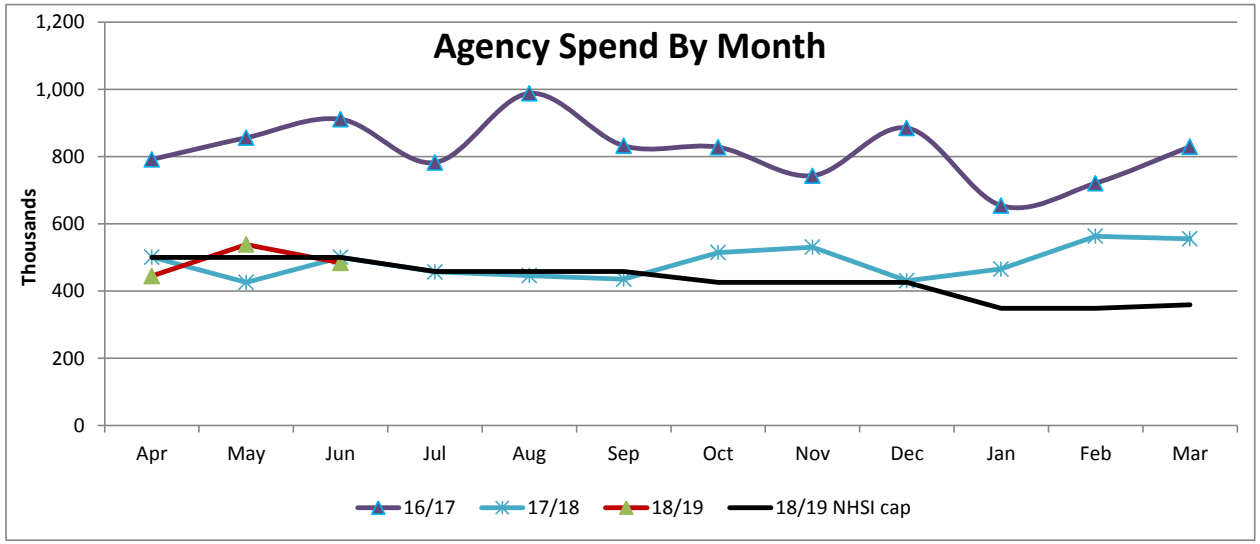
At month 3 agency spend is £484k, 3% below cap. Overall the year to date expenditure is 2% below cap.

Small decreases in agency spend have been seen across all staff groups in June. Medical vacancy cover and nursing shift requirements to support the inpatient wards remain high.

Forecast agency usage within Specialist services accounts for 47% (£2.7m) of total agency expenditure.

The agency cap profile begins to reduce in July, expenditure is forecast to exceed the cap for the remainder of the year, and to exceed cap by £0.6m (12%) by the end of the year.





2.1 Inpatient Wards Pay Expenditure Focus

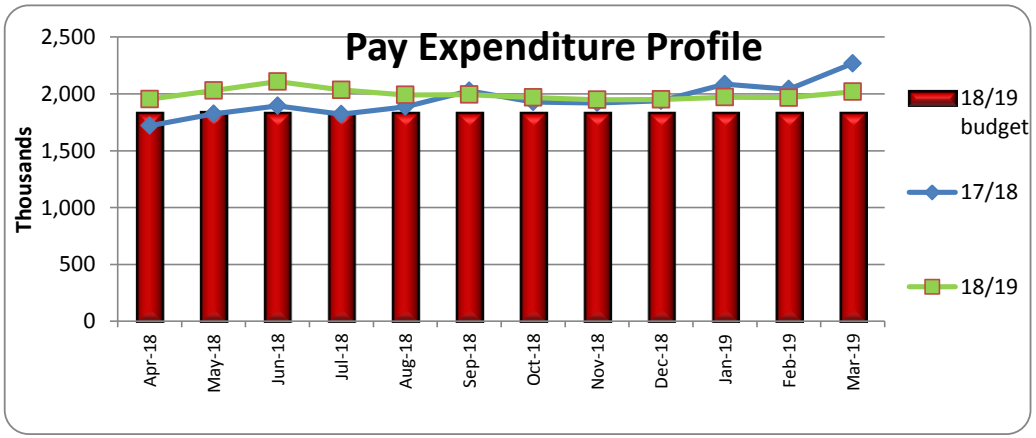
On an ad hoc basis additional focussed information is provided to highlight financial pressures or good practice. This provides a consolidated Trustwide view which may help to identify a whole system response.

This specific focus is on current spend and run rate for inpatient ward areas. Whilst non pay and income have been reviewed the largest pressure is pay related and as such the focus is on that area. This focus does not include forensic services and, as it considers direct ward spend only, does not include any medical input or other costs.

Inpatient wards have funded staffing establishment based upon clinically agreed safer staffing models. In line with contracts with commissioners these are based upon normal activity levels, 85% occupancy (which is the commissioned level) and normal levels of acuity.

Changes to these base assumptions, such as additional staffing to meet levels of demand, result in financial pressures.

Inpatient Type	Year to Date			Forecast		
	Budget £k	Actual £k	Variance £k	Budget £k	Actual £k	Variance £k
Adult Working Age	1,826	2,074	(248)	7,304	8,202	(898)
Older Peoples	1,131	1,295	(164)	4,524	5,237	(713)
Rehab	201	196	5	803	769	34
PICU	695	767	(72)	2,779	2,968	(189)
Other	1,652	1,759	(107)	6,597	6,755	(158)
Total	**5,505**	**6,092**	**(587)**	**22,007**	**23,931**	**(1,924)**
Substantive	5,505	4,879	626	22,007	19,470	2,537
Bank	0	908	(908)	0	3,383	(3,383)
Agency	0	304	(304)	0	1,078	(1,078)
Total	**5,505**	**6,092**	**(587)**	**22,007**	**23,931**	**(1,924)**



This focus looks at 19 wards which in total are forecasting an overspend of £1.9m. Of these, 3 wards represent £1.1m (57%) of this overspend. These are wards 18 and 19 at Priestley and Priory ward at Fieldhead.

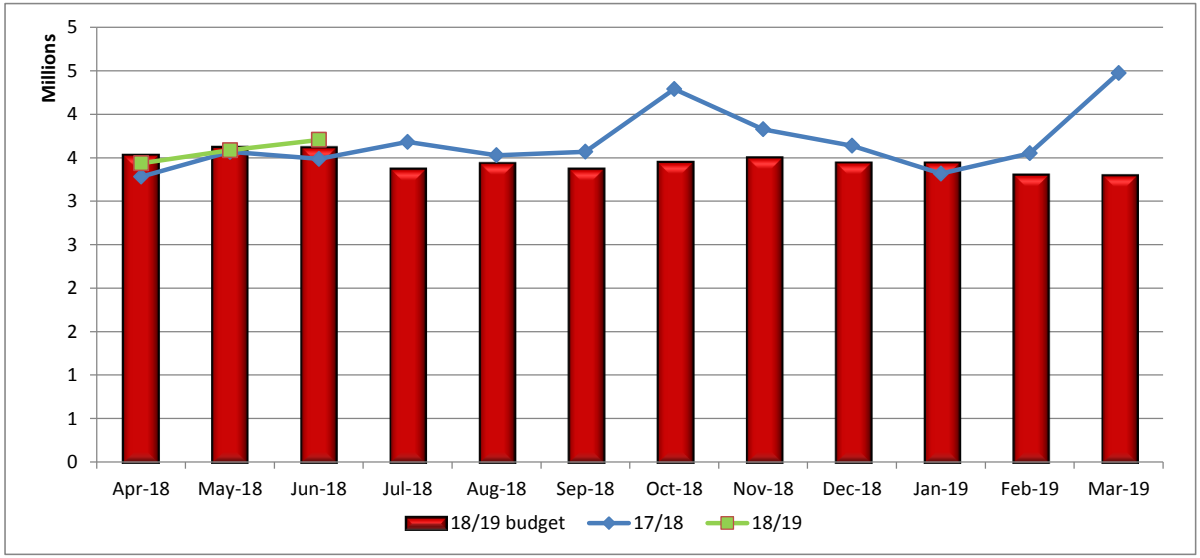
Across all wards the same themes of high acuity levels, vacancies, sickness, maternity leave and escorts are driving the high levels of overspend. On one ward an additional 29 shifts a week were used throughout the month.

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).

	Apr-18 £k	May-18 £k	Jun-18 £k	Jul-18 £k	Aug-18 £k	Sep-18 £k	Oct-18 £k	Nov-18 £k	Dec-18 £k	Jan-19 £k	Feb-19 £k	Mar-19 £k	Total £k
2018 / 2019	3,437	3,588	3,706										**10,731**
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**

Non Pay Category	Budget YTD £k	Actual YTD £k	Variance £k
Clinical Supplies	699	712	(12)
Drugs	738	818	(80)
Healthcare subcontracting	1,363	1,698	(336)
Hotel Services	454	468	(15)
Office Supplies	1,316	1,279	37
Other Costs	1,144	1,009	134
Property Costs	1,625	1,677	(52)
Service Level Agreements	1,520	1,513	7
Training & Education	149	118	30
Travel & Subsistence	971	804	167
Utilities	291	303	(12)
Vehicle Costs	326	330	(4)
Total	**10,596**	**10,731**	**(135)**
Total Excl OOA and Drugs	**8,495**	**8,214**	**281**



Key Messages

Healthcare subcontracting relates to the purchase of all non-Trust bed capacity and is overspending by £336k. As a fluctuating pressure the out of area focus provides further details on this.

The next largest non pay variance to plan relates to drugs. The run rate has reduced in June 2018 (£10k overspend in month compared to £46k over in month 2) and the impact of actions led by the pharmacy department continue to be assessed. Costed schemes illustrate a recurrent full year effect of £263k whilst review of prescribing practices, standardisation of drugs used and pricing changes continue to provide new savings opportunities. In 2017/18 drugs had overspent by £173k at Q1.

Property costs in June include an additional £0.3m LIFT adjustment to account for a contract variation to reimburse property costs, all quarter 1 income and expenditure has been reported in month 3, the adjustment does not create an additional pressure in year.

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 excludes activity relating to locked rehab in Barnsley.

Out of Area Expenditure Trend (£)

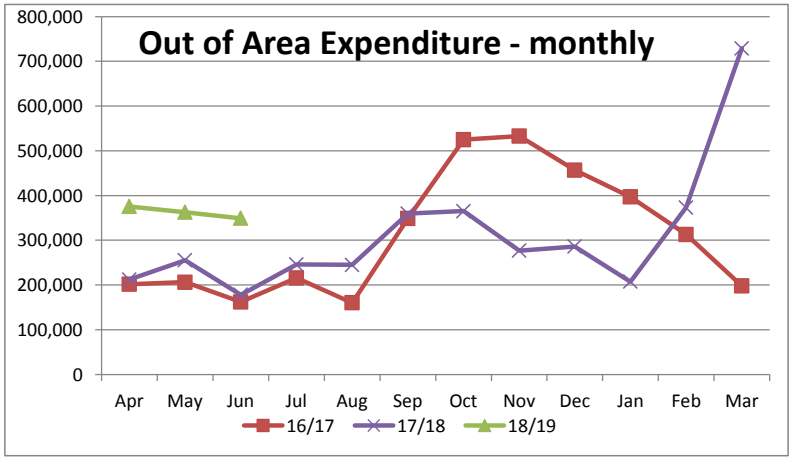
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
16/17	202	206	162	216	160	349	525	533	457	397	313	198	**3,718**
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	0	0	0	0	0	0	0	0	0	**1,088**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
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**
18/19	598	382	414	0	0	0	0	0	0	0	0	0	**1,394**

Bed Day Information 2018 / 2019 (by category)

PICU	316	204	128	**648**
Acute	277	125	181	**583**
Gender	5	53	105	**163**
Total	598	382	414	**1,394**



Due to the increasing levels of high demand from January to March 2018 the out of area budget has been weighted to account for higher spend at the start of the year reducing significantly across the year as actions from the project board are implemented.

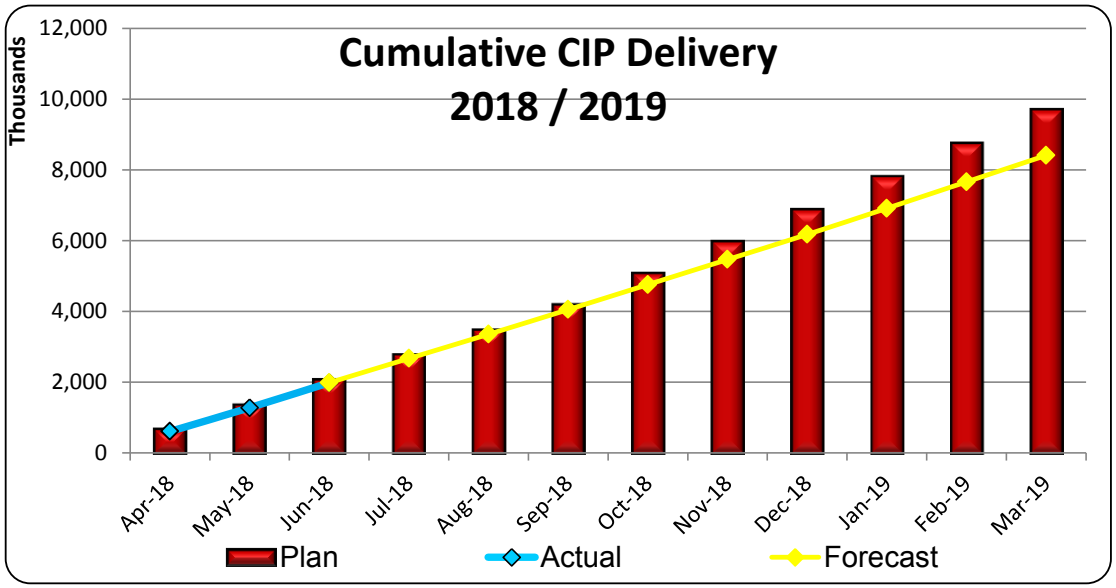
Even with this budget phasing, out of area has overspent by £367k year to date.

Both PICU and Acute demand are higher than commissioned levels. Work continues to focus on the reason for each admission and to take appropriate action to reduce. We are working collectively on an action plan to address with our commissioning colleagues.

These actions will include working closely with STP partners to gain an understanding of bed utilisation across the area.

2.1 Cost Improvement Programme 2018 / 2019

	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	691	1,382	2,091	2,798	3,501	4,203	5,100	5,997	6,894	7,823	8,762	9,701	2,091	9,701
Delivery as originally planned	565	1,155	1,727	2,303	2,877	3,464	4,056	4,649	5,242	5,867	6,500	7,133	1,727	7,133
Mitigations - Recurrent & Non-Recurrent	37	119	254	364	474	584	699	814	930	1,045	1,160	1,275	254	1,275
Mitigations - Upside schemes							215	430	645	860	1,075	1,292	0	1,292
Total Delivery	**602**	**1,274**	**1,981**	**2,667**	**3,351**	**4,048**	**4,970**	**5,894**	**6,817**	**7,772**	**8,735**	**9,700**	**1,981**	**9,700**
Variance	(89)	(108)	(110)	(131)	(150)	(155)	(130)	(104)	(77)	(52)	(27)	(0)	(110)	(0)



The Trust has a CIP requirement for 2018 / 19 totalling £9.7m. This includes £1.6m of unidentified savings at the beginning of the year.

Schemes forecast to achieve savings now total £8.4m (up £0.3m from month 2 and a total £0.5m from month 1). This follows the realisation of planned upsides (income contributions) and identification of new non pay savings through continued cost review and challenge.

Currently a value of £1.3m is rated as red for delivery or unidentified. As potential upsides continue to be finalised these will reduce this value. Month 4 should incorporate the financial impact of management structural changes and additional insurance savings.

3.0 Balance Sheet 2018 / 2019

	2017 / 2018 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	123,810	124,393	124,206	1
Current Assets				
Inventories & Work in Progress	232	232	232	
NHS Trade Receivables (Debtors)	1,388	2,707	5,713	2
Non NHS Trade Receivables (Debtors)	1,867	3,377	1,657	
Other Receivables (Debtors)	1,219	1,000	2,400	3
Accrued Income	3,660	4,650	5,598	4
Cash and Cash Equivalents	26,559	23,125	19,772	5
Total Current Assets	**34,925**	**35,091**	**35,373**	
Current Liabilities				
Trade Payables (Creditors)	(4,158)	(5,270)	(4,323)	6
Capital Payables (Creditors)	(1,142)	(1,742)	(823)	6
Tax, NI, Pension Payables	(5,782)	(6,000)	(6,501)	
Accruals	(5,799)	(6,000)	(6,693)	7
Deferred Income	(670)	(670)	(806)	
Total Current Liabilities	**(17,552)**	**(19,682)**	**(19,145)**	
Net Current Assets/Liabilities	**17,373**	**15,409**	**16,227**	
Total Assets less Current Liabilities	**141,183**	**139,802**	**140,433**	
Provisions for Liabilities	(6,490)	(6,240)	(6,479)	
Total Net Assets/(Liabilities)	**134,693**	**133,562**	**133,955**	
Taxpayers' Equity				
Public Dividend Capital	44,015	44,015	44,015	
Revaluation Reserve	24,938	24,938	24,938	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	60,520	59,389	59,782	8
Total Taxpayers' Equity	**134,693**	**133,562**	**133,955**	

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.

Additional levels of detail have been included when compared to 2017 / 2018 to highlight accrued income and payables due to tax, National Insurance (NI) and pension arrangements.

1. Capital expenditure is detailed on page 15. Overall spend is below plan meaning that the value of Trust assets is lower than plan.

2. NHS Debtors are higher than plan, as two block contracts were not paid within month (£3.5m). Both of these were paid on the 2nd July.

3. Other Receivables includes prepayments, this is currently higher than plan and the majority relates to licences.

4. Accrued income is currently higher than plan, This includes £1m with Barnsley Metropolitian Borough Council (BMBC) awaiting purchase order, £0.8m lease cars, £2.1m PSF (£2m of which was received 6th July) and £0.4m CQUIN.

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

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

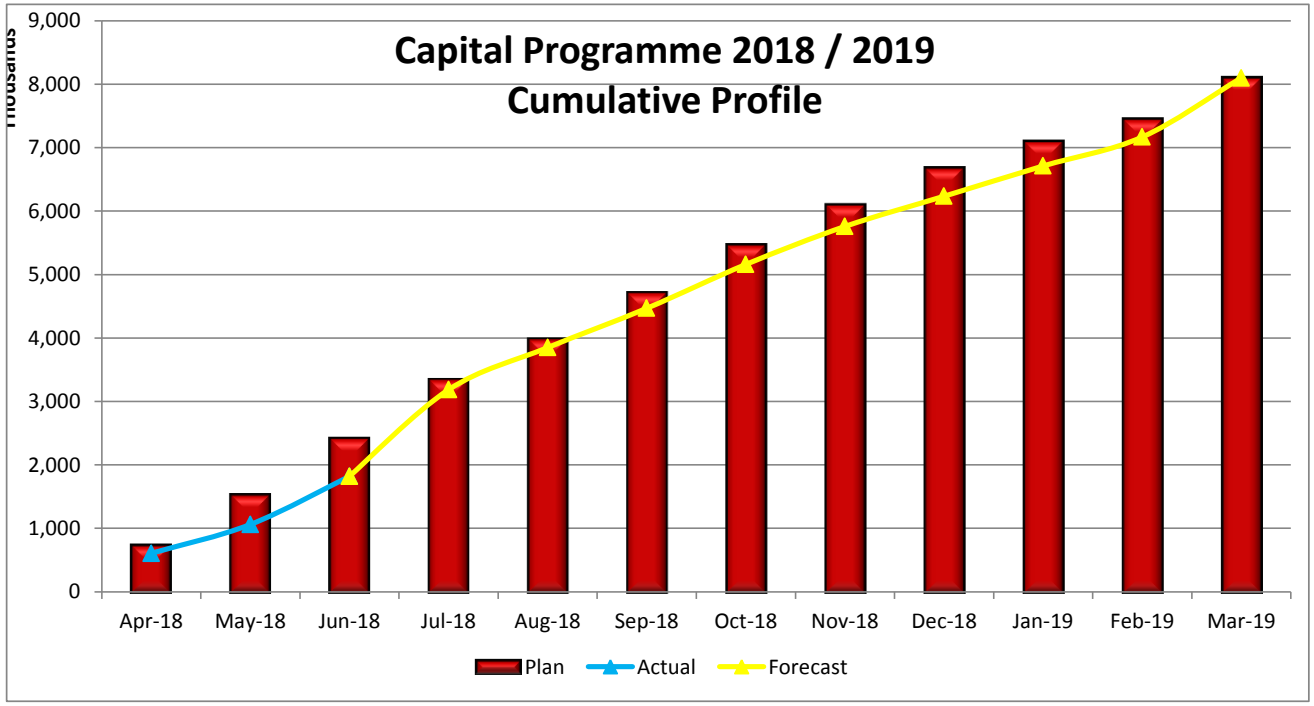
7. Accruals are higher than plan due to timing of invoices.

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

3.1 Capital Programme 2018 / 2019

	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	1,493	132	101	(31)	1,598	105	
Equipment Replacement	0	0	27	27	27	27	
IM&T	1,550	450	57	(393)	1,417	(133)	2
Major Capital Schemes							
Fieldhead Non Secure	4,229	1,604	1,513	(92)	4,229	(0)	
Clinical Record System	828	251	147	(104)	853	25	
VAT Refunds	0	0	(24)	(24)	(24)	(24)	
TOTALS	**8,100**	**2,437**	**1,820**	**(617)**	**8,100**	**(0)**	1

Spend to date is behind plan specifically within IM & T. Work schemes are being progressed to ensure value for money.



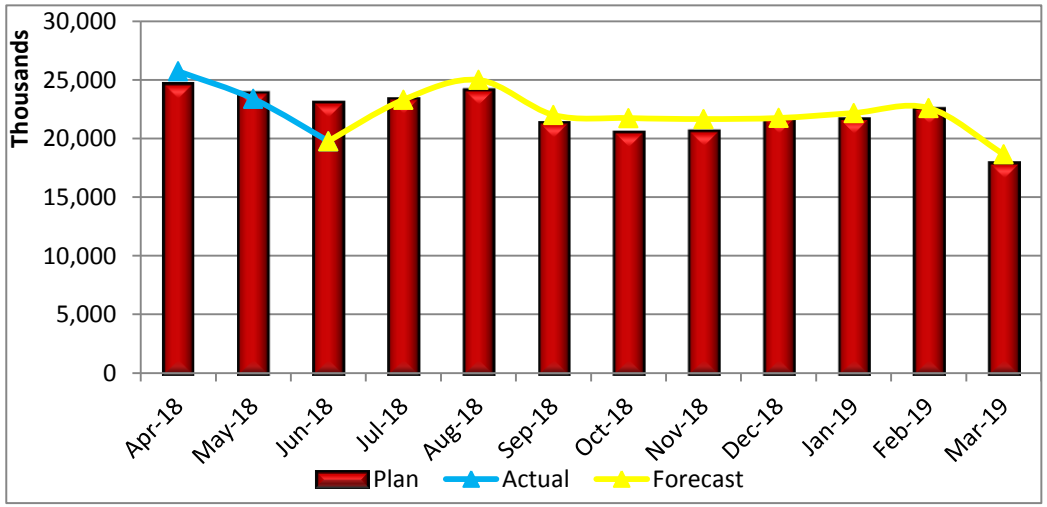
Capital Expenditure 2018 / 2019

1. The capital plan for 2018 / 2019 is £8.1m and schemes are guided by the current Estates Strategy.

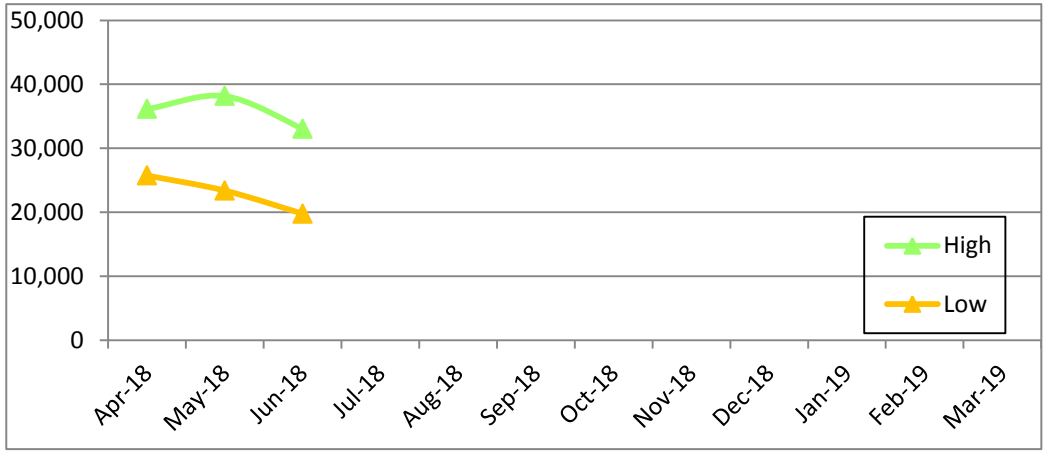
The year to date position is £617k (25%) lower than plan excluding VAT refunds.

2. IM&T expenditure is currently below plan, but orders have typically been placed for the major items. As such it is expected that this is very much a timing issue.

3.2 Cash Flow & Cash Flow Forecast 2018 / 2019



	Plan £k	Actual £k	Variance £k
Opening Balance	26,559	26,559	
Closing Balance	23,125	19,772	(3,353)



Cash is £3.4m behind plan. Block payments for June 2018 (£3.5m) were not received until 2nd July.

Cash is below plan due to the late payments relating to 2 block contracts. These were subsequently paid on July 2nd and it is forecast that cash will be closer to plan next month.

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

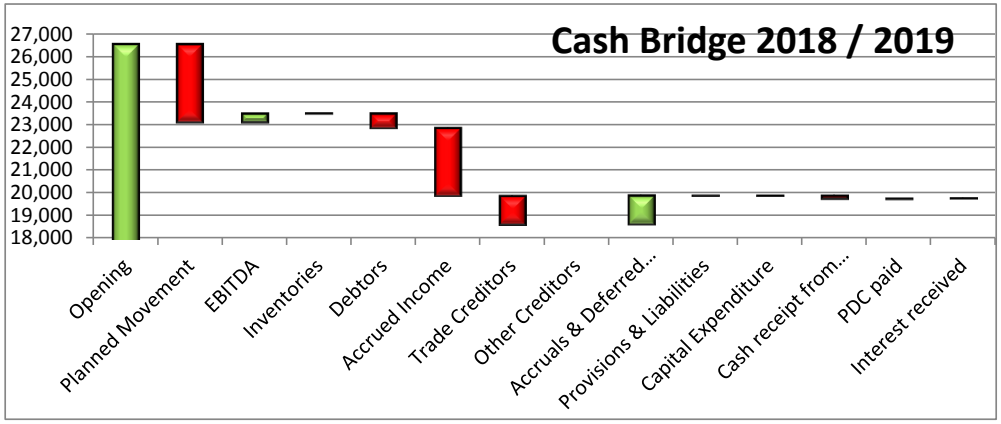
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£33m
The lowest balance is:	£19.8m

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	**26,559**	**26,559**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	1,209	1,592	383	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(3,600)	(4,241)	(641)	3
Accrued Income / Prepayments	0	(2,993)	(2,993)	4
Trade Payables (Creditors)	1,200	(47)	(1,247)	5
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	(250)	1,030	1,280	2
Provisions & Liabilities	0	(11)	(11)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(2,005)	(2,139)	(134)	
Cash receipts from asset sales	0	2	2	
PDC Dividends paid	0	0	0	
PDC Dividends received			0	
Interest (paid)/ received	12	22	10	
Closing Balances	**23,125**	**19,772**	**(3,352)**	



The plan value reflects the April 2018 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. Whilst we are reporting an in year deficit the actual position is favourable to plan which has a positive impact on cash.

2. Accruals and deferred income are higher than plan, this is expected to reduce further in July 2018 as invoices will be received for Quarter 1 charges.

Factors which decrease the cash position against plan:

3. Debtors are higher than plan, this is due to the delay in payment of 2 NHS block contracts, these were paid on the 2nd July. From a cash perspective these have been offset with other debtors being lower than planned. Debtor management remains the key focus of the Trust cash management work.

4. Accrued income is higher than plan, purchase order numbers are still outstanding for £1.0m. These are been actively chased. We would not normally raise these invoices without a purchase order as they would be returned unpaid.

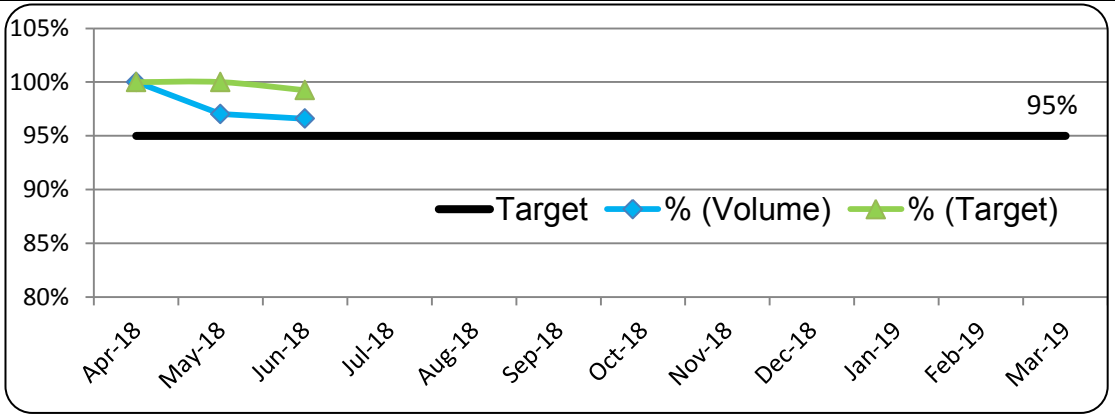
5. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code and any aged creditors are reviewed and action plans for resolution agreed.

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

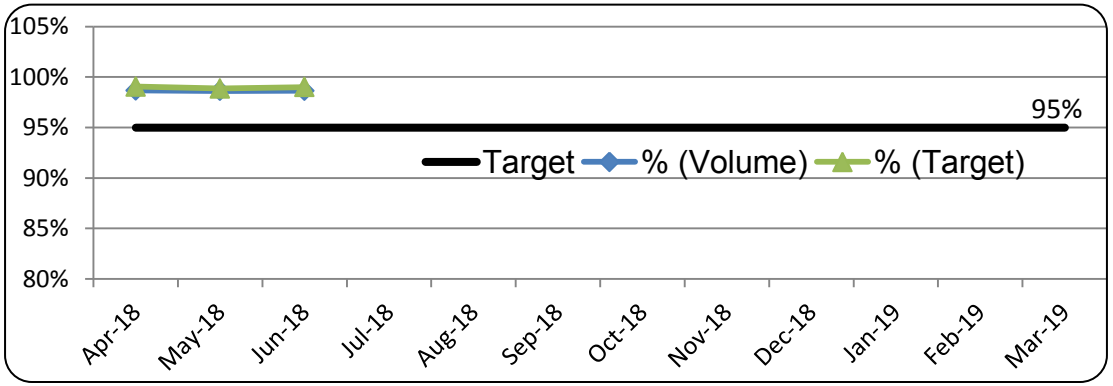
4.0 Better Payment Practice Code

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.
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 May 2018	97%	100%
Year to June 2018	97%	99%



Non NHS	Number %	Value %
Year to May 2018	99%	99%
Year to June 2018	99%	99%



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

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 (£)
06-Jun-18	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3073730	219,053
02-May-18	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	3070758	112,531
05-Jun-18	Property maintenance	Kirklees	Mid Yorkshire Hospitals NHS Trust	3073561	68,851
18-Jun-18	Legal/Prof fees	Trustwide	NHS Litigation Authority	3074752	61,855
28-Jun-18	Staff Recharge	Trustwide	Wakefield MDC	3075800	61,835
22-May-18	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	3072493	48,310
04-Jun-18	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3073343	47,057
06-Jun-18	Clinical Services	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3073729	46,559
05-Jun-18	Property maintenance	Kirklees	Mid Yorkshire Hospitals NHS Trust	3073561	45,391

4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

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

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. For 2018 / 2019 the Trust were set a control total deficit.

* 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.

* Provider Sustainability Fund (PSF) - is an income stream distributed by NHS Improvement to all providers who meet certain criteria (this was formally called STF - Sustainability and Transformation Fund)

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.1%	5.2%	5.1%	4.4%	4.1%	4.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.5%	5.9%	4.8%	4.4%	3.9%	3.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	96.6%	96.6%	96.7%	7.0%	25.4%	78.3%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	94.5%	94.3%	94.3%	1.0%	2.5%	6.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	77.4%	77.5%	77.9%	81.3%	81.9%	82.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	77.2%	78.7%	80.7%	80.2%	83.0%	84.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	87.4%	88.0%	88.9%	90.8%	90.4%	90.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.0%	92.4%	91.4%	91.3%	92.1%	92.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.0%	82.0%	84.1%	84.2%	86.4%	86.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	66.4%	62.9%	63.3%	60.7%	63.2%	61.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	84.4%	85.2%	85.6%	85.8%	86.4%	87.1%
Information Governance	Resources	Well Led	AD	>=95%	88.4%	95.9%	96.8%	91.6%	91.9%	91.6%
Moving and Handling	Resources	Well Led	AD	>=80%	84.0%	84.7%	83.9%	82.1%	81.5%	81.4%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	84.3%	84.2%	83.3%	84.3%	84.7%	84.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	78.6%	77.8%	76.3%	78.9%	81.4%	80.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	88.0%	88.7%	89.2%	89.9%	90.9%	91.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	85.8%	86.7%	87.9%	88.2%	88.9%	89.3%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.0%	94.3%	93.2%	95.6%	96.3%	96.3%
Agency Cost	Resources	Effective	AD		£105k	£104k	£87k	£78k	£79k	£55k
Overtime Costs	Resources	Effective	AD		£4k	£3k	£1k	£3k	£5k	£4k
Additional Hours Costs	Resources	Effective	AD		£17k	£11k	£13k	£14k	£8k	£11k
Sickness Cost (Monthly)	Resources	Effective	AD		£163k	£151k	£132k	£115k	£118k	£107k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		191.9	166.28	166.52	79.14	92.5	91.03
Business Miles	Resources	Effective	AD		101k	90k	90k	96k	93k	90k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.1%	5.3%	5.3%	5.0%	4.9%	4.7%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.9%	6.5%	5.2%	4.8%	4.7%	4.4%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	97.9%	97.9%	97.9%	6.1%	33.8%	93.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.8%	96.0%	95.9%	0.0%	1.5%	9.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.0%	77.6%	78.5%	78.4%	80.7%	81.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	73.1%	75.1%	78.7%	80.9%	84.3%	85.4%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	84.2%	87.5%	86.7%	86.9%	86.2%	86.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	86.9%	86.8%	87.8%	88.1%	89.0%	89.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.4%	84.3%	85.4%	84.7%	86.1%	86.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	83.3%	80.3%	79.6%	76.5%	78.7%	75.7%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	85.2%	86.5%	87.2%	87.3%	86.7%	87.6%
Information Governance	Resources	Well Led	AD	>=95%	94.1%	98.5%	98.3%	93.6%	93.1%	93.0%
Moving and Handling	Resources	Well Led	AD	>=80%	83.0%	84.1%	84.3%	85.8%	86.2%	86.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.7%	93.1%	92.9%	93.1%	93.9%	94.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	90.2%	90.5%	89.8%	91.4%	91.9%	91.8%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	86.8%	89.8%	89.6%	89.8%	89.9%	90.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	82.4%	84.5%	85.1%	85.3%	84.5%	86.0%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.1%	95.6%	95.1%	95.4%	95.9%	95.7%
Agency Cost	Resources	Effective	AD		£108k	£131k	£133k	£98k	£143k	£104k
Overtime Costs	Resources	Effective	AD		£2k	£8k	£4k	£3k	£8k	£1k
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£1k	£3k	£0k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£167k	£139k	£118k	£107k	£106k	£92k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		62.78	67.83	62.79	58.91	62.81	60.56
Business Miles	Resources	Effective	AD		65k	69k	53k	70k	53k	58k

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	6.6%	6.8%	6.8%	6.2%	6.1%	6.1%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	8.4%	8.4%	7.1%	6.2%	6.0%	6.0%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.7%	98.7%	98.7%	14.1%	32.1%	83.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	97.7%	97.7%	98.0%	3.1%	8.1%	16.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.3%	84.9%	84.9%	85.1%	88.1%	87.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	80.4%	82.1%	86.6%	88.0%	87.3%	84.8%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	86.0%	86.9%	85.8%	86.3%	86.5%	87.7%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.4%	88.8%	89.5%	90.2%	91.7%	93.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	91.8%	88.8%	90.7%	90.4%	92.7%	90.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	84.7%	87.3%	85.3%	85.4%	84.4%	87.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	86.5%	89.2%	91.4%	89.7%	90.5%	90.5%
Information Governance	Resources	Well Led	AD	>=95%	89.8%	95.6%	96.4%	91.9%	92.4%	92.9%
Moving and Handling	Resources	Well Led	AD	>=80%	88.9%	89.0%	90.9%	90.2%	91.2%	90.8%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.0%	92.2%	91.9%	92.2%	92.9%	92.7%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	85.7%	85.5%	83.9%	83.4%	83.6%	83.0%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.8%	89.7%	89.2%	89.0%	91.9%	93.4%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	87.4%	86.6%	86.3%	86.8%	87.5%	89.1%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.0%	94.7%	86.4%	87.5%	83.3%	82.6%
Agency Cost	Resources	Effective	AD		£26k	£36k	£35k	£41k	£39k	£39k
Overtime Costs	Resources	Effective	AD		£0k	£0k	£0k	£1k	£0k	£-1k
Additional Hours Costs	Resources	Effective	AD		£3k	£1k	£0k	£1k	£0k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£82k	£72k	£65k	£59k	£56k	£54k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		42.11	45.72	45.42	52.45	49.26	53.13
Business Miles	Resources	Effective	AD		8k	6k	4k	7k	9k	6k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.7%	5.6%	5.6%	5.3%	5.6%	5.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.2%	4.7%	5.1%	5.3%	5.8%	4.4%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.4%	99.4%	99.4%	1.8%	14.7%	65.0%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	100.0%	100.0%	99.0%	0.0%	4.0%	7.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	71.9%	71.4%	75.9%	76.8%	80.9%	81.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	80.1%	83.8%	86.5%	87.9%	86.2%	85.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	85.6%	84.7%	86.0%	86.2%	90.2%	90.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	84.4%	85.6%	84.9%	86.0%	87.0%	85.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	79.7%	84.0%	83.0%	81.8%	81.6%	80.9%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	75.0%	69.2%	69.2%	68.0%	68.0%	69.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	84.7%	87.7%	87.3%	87.4%	88.2%	86.2%
Information Governance	Resources	Well Led	AD	>=95%	85.7%	95.3%	95.3%	92.4%	93.6%	92.0%
Moving and Handling	Resources	Well Led	AD	>=80%	81.1%	84.7%	86.1%	86.0%	86.8%	87.2%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.9%	92.0%	92.5%	92.6%	92.9%	91.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.1%	85.5%	84.1%	84.6%	87.1%	85.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	87.0%	88.9%	89.0%	89.6%	89.7%	89.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	87.5%	87.3%	87.3%	89.3%	89.5%	89.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	91.0%	91.6%	91.0%	92.3%	95.0%	94.5%
Agency Cost	Resources	Effective	AD		£153k	£174k	£182k	£144k	£183k	£193k
Overtime Costs	Resources	Effective	AD		£5k	£0k				£1k
Additional Hours Costs	Resources	Effective	AD		£3k	£1k	£1k	£3k	£0k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£67k	£42k	£64k	£64k	£64k	£47k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		54	50.8	53.28	43.32	41.54	48.85
Business Miles	Resources	Effective	AD		37k	35k	35k	38k	39k	39k

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

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.6%	4.6%	4.6%	3.5%	3.6%	3.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	5.7%	5.4%	4.1%	3.5%	3.8%	4.6%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.0%	98.0%	98.0%	8.9%	17.7%	92.1%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	96.6%	96.6%	96.8%	0.2%	1.0%	10.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	72.6%	74.9%	77.2%	76.6%	79.5%	78.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	96.3%	96.3%	92.3%	92.3%	92.9%	92.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.5%	88.1%	87.4%	87.9%	89.0%	87.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.0%	88.0%	87.4%	88.5%	89.7%	88.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	100.0%	98.1%	98.2%	97.3%	97.3%	97.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.6%	87.0%	87.3%	87.7%	88.6%	86.9%
Information Governance	Resources	Well Led	AD	>=95%	88.2%	93.3%	95.7%	92.9%	93.7%	92.0%
Moving and Handling	Resources	Well Led	AD	>=80%	90.4%	90.9%	90.6%	90.1%	92.9%	92.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	98.8%	98.9%	98.9%	99.1%	98.9%	99.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	92.3%	88.9%	85.7%	84.6%	85.2%	90.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.1%	91.8%	91.9%	92.3%	94.0%	94.4%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	96.1%	95.9%	94.6%	94.8%	95.9%	95.4%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Agency Cost	Resources	Effective	AD		£1k	£5k	£1k			£0k
Overtime Costs	Resources	Effective	AD		£1k	£1k	£0k	£1k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£8k	£9k	£6k	£8k	£5k	£6k
Sickness Cost (Monthly)	Resources	Effective	AD		£90k	£76k	£65k	£54k	£55k	£63k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		57.42	60.97	64.78	30.78	35.33	35.6
Business Miles	Resources	Effective	AD		26k	36k	19k	32k	35k	30k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	5.0%	5.0%	4.9%	2.7%	3.0%	3.5%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	5.6%	4.8%	3.3%	2.7%	3.2%	4.6%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.9%	98.3%	97.8%	11.7%	33.2%	90.3%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	94.4%	95.4%	95.2%	0.4%	2.6%	10.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.9%	82.5%	82.1%	77.7%	80.2%	79.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	77.4%	75.4%	78.9%	80.0%	80.9%	82.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	76.3%	77.6%	76.7%	76.8%	74.6%	74.9%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.0%	87.9%	86.6%	88.0%	87.4%	87.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.4%	84.3%	82.8%	82.9%	84.3%	85.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	70.9%	68.6%	67.4%	64.4%	64.9%	66.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	84.4%	85.3%	83.7%	85.7%	85.1%	86.0%
Information Governance	Resources	Well Led	AD	>=95%	86.7%	93.8%	94.5%	91.6%	91.4%	91.7%
Moving and Handling	Resources	Well Led	AD	>=80%	74.5%	78.1%	78.3%	79.1%	80.5%	80.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.3%	91.5%	90.7%	90.3%	90.2%	90.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.5%	86.4%	84.5%	83.8%	85.1%	85.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.8%	90.2%	90.4%	88.4%	88.9%	88.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	80.8%	83.2%	83.9%	85.9%	84.5%	87.5%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	92.9%	93.7%	92.9%	93.8%	93.4%	93.0%
Agency Cost	Resources	Effective	AD		£73k	£114k	£116k	£83k	£95k	£92k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£1k		£0k	
Additional Hours Costs	Resources	Effective	AD		£4k	£1k	£1k	£1k	£1k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£64k	£52k	£39k	£29k	£44k	£53k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		55.2	62.34	60.66	56.33	53.65	48.67
Business Miles	Resources	Effective	AD		33k	38k	29k	31k	35k	36k

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 31 July 2018
Agenda item 8.2

Title:	**Out of Area Placements – update report**
Paper prepared by:	Director of Delivery
Purpose:	This document aims to provide the Trust Board with a summary of activity that has taken place, and continues to take place, to seek to reduce and ultimately end out of area hospital placements. The report had been requested by the Trust Board and is for information and discussion.
Mission/values:	Activity within the Out of Area project supports delivery of the Trust mission and values. The aim of the project is to reduce the number of people that require admission to a hospital bed outside of the Trust local area. This will be achieved by putting in place changes to systems that lead to a reduction of the number of people that need to access a hospital bed. It will also support people to be discharged home more promptly. This enables more people to live well in their community.
Any background papers/ previously considered by:	Out of Area placement activity is discussed as part of the Integrated Performance Report, on a monthly basis, at Trust Board.
Executive summary:	The purpose of the paper is to provide information on the use of out of area bed placements by the Trust (SWYPFT) for adult acute and PICU service users in Calderdale, Kirklees and Wakefield. Also included is the activity taking place to move the trust to a position where we always provide an inpatient stay within the SWYPFT footprint. Over the last two years we have typically admitted more people to beds than we have available in the Trust. People therefore have to be placed outside the Trust bed base and this impacts on both them and their family/friends. Some placements have been a significant distance from their home. It also contributes significantly to financial pressures within the Trust. The factors which are contributing to this situation are many and complex. A considerable amount of work has already been undertaken to address the out of area issue in order to improve the quality of service and reduce the cost. Whilst the usage and associated cost has remained high it is likely it would have been even higher without this level of focus and attention. Over the last 18 months there has been an Out of Area Project Board consisting of a focused team of people. This group have been benchmarking/learning both within and outside the Trust, joint working across the West Yorkshire system, and have analysed significant amounts of information to increase our understanding of the many different factors which are contributing to

	this issue. Our improvement work is concentrating on the areas which will have the greatest impact on reducing out of area placements. The three main strands of activity are: ➢ **Increased Operational Focus** e.g. daily monitoring, fortnightly project board meetings ➢ **Improvement Approach** e.g. data analysis, peer reviews, workshops, Change Acceleration Programme techniques ➢ **Partnership Approach**, visits to other Trusts, working with our colleagues across West Yorkshire to share learning and use our collective resources, working with the AHSN. Along with our commissioners, we have agreed a trajectory for the next three years. This trajectory is jointly owned by the Trust and the West Yorkshire CCG commissioners. There is the risk that the quality of care will be compromised if people continue to be sent out of area. The risk has been captured in Datix and is subject to ongoing review by the Executive Management Team. Mitigating actions form part of the change plan. Continued out of area placements do have a financial impact on the Trust and risk having an impact on the reputation of the Trust if it cannot be resolved in the longer term. More detail on the financial impact can be found in the submitted report.
Recommendation:	**Trust Board is asked to RECEIVE the report for information and discussion.**
Private session:	Not applicable.

Out of Area Placements

Update Report

July 2018

Director of Delivery

With **all of us** in mind.

Out of Area Placements

1 Introduction

The purpose of this paper is to provide information on the use of out of area bed placements for adult acute and psychiatric intensive care (PICU) service users in Calderdale, Kirklees and Wakefield and activity that is taking place to move the Trust to a position where we no longer send people to out of area placements.

Over the last two years we have typically admitted more people to beds than we have available in the Trust. People, therefore, have had to be placed outside the Trust bed base and this impacts on both them and their family/friends. Some placements have been a significant distance from their home. Out of area placements are contributing significantly to financial pressures within the Trust. The factors which are contributing to this situation are many and complex.

2 Current Position

A considerable amount of work has already been undertaken to address the out of area issue in order to improve the quality of service and reduce the cost. Whilst the usage and associated cost has remained high it is likely it would have been even higher without this level of focus and attention. Over the last 18 months there has been an Out of Area Project Board consisting of a cross section of Trust staff from operations and corporate services. This group have been benchmarking/learning both within and outside the Trust, joint working across the West Yorkshire system, and have analysed significant amounts of information to increase our understanding of the many different factors which are contributing to this issue. Our improvement work is concentrating on the areas which will have the greatest impact on reducing out of area placements.

The three main strands of activity are:

- **Increased Operational Focus** e.g. daily monitoring, fortnightly project board meetings

- **Improvement Approach** e.g. data analysis, peer reviews, workshops, Change Acceleration Programme techniques

- **Partnership Approach**, visits to other Trusts, working with our colleagues across West Yorkshire to share learning and use our collective resources, working with the AHSN.

The mental health system, and therefore the out of area issue, is a complex evolving system with many interconnections. Consequently our approach has involved studying how the whole system operates in order to gain a shared understanding. Our improvement actions and in particular our planned future actions are based on this whole system understanding and implementing a range of well thought out and constructive interventions which are levers to change the system and reduce the

number of people who are placed out of area. This is in line with the evidence base which tells us when dealing with a complex system it is better to conduct a range of smaller improvements and learn from the results, adjusting the next steps rather than to work to a set plan.

The government has set a national ambition to eliminate inappropriate out of area (OOA) placements in mental health services for adults in acute inpatient care by 2020/21. Along with our commissioners, we have agreed a reduction trajectory for the next three years. We are now focussing on what further actions can be taken in order to reduce this pressure which is having an impact on quality of care for service users and experience for families and carers.

For the purposes of this project, an out of area placement is considered to be anyone that goes to a non SWYPFT hospital bed. For example, someone from Calderdale that accesses a SWYPFT bed in Barnsley has not been considered as an out of area placement through our reporting process. Any placement to a private provider bed is considered as out of area, even if this is within the SWYPFT footprint.

2.1 Available beds and the number of OOA Placements since April 2015

The tables below show the number of acute and PICU beds available across the Trust footprint, also broken down by per 100, 000 (unweighted) population:

Acute

NAME	18-64 population	Beds available	Available beds per 100,000 population
Barnsley	144,824	28	19.33
Calderdale	125,396	24	19.14
Kirklees	262,373	47	17.91
Wakefield	201,989	44	21.78

PICU

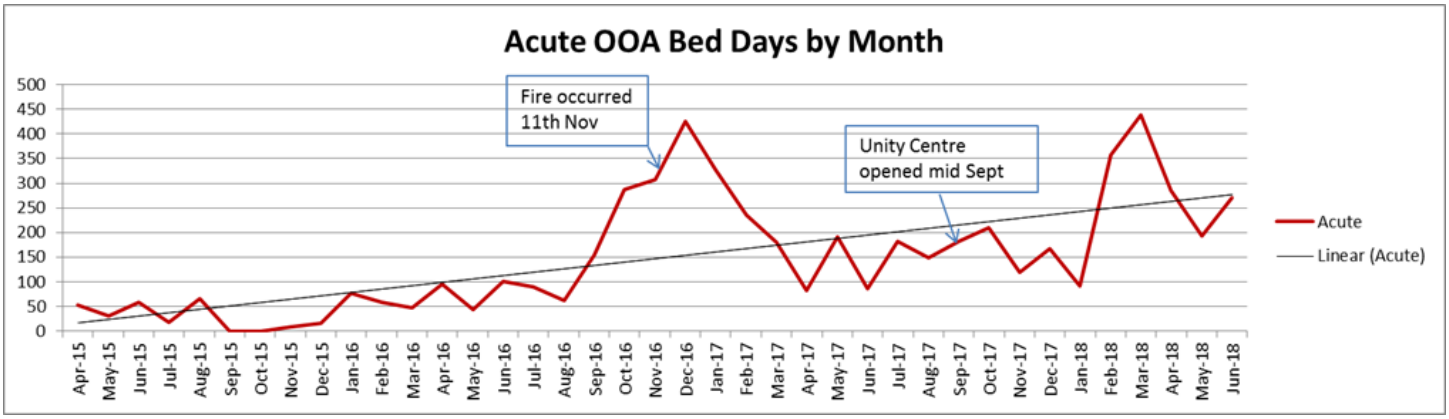
NAME	18-64 population	Beds available	Available beds per 100,000 population
Barnsley	144,824	6	4.14
Calderdale	125,396	3	2.39
Kirklees	262,373	6	2.29
Wakefield	201,989	5	2.48

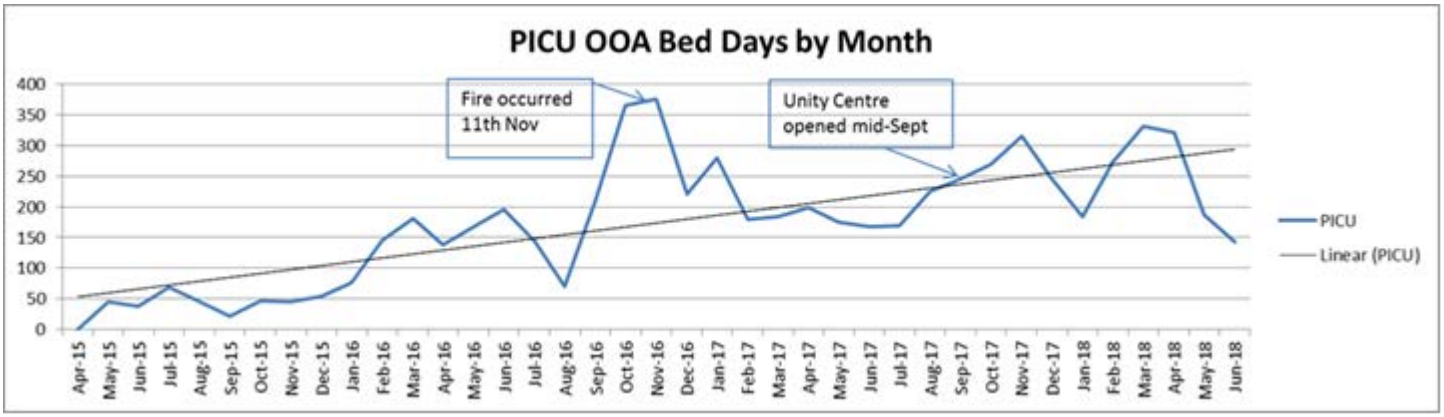
Wakefield has the highest number of acute beds available per head of population, whilst Kirklees has the lowest. Kirklees commissioners do provide funding for 2 OOA beds above the 47 available acute beds. With these beds factored in, Kirklees still has the lowest available beds per 100,000 but it would be only slightly lower than Calderdale and Barnsley.

Barnsley has the highest number of available PICU beds. Calderdale, Kirklees and Wakefield all use the Fieldhead site for PICU.

The use of OOA beds has steadily increased since April 2015; the following graphs show the number of OOA bed days required each month until June 2018.

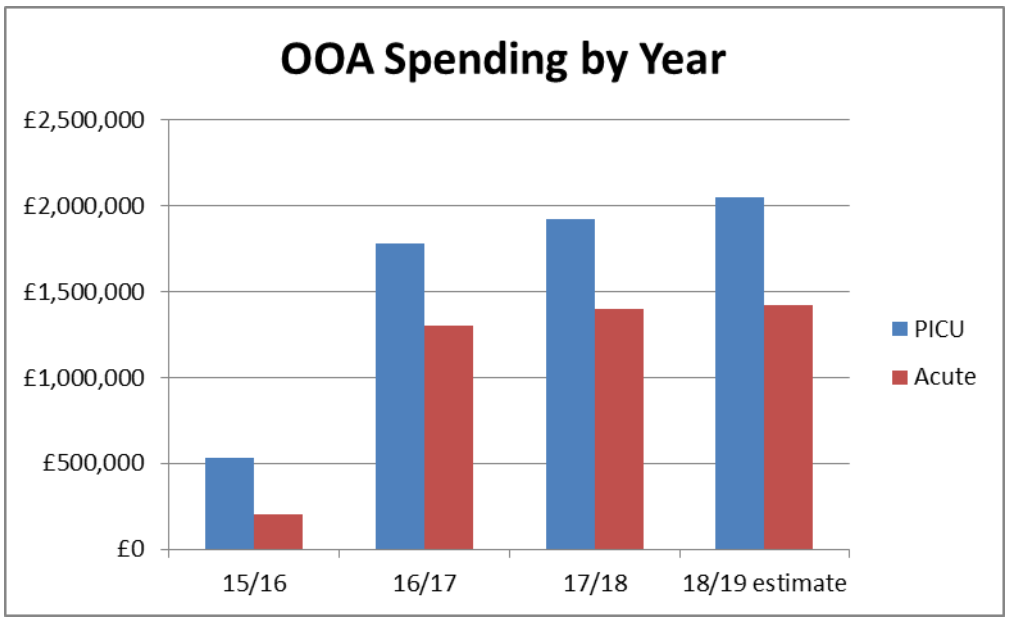
Note: the spike in October 2016 was prior to the Trinity fire.



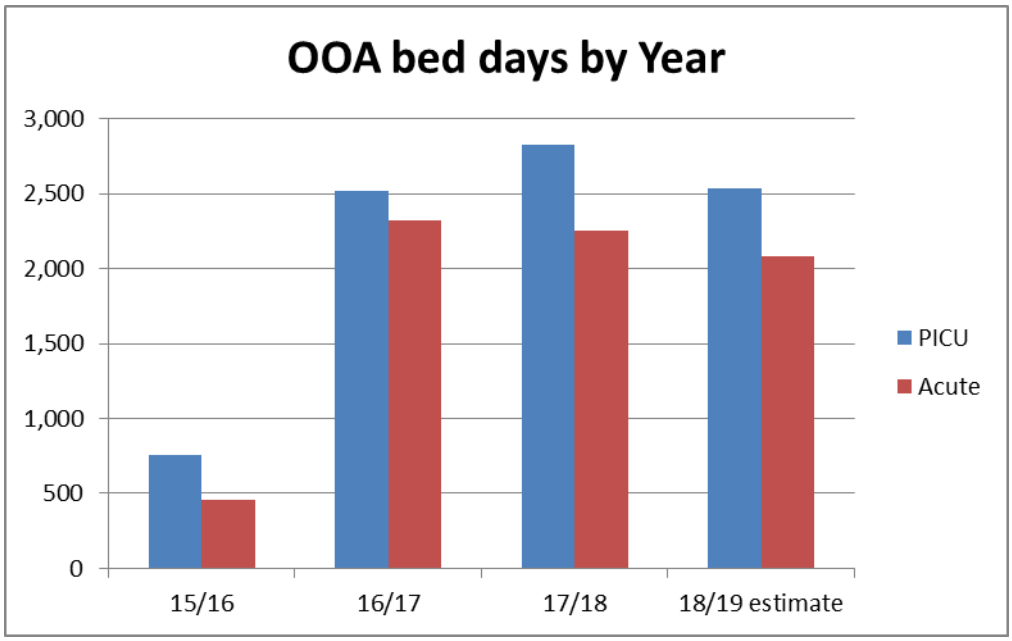


2.2 Financial Impact

The tables below summarise the financial impact of increasing OOA placements, year by year and include the estimated spend for 2018/19:



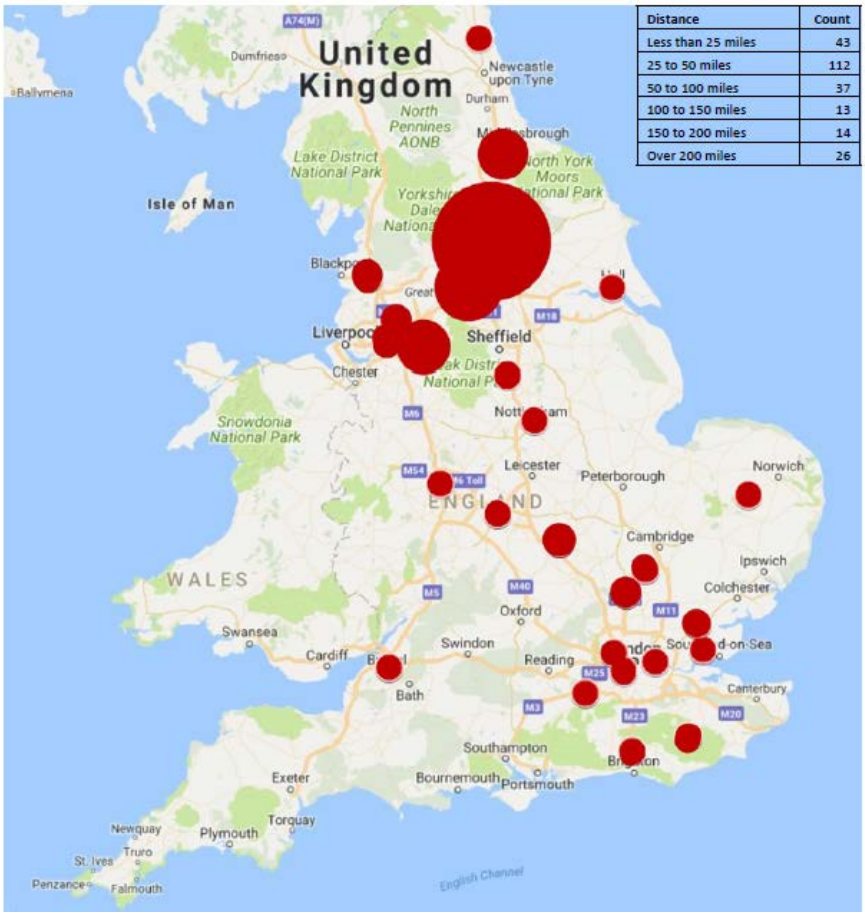
The table below shows the projected OOA activity year on year:



The total activity is expected to reduce in 18/19 but the costs are expected to be higher. This is because average bed day costs are increasing and additional costs for enhanced care and transport have increased significantly in recent months. This means average bed day costs for OOA patients in 18/19 are £690 for acute patients and £890 for PICU patients.

2.3 Out of Area placement map

The map below shows where the out of area placements have gone over the last 15 months:



Whilst the majority are within 50 miles of the person's home, there are 26 people that have accessed beds more than 200 miles from their home.

3 Summary of work already undertaken

A significant amount of work has already been undertaken, a summary of which is presented here.

The three main strands of activity are:

- Increased operational focus
- Improvement approach
- Partnership approach

3.1 The Trust has increased the operational focus on people who have been placed out of area with an increase in the managerial and clinical scrutiny on all in-patient admissions and therefore all out of area placements. This has included:

- Daily monitoring of patients in all beds
  Ward staff have a daily overview of the service users on their wards. This is supplemented by the patient flow managers who produce a daily sitrep that describes the state of the ward, including the count of people in beds and on leave. This work produces an overview of potential admission and discharges that supports flow in and out of our wards, and step up or down from PICU. The patient flow managers have a daily overview of all service users placed in an OOA bed, which includes their progression to recovery, care coordination issues and repatriation or discharge needs.
- Fortnightly Out of Area (OOA) project board meetings with one meeting per month focusing on operational issues and one meeting per month looking at all the issues – both operational and improvement, which reports to the Operational Management Group (OMG) and Executive Management Team (EMT).
- Regular communications, with information cascaded from the OOA Board through line management structures and as part of Trust internal briefing systems, such as the The Headlines and The Brief.

This has resulted in a shared understanding of the position that exists and several high profile examples have been resolved by unblocking the system leading to people being discharged appropriately. Examples include service users whose future placements have been the responsibility of other Clinical Commissioning Groups (CCGs) or NHS England, people with learning disabilities who have needed highly specialised placements, and service users who have required access to forensic pathways.

3.2 Other activity that has taken place through the course of the project include:

3.2.1 Tools for monitoring patient flow

Development of a Virtual ward – Reporting systems are now available for staff that show a daily snap shot of OOA and beds used by all CCGs and BDUs. The virtual ward enables all OOA placements to be managed through one system and therefore ensures that follow up is timely.

A forecasting tool for demand has also been developed through the project.

3.2.2 72 hour formulation meetings

72 hour formulation meetings were implemented via a PDSA cycle, with input from community services to input into 72 hour formulation work.

3.2.3 Bed Manager Structure

These were reviewed and patient flow managers are now working closer together and have a more standardised role, with some extra resource in place to support this activity.

3.2.4 Operating Policies

New acute inpatient operating policies were agreed as part of the project. These included guidance on when someone should be accepted into a bed, which were communicated to all relevant staff. All exceptions are recorded on Datix so that any declined admissions can be tracked and the reasons understood.

3.3 The Trust has undertaken work using evidence based quality improvement approaches in order to identify the areas that require improvement and to take action to improve patient flow and minimise the need for admission to an acute or PICU bed. This has included:

- Extensive data collection, analysis and reporting
- Weekly performance reports into the Operational Management Group (OMG) with a summary into EMT. This has covered information on numbers of people who have been admitted and numbers of bed days that have been used.
- The alignment of a series of different data sources into one 'Critical to Quality' (CTQ) tree which helps focus on the key issues that will have the most impact if addressed. A copy of the CTQ is attached at Appendix A for reference.
- Weekly financial reports on the impact of performance on financial expenditure
- Qualitative peer reviews of what has actually happened with individuals that has necessitated an admission into an acute bed.
- Workshops
  We have held a wide range of events and workshops to explore the issues with front line staff and managers and to generate ideas and plans for improvement. These have included:
  'Thinking Differently' workshop which used learning from other sectors
  An Out of Area Summit which brought front line staff and support service staff together along with support from NHSI
  Workshops to learn from Bradford District Care Trust about the Criteria Led Discharge tool and the impact on length of stay. A series of

workshops with key staff to adapt this approach for SWYPFT and plan and deliver its implementation.

A series of workshops in each BDU to explore the data for the people from that locality and how this compares with data across the rest of the Trust and national benchmarks. These workshops add qualitative detail to the quantitative information to give a rich picture of what is happening and have helped in the population of the Critical to Quality tree.

- Benchmarking our Intensive Home Based Treatment (IHBT) teams against fidelity criteria to see where opportunities exist to improve the operation of these teams. The teams work to the same standard operating procedure across all areas which requires them to consider all possible alternatives to admission.
- A group of staff undertook Change Acceleration Programme (CAP) training over 3 days in December 2017. This group consisted of a clinical team leader, 2 operational managers, a finance manager and 2 people from the integrated change team. The CAP training utilised a series of evidence based tools to help progress change projects and programmes. The group used the Out of Area programme as a specific example to test the different tools and techniques. This led to additional learning and insight which has continued.

3.4 Significant opportunities have been sought in order to learn from other organisations who have made progress with addressing their out of area placements. This has included:

- Visiting other trusts e.g. Bradford District Care NHS FT, Leeds and York Partnership NHS FT, Northumberland Tyne and Wear (NTW) NHS FT, Tees Esk and Wear Valley (TEWV) NHS FT. People attending the visits have heard about the different ways in which patient flow is managed in other areas and this has been brought back and shared with colleagues, including presentations at the Out of Area Board. Specific examples of ideas brought back for consideration include, criteria led discharge approaches, removal of barriers (including duty system) to productive community functions and the use of short stay wards. In particular this has led to us:

  Working toward implementing criteria led discharge that will improve outcomes for services users in terms on purpose of admission and time on the ward (planned go live in September).

  Learning from the NTW visit has supported changes to our community approach in Calderdale and Kirklees, see plan in appendix B for more detail.

  The PICU learning visit to TEWV has led to proposals being considered about PICU outreach to wards for onsite assessments to support acute wards with behaviour that challenges.

  Other information collected from visits has helped inform the case for ward based discharge coordinators, helped develop thinking around reporting methods that have led to the production of reporting tools and is informing the development of a system health check.

- Attending events where other NHS organisations have shared their learning, e.g. the event run by the West Yorkshire and Harrogate Health and Care Partnership where Cheshire and Wirral explained their approach.
- Working with our provider colleagues across West Yorkshire to share learning and use our collective resources as part of the West Yorkshire & Harrogate Health and Care Partnership. Different people in a variety of roles within SWYPFT attend regular meetings with their counterparts across the system. This includes a weekly data collection and phone call to see how we can practically support each other to reduce the need for people to be placed out of area.
- Meeting with our West Yorkshire commissioners to see how we can work together to address the issues. This has led to a joint plan being established (the plan with commissioners forms part of appendix B) and a focus on:
  - Population issues that could be contributing, including whether the JSNA points to any particular issues.
  - Issues linked to wider community support that could be a contributing factor, including alternatives to admissions.
  - Issues in terms of wider community infrastructure that could be a contributing factor such as primary care or the local authority.
- Undertaking a pilot with the Academic Health Sciences Network to review patient flow and learning from the acute sector. This recently culminated in a workshop focusing on flow in Calderdale.
- Sharing good practice and learning from each other across the SWYPFT footprint. This has included learning from Barnsley where the IHBT team is particularly effective and patient flow systems are well established.

3.5 The group of people who focused on the OOA project on the Change Acceleration Programme training have continued to meet in order to:

- Further explore the use of the different tools within the context of this programme of work including the population of the Critical to Quality (CTQ) prioritisation tree.
- Develop further understanding of the complex issues which require addressing and which of the tools/approaches will help.

3.6 Critical to Quality (CTQ) prioritisation tree

Recent Critical to Quality (CTQ) analysis (see appendix A) has been undertaken by the trust.

Some of the main findings from the CTQ include:

- Admission rates in Calderdale and Kirklees are higher than elsewhere
- LOS is higher in Barnsley and Wakefield

As covered above, the analysis helps focus on the key issues that will have the greatest impact. For example, there is not a day of the week where admissions are higher; 'out of office hours' admissions do not appear to be a major cause of out of area placements. The use of the Mental Health Act on admission does differ across the Trust. Activity is taking place to populate local CTQs

which should support identifying further change activity that will have the most significant impact.

4 Our Forward Plan

A detailed plan for ongoing remedial and improvement activity is attached in appendix B.

The plan is in line with the Integrated Change Framework in the Trust and covers the following areas:

- **Community Improvement:** Specific improvement projects identified within the acute improvement work that require system changes in community.
- **Acute improvement:** System change to: Reduce admissions and reduce length of stay
- **PICU Improvement:** System change to: Reduce admissions and reduce length of stay
- **Partnership work:** including joint plan with commissioners, support from the Academic Health and Science Network and STP activity.
- **Operational Grip:** Managing the current system closely to make it as efficient as possible

4.1 Community Improvement

As the CTQ analysis found admission rates to be higher in Calderdale and Kirklees, there is considerable activity taking place in community services in these localities to support a reduction in admissions, though much activity is taking place in all BDUs.

4.1.1 Personality Disorder:

There is a new project to develop a strategy for the care and management of people who are diagnosed with a personality disorder under the care of Trust adult community and acute services.

People with this diagnosis can have complex mental health difficulties and often this diagnosis is misunderstood, leading to stigma and exclusion. There is a substantial risk of self-harm and suicide and hospital admission is frequently used to manage risk.

Barriers to care and inadequate treatment are recognised as national problems leading to unhappiness, poor outcomes, adverse incidents and an over-reliance on A&E departments and acute services. Although there are many examples of good practice within the Trust, and around the country, this is not consistent and we need to learn from areas of good practice.

The aim of the project is to improve our understanding of the many issues surrounding personality disorder and the services we currently provide; to develop a plan to ensure that our services represent recognised best-practice and to meet the needs of this group consistently, with the aim of improving outcomes and reducing reliance on acute services.

Hospital admission figures show that service users diagnosed with personality disorder from the Calderdale & Kirklees community pathway are the highest users of Trust in-patient beds.

High level milestones for the plan are set out below (all 2018):

- Phase 1: Scoping (Feb-Mar)
- Phase 2: Discovery (April-June)
- Phase 3: Co Design (July-Sept)
- Phase 4: Co Create and Co Deliver (Oct onwards)

This Trustwide plan is linked into the pathway work which is taking place in Wakefield under the New Models of Care Board and the developing Mental Health Alliance. This work is also looking at the service offer for this group of people.

4.1.2 Other activity

A series of workshops have been held with Calderdale and Kirklees with the intention of identifying barriers to community services operating as effectively as possible.

Outputs and planned change activity from this includes:

- Implementing new ways of working with the aim of reducing admissions, reducing delay when transferring between pathways and freeing up additional clinical time to focus on priorities
- These include
  - Lowering IHBT threshold so CMHT can refer sooner
  - Implementing a trusted assessor role
  - Reviewing the duty system
  - Focusing on medical caseload and ways of working
  - Activity to improve partnership working across the pathways
  - Reviewing of discharge from services pathway.

4.2 Acute and PICU Improvement

The analysis showed length of stay is a particular issue in Wakefield and Barnsley. As a consequence Wakefield is leading a project to implement criteria led discharge pathways.

The criteria lead discharge project will design, produce and deliver an acute service wide system for identifying and tracking elements that are critical to a service user's discharge from acute wards. The project will build on the work undertaken in other trusts in West Yorkshire.

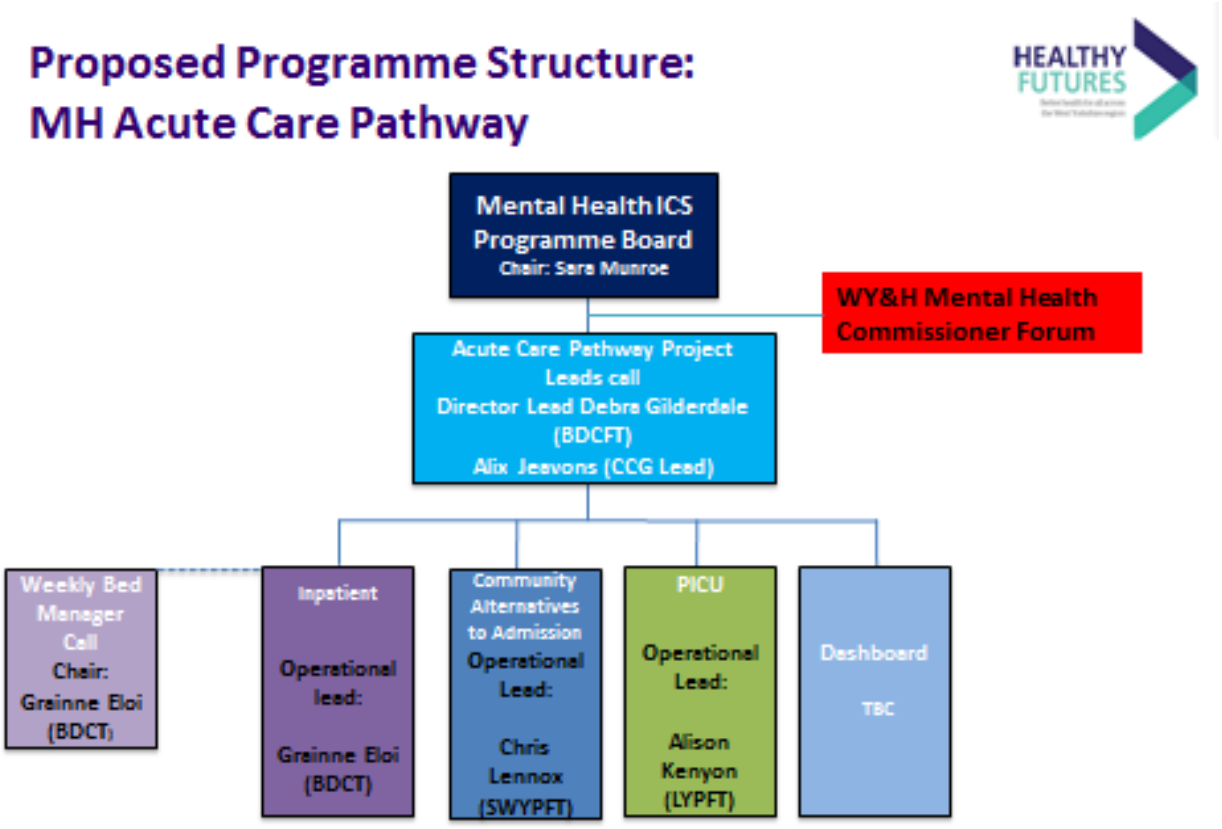
The criteria lead discharge system is being developed and tested in Wakefield and then rolled out to all acute wards across the Trust by the end of December.

The project aims to ensure that a system is put in place that supports timely discharge from the wards. Outcomes from this project will be tracked closely to establish the impact on length of stay.

4.3 Partnership work

A joint plan of activity is now in development with commissioners. This links in closely with activity already taking place in the Trust, such as developing a personality disorder pathway across partner organisations in Wakefield. Other activity includes a review of PICU across West Yorkshire and Harrogate, reviewing variation in community services across the same footprint, mapping health needs in each locality and comparing and mapping community based assets in each locality.

Current work is also underway in WY&H H&SCP regarding OOA beds. The latest programme structure for the Mental Health Acute Care Pathway work programme is set out below:



The West Yorkshire Care Closer to Home work programme has been focussing activities on admission to acute beds at the point of crisis, supporting the governments ambition to eliminate all inappropriate Out of Area Placements (OAPs) in mental health services for adults in acute inpatient care by 2020-2021. To date there has been focus on OOA data collection, mechanisms and usage, inpatient areas and practice, and the use of PICU. It is recognised that there now needs to be

a greater understanding of the community MH provision across West Yorkshire and Harrogate. In addition to the programme, the roll out of criteria led discharge across West Yorkshire is now gathering momentum and there is a need to ensure that services within the community are well equipped to manage patient flow.

Providers and commissioners across West Yorkshire have also been engaged in weekly calls between trusts which have provided insight into some of the challenges facing providers to ensure that service users receive the most appropriate care as close to home as possible. The calls have provided a platform to share and learn, building upon and providing narrative to the weekly Out of Area data collection.

4.4 Operational Grip

As previously mentioned in this report the OOA issue has been the focus of attention across all BDUs. Examples of the initiatives taken are:

- Streamlined patient flow/bed management across all BDUs
- Daily monitoring of all in-patients
- Daily sit rep which includes all anticipated admissions and expected discharges
- Fortnightly OOA Project Board focusing on operational issues
- Regular communications to front line staff
- New initiatives trialled in various BDUs prior to full roll out, for example Criteria Led Discharge
- Weekly teleconference and focus on problematic cases
- Section 3 details other initiatives undertaken

5 Reporting and Monitoring of Performance

There are a variety of systems in place to report our performance in respect of out of area beds. These include:

- Weekly reporting to EMT and the project board on numbers of people in out of area beds (both acute and PICU)
- Weekly reporting to EMT and the project board on the financial impact of people being placed out of area
- Monthly reporting to EMT and Trust Board in the IPR
- Fortnightly reporting into the Operational Management Group
- Monthly reporting into the Out of Area project board on improvement activity

Additional development work on reporting and monitoring performance is included in the forward plan. This includes:

- Development work on a dashboard for system effectiveness to enable people at different levels in the organisation to understand the issue
- Work to use Statistical Process Control run charts to allow for greater understanding of variation
- Detailed work to look at how we manage length of stay within a complex system

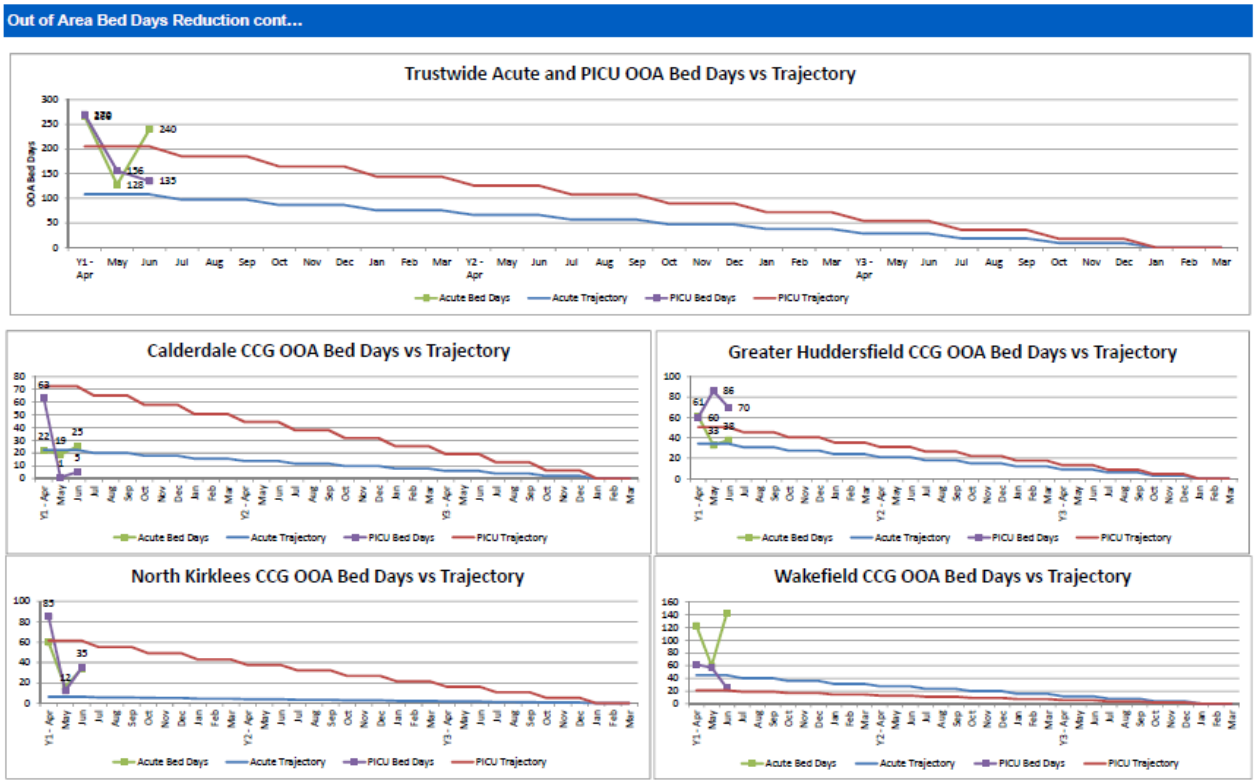
5.1 Trajectories for Improvement

The Trust were required to agree trajectories for reduced out of area bed usage over 18/19. The agreements are presented below

Below are the OOA trajectories agreed across the STP footprint:

Year	Checkpoint	BDCFT	LYPFT	SWYPFT	WYH STP
	Figures should be based on the expected OAP bed day activity at this point in time and relate to the quarter ending in the time period. National data to monitor activity will use rolling quarter figures at each month in time i.e. June data will take account of April/May/June data.	Bradford Districts, Bradford City, Airedale Wharfedale & Craven	Leeds CCG		
Year 1 (18/19)	Jun-18	41	1,092	940	2,032
	Sep-18	41	1,104	846	1,950
	Dec-18	41	920	752	1,672
	Mar-19	41	720	658	1,378
Year 2 (19/20)	Jun-19	36	546	576	1,122
	Sep-19	31	552	494	1,046
	Dec-19	26	368	411	779
	Mar-20	21	270	329	599
Year 3 (20/21)	Jun-20	16	182	247	429
	Sep-20	11	184	165	349
	Dec-20	6	92	82	174
	Mar-21	0	0	0	0

The SWYPFT Target trajectory, overall and broken down by locality are below:



Note: We know from monitoring recent performance that bed usage is not linear and that the system operates within a range. Therefore, there will be periods of higher and lower bed usage on the journey to achieving zero out of area bed placements.

6 Risk Management

There are two areas of risk relating to placing people out of area. These relate to the service user and carer experience when placed a significant distance from home, along with the financial consequences of the placements.

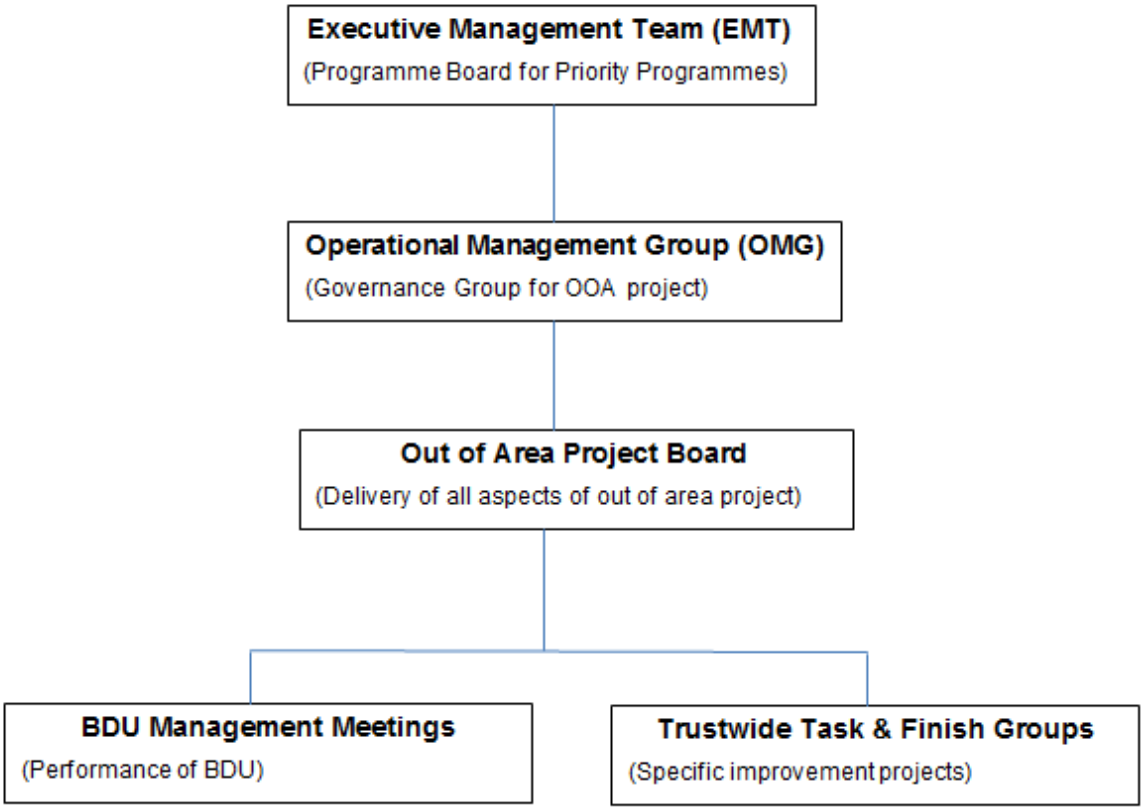
The out of area risk is registered on Datix and reviewed by the project board and EMT. Remedial actions identified in the plan are included as part of the risk control measures and action plan.

The full risk report can be found in appendix C.

7 Governance

The out of area project was one of the priority programmes of work for 2017/18 and this continues in 2018/19. Consequently the governance sits within the priority programme governance for the Trust.

The structure is described diagrammatically below:



8 Summary

- The mental health system and the out of area issue are complex and evolving issues.
- A significant amount of work has already been undertaken to address issues with regards to out of area placements in order to improve the quality of service and reduce the cost.
- It is very difficult to quantify the impact of each individual activity and whilst activity clearly has not resolved the OOA problem, the OOA project board believe there would have been a much higher number of placements if this activity had not taken place.
- More work is ongoing or planned for the coming months.
- The critical to quality activity has given us the clearest picture yet of where we need to prioritise activity and the learning visits has showed us how others have overcome some of these issues.
- This has helped us to shape a plan that we believe can improve the system and reduce the bed pressures over the coming months.
- Whilst we are clear that we understand the issues in more detail than previously and are establishing changes that are targeted at the right areas, we still acknowledge there is a risk that we might not quickly resolve the problems.
- The plan for change is a shared plan with commissioners and we are also working closely with partners across the West Yorkshire and Harrogate Health and Care Partnership footprint.
- The trust has robust mechanisms in place for tracking performance, monitoring risks and overseeing activity in the plan.
- There is a clear trajectory in place for OOA reductions, which has been agreed with commissioners and will be tracked jointly.

10 The Trust Board is asked:

To recognise the complexity of the OOA issue and support continuation of the work being undertaken.

Appendix A – CTQ
Appendix B – current project plan
Appendix C – risk report

Appendix A

5/8/2018

OOA BEDS – CRITICAL TO QUALITY – PRIORITISATION TREE

NATIONAL {N}:
TRUSTWIDE {T}:
BARNSLEY
CALDERDALE
KIRKLEES
WAKEFIELD

Person placed in a bed

Person placed on OOA acute bed

- No bed available in SWYPFT — 0 95% 86% 71%
- Bed in use by younger person — {T}: 21 CYP in 17/18 270 OBD
- Acuity — 0 2% 10% 14%
- Not enough staff for available bed — {T}: 1%
- Other factors e.g. mixed gender Staff member — {T}: 4%

Not enough commissioned beds

- Benchmarked — Beds per 100K non-weighted population — T: 18 (Bradford 29, Leeds 19) — {N}: mean = 20
- Benchmarked — Beds per 100K weighted population — T: 23 (Bradford 21, Leeds 19, Sheffield 11) — {N}: mean = 20
- Per 100K — 17/19 23/19 21/18 20/22
- Actuals — 24/28 29/24 54/47+2 40/44
- Per 100k (6 months) — 62 129 123 81
- Actuals (6 months) — 90 162 324 164

Bed free but not made available Trustwide bed base

High demand – OBD (85% occupancy) — 8272/8687 10225/7446 19553/15202 14106/13651

High number of admission requests (6 months)

People Gatekept — {T}: >above 95% target for the last 12 months

Number of people LOS >60 days per 100K — {N}: mean = 33 — {T}: 34

People on ward too long

- Average length of spell — 53 25 33 48 — {N}: mean ALOS = 36
- W/O OOA — 53 29 35 58
- Patient flow on ward not assertive enough
- Lack of discharge options
- D.T.O.C. — {T}: 3%

- % Detained on admission — 60 31 28 27
- Days of Week

Sunday	8%
Monday	13%
Tuesday	12%
Wednesday	16%
Thursday	21%
Friday	16%
Saturday	15%

- In hours — {T}: 58%
- Out of hours — {T}: 42%

- Person known to service — {T}: 90 days - 51%
- Person previously unknown to service — {T}: 15%
- Person re-admitted — {T}: 28 days – 7% — {T}: 3 months – 16%
- Person previously known to service

- People without PD or dual diagnosis
- People with PD diagnosis — {T}: 12%
- People with dual diagnosis — {T}: 2%

- % Contact with any team — 96 95 95 85
- % Contact with IHBT 7 days prior — 83 80 84 70
- Not enough support in the community to maintain people
- Acuity – population more unwell
- Person/individual deteriorated (little we could to prevent)

- IHBT
  - Capacity of IHBT
    - IHBT doing additional work (not just preventing admission)
    - Staffing of IHBT
  - Approach of IHBT
    - Thresholds and positive risk taking
  - Number of people LOS <3 days per 100K — {N}: mean = 34 — {T}: 15
- Wider community team
  - Caseloads
  - Capacity of community team
  - Approach of community team
    - Flow in community team
    - Positive risk taking
  - Crisis Plans — {T}: 86% plans in place

Sheet 1

Out of Area (OOA) – Our focused plan v9 (updated 04/07/18)

Issue: We are admitting more people to beds than we have available in the Trust. People therefore have to be placed outside the Trust bed base and this impacts on them, their family/friends and also costs money

The overall improvement aim: To stop people under the care of SWYPFT being placed out of area and ensure everyone is as near to their own home as possible. To work with others across West Yorkshire & Harrogate to help stop all of us placing people out of area

Community Improvement

Specific improvement projects identified within the acute improvement work that require system changes in community

Acute Improvement

System change to:

- Reduce admissions
- Reduce length of stay

PICU Improvement

System change to:

- Reduce admissions
- Reduce length of stay

Improvement work in SWYPFT

Partnership work

- **West Yorkshire Commissioners**
- **West Yorkshire & Harrogate**
- **AHSN**

- Partnership work between West Yorkshire commissioners and SWYPFT to consider system wide improvements
- West Yorkshire & Harrogate H&CP to share good practice across organisations + work across boundaries where it makes sense & stops people being placed OOA
- AHSN Learning from flow work in other sectors and applying this to our improvement

Operational Grip

Managing the current system closely to make it as efficient as possible

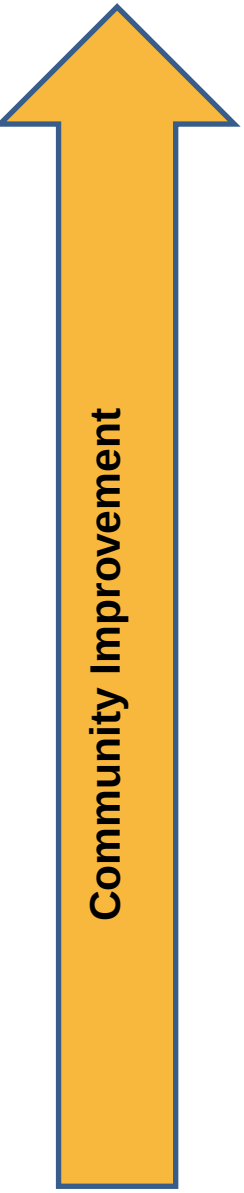
Community improvement aim: Specific improvement projects identified within the acute improvement work that require system changes in community

Community Improvement

What	When	Measures	Progress update 04/07/18
C1. Complete CTQ with data to identify exact nature of issue by area and provide one place for all data to be presented	By 8/5/18	Version 1 of Critical to Quality tree (CTQ) complete for each District and one for overall	Version 1 of CTQ **complete**
C2. Develop pathway for supporting people with Emotionally Unstable Personality Disorder	Various	Pathway in place	Launch event took place on 01/06/18
C3. Deliver a workshop to articulate workforce issues in Community Teams and identify actions that will address them . Pilot in Wakefield then decide if roll out	July 18	Workshop happened, issues and actions identified and added to action plan	Workshop planned for W, C & K together in July has been delayed and is now booked for August
C4. Develop clear plan to reduce admissions for Calderdale and Kirklees residents	June 18	Number of admissions by CCG area tracked using SPC run chart	**Complete** See separate action plan for more detail.
C5. Finalise report on results of peer review and feed this learning into the action plan	By 8/5/18	Results finalised and fed in	**Complete** Results fed into OOA project Board and being fed into action plan in C4
C6. Report results of audit on crisis and contingency plans to OOA Board	May 18	Minuted that discussed at Board with any actions identified .	**Complete** Discussed at OOA Board on 11/5/18

C4. Develop clear plan to reduce admissions for Calderdale and Kirklees residents (part 1)

Measures: Number of admissions by CCG area tracked using SPC run chart



What	When	Measures	Progress update 04/07/18
C4a. Add additional community data to CTQ to help identify exact nature of issue. Meet with key community staff to discuss data and add local knowledge	By July 18	Version 2 of Critical to Quality tree (CTQ) contains more community data	2 initial meetings held and group of Calderdale staff taking this forward. Some interesting issues being highlighted to be explored
C4b. Identify conclusions/hypotheses regarding key contributory factors , share these and make any required amendments to the action plan	By August 18	Conclusions/hypotheses shared and action plan amended	
C4c. Develop temporary band 7 role to focus on case managing people out of area	May-18	Person in post	**Complete**
C4ci. Review impact of temporary role	Sep-18		
C4d Undertake a series of workshops using lean approaches to maximise the efficiency of the community system working. Identify key actions from this work	Commenced May 18	Workshops are being held and follow on actions being planned.	**Complete**
C4f. Undertake further analysis of impact of 5 day working of enhanced team on admissions	Jul-18	Analysis undertaken & presented to OOA Board	Commencing

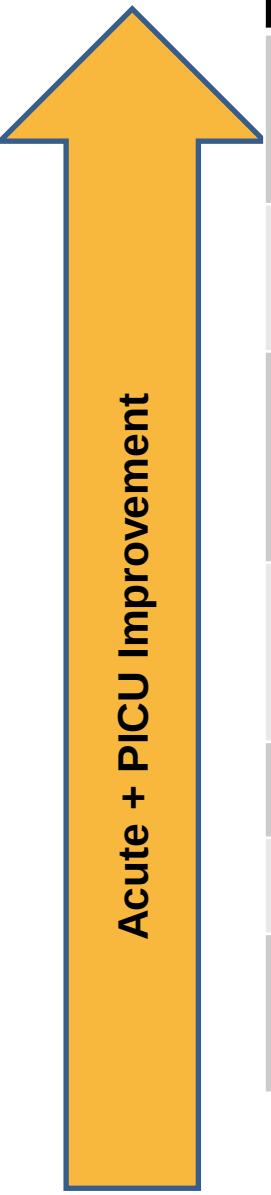
C4. Develop clear plan to reduce admissions for Calderdale and Kirklees residents (part 2)

Measures: Number of admissions by CCG area tracked using SPC run chart

Community Improvement

What	When	Measures	Progress update 04/07/18
C4g. Lead a project to ensure that appropriate pathways are established for people with personality disorder.	TBC	Posts in place	
C4h. Add in any specific actions that were identified at the AHSN event on 1/5/18	Jun-18	Items added in	**Complete**
C4i. Add in any specific actions from peer reviews	Jun-18	Items added in	**Complete**
Implement new ways of working, including: - lowering IHBT threshold so CMHT can refer sooner - implement trusted assessor role	Commenced Jun 18; Review impact Sep 18	Evidence of reduced admissions, reduced delay when transferring between pathways, additional clinical time freed up to focus on priorities	Lower threashold aims to prevent more admissions by delivering intensive care for a short period of time before someone becomes acutely unwell
Review of duty system	TBC	Need to agree expected outcomes	
Medic Capacity and ways of working strand	TBC	Need to agree expected outcomes	
Partnership working with LAs	TBC	Need to agree expected outcomes	
Communication - Discharge (from community) Documentation	TBC	Need to agree expected outcomes	

Acute + PICU improvement aim:
System change to: Reduce admissions + Reduce length of stay



What	When	Measures	Progress update 04/07/18
A1. Map process between acute/PICU and forensic services and use lean methodology to address inefficiencies in process	July 18	Process mapped Process remodelled Measure of reduction in length of time for person to transfer	2 x mapping workshops taken place, one in acute, one in forensics. Feedback information being collated
A2. Develop clear measure to understand length of stay and establish reporting of this	June 2018	Measure identified and reporting in place	Mike Garnham has done some work on options which looks really useful. Further work being planned. To be shared with project board
A3. Plan to reduce length of stay on all wards including Implement criteria led discharge and pilot checklist developed by Arasu	July 2018	Length of stay by ward tracked using SPC run chart Criteria led discharge in place and working Pilot complete and results reported at OOA Board	Did 2 visits to Bradford in May Plan in place (see separate slide) to implement in Wakefield and then roll out to other areas
A4. Develop clear plans for PICU (Wakefield) to • Reduce admissions of Wakefield residents • Reduce length of stay	June 2018	Number of admissions by CCG area + length of stay by ward tracked using SPC run chart	Plan under development
A5. Report results of IHBT fidelity audit	9/5/18	Reports shared	Reports shared
A6. Explore reinstating discharge coordinator roles	April 18	Report on EMT agenda	Discussed at EMT in April, further work under discussion
A7. Report on results of peer review and feed this learning into the action plan	May 18	Report produced and shared	Report shared. All learning to be fed into actions plans

A3: Reduce Length of Stay on all wards: Implement Criteria Led Discharge (CLD) tool and methods of working
Measure: Length of stay using SPC run charts, by locality.

Acute + PICU Improvement

What	When	Measures	Progress update 04/07/18
A3a) Attend learning visits to other areas, including Leeds and Bradford with a senior leadership and a technical workshop.	2017 – May 2018	Visits attended and learning fed into improvement work	Complete
A3b) Reference group established	June 2018	First meeting held	Occurred early June Complete
A3c) Implementation group established. Led by Wakefield but includes other parts of the trust.	June 2018	First meeting held	Meeting held
A3d) Overview of CLD system and tools. Agree work plan and the criteria we will focus on. Plan to acknowledge culture work	July 2018	Work plan in place CLD tool agreed	
A3f) Trust-wide acute workshop to be held (Focus on shared learning and agreeing to priority actions across the organisation.)	Jul 2018	Workshop happened with actions agreed	
A3g) Clear change plan in place that covers • Barriers we need to overcome. • Wakefield implementation then spread with local influence and adoption • Devise metrics	Aug 2018	Change plan in place and update provided to OOA Board	
A3h) CLD in place (Wakefield)	Sep 2018	CLD in place on wards in Wakefield	
A3i) Ongoing review (Wakefield) and system rollout (trust-wide)	Oct – Dec	CLD in place on wards across SWYPFT	
A3j) Post implementation review	Feb 2019	Implementation review presented to OOA Board	

Partnership work (1)

- **West Yorkshire Commissioners**
- **West Yorkshire & Harrogate H & CP**
- **AHSN**

- to consider system wide improvements
- to share good practice across organisations
- to work across boundaries where it makes sense & stops people being placed OOA

What	When	Measures	Progress update 04/07/18
Deliver the Personality Disorder Project across Wakefield and share the learning	December 18	Business case presented to NMoC Board	Partnership workshops taking place
Continue to monitor OOA placements through the WY&H weekly call	Ongoing	Calls happening and impacting on partnership working	Weekly calls taking place
Progress the Criteria Led Discharge model as advocated across WY&H	See separate action plan		
Scope out the Community Variation piece across WY&H	End June	Community variation described and presented to WY & H meeting	
Complete the PICU review across WY&H			
Mapping health needs across each place and undertake a comparison exercise			
Mapping community based assets across each place			

Operational Grip

Managing the current system closely to make it as efficient as possible

What	When	Measures
Op1. Continuous challenge to alternatives to admission	Ongoing, daily basis	Consider monitoring Number of people diverted
Op2. Continuous management of flow to ensure that people do not stay any longer than they need to	Ongoing, daily basis	New length of stay measure
Op3. Creative use of all options to reduce need to place somebody out of area	Ongoing, daily basis	Monitored by TRIO
Op4. Continue to reporting to help illustrate and understand the issues and manage our performance	Ongoing	
Op5. Continue to use operational line management structures to unblock issues	Ongoing, as required	Monitored by TRIO
Op6. Establish simple system for measuring system effectiveness	June 2018	Proposed dashboard developed on OOA project board agenda
Op7. Work with West Yorkshire Commissioners	From April	Happening

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk appetite:
Clinical risks (1-6): Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.
Commercial risks (8-12): 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.
Compliance risks (1-6): Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.
Financial risks (1-6): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.
Strategic risks (8-12): 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	Application
Minimal / low - Cautious / moderate (1-6)	• Risks to service user/public safety. • Risks to staff safety • Risks to meeting statutory and mandatory training requirements, within limits set by the Board. • Risk of failing to comply with Monitor requirements impacting on license • Risk of failing to comply with CQC standards and potential of compliance action • Risk of failing to comply with health and safety legislation • Meeting its statutory duties of maintain expenditure within limits agreed by the Board. • Financial risk associated with plans for existing/new services as the benefits for patient care may justify the investment • Risk of breakdown in financial controls, loss of assets with significant financial value.
Open / high (8-12)	• Reputational risks, negative impact on perceptions of service users, staff, commissioners. • Risks to recruiting and retaining the best staff. • Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance Trusts current and future services.

	Likelihood				
Consequence	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		
Improving health	**Improving care**	**Improving resources**
A priority for joining up care	A priority for safety first, quality counts	A priority for operational excellence

KEY:
CEO=Chief Executive Officer
DFR=Director of Finance and Resources
DHR=Director of HR, OD and Estates
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

Actions in green are ongoing by their nature.

Trust Board – business and risk 31 July 2018

Out of area bed risk

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
1319	Quality of care will be compromised if people continue to be sent out of area.	➢ Bed management process. ➢ Critical to Quality map to identify priority change areas. ➢ Joint action plan with commissioners. ➢ Internal programme board. ➢ Weekly oversight at OMG.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of local plans of change activity to reduce admissions and plans to reduce length of stay. (DD) (End of June 2018) ➢ Development of local plans of change activity to reduce PICU bed usage (DD) (July 2018) ➢ Development of pathway for supporting people with Emotionally Unstable Personality Disorder. (DD) (Pathway ready September 2018, implemented by December 2018) ➢ Implementation of actions agreed in the joint action plan. (DD) (December 2018) ➢ Implement changes via PDSA cycles. (DD) (PDSA cycles to be undertaken by December 2018 (some sooner)) ➢ Negotiation with commissioners to develop a risk share agreement. (DD) (to be in place by January 2019) ➢ Working with STP partners to review bed management across West Yorkshire. (DD)	DD	January 2019	OMG	9 Amber / high (8-12)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – July 2018

With all of us in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 9.1

Title:	**Estates Strategy and Facilities update**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper is designed to provide the Board with an update on the implementation of the Estates Strategy and developments across Facilities, Emergency Planning, Health and Safety and Fire Safety.
Mission/values:	The Trust's Estates Strategy was developed through an extensive engagement process including Service Users and Carers, Clinicians, Service Managers and Specialist Advisers and aims to ensure that we have the right environments to enable people to reach their potential and live well in their communities.
Any background papers/ previously considered by:	The attached report has been considered and supported by the Executive Management Team (EMT). The Capital Programme is also part of the Trust Board Integrated Performance Report (IPR).
Executive summary:	The Trust Board approved a 10-year Estates Strategy in 2012 with three key aims: ➢ Modernising inpatient environments ➢ Developing the Trust's community infrastructure ➢ Disposing of buildings and land surplus to requirements Over the past 6 years there has been major capital expenditure across all our inpatient areas including a new build, adult acute wards on the Fieldhead site. The Fieldhead development has seen phase 1, the Unity Centre, open and become operational and the final phase is due to complete around March 2019. A number of disposals of surplus properties are due to take place this year in Wakefield, namely Castle Lodge and Ossett Health Centre. In addition, work has progressed well on two major disposals in Barnsley, including Keresforth, which is part of a one-Barnsley estate plan in partnership with the Local Authority and the South Yorkshire Fire Service. The development of community hubs has progressed well with the opening of Laura Mitchell, Halifax, Baghill House, Pontefract and Drury Lane, Wakefield. There still continue to be teething problems at Drury Lane and remedial work has been undertaken there. The local building user group is being supported to deal with issues and ensure the effective operation of the building. The attached report also provides an update on emergency planning, fire safety and health and safety where significant work has been undertaken in light of national developments.

With all of us in mind.

	Risk Appetite The management of risk associated with emergency planning, fire safety and health and safety are in line with the agreed risk tolerance.
Recommendation:	**Trust Board is asked to NOTE the update on the Estates Strategy and safety arrangements in the Trust.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Estates Strategy and Facilities update

Estate Strategy

The Trust Estates Strategy has three core aims:

- To modernise the inpatient estate
- To develop the community infrastructure
- To dispose of buildings and land that are surplus to requirements

Delivery against the Estates Strategy three core aims has been good.

Inpatient Estate

- The phase one of the new build adult acute inpatient unit on the Fieldhead site is completed and phase 2 is now well underway. The completion date for the whole scheme is March/April 2019.

Community Infrastructure

- There continue to be teething issues with Drury Lane, Community Hub in Wakefield. A range of remedial work has been carried out by the Landlord on the Trust's instruction, including greater sound proofing of the clinical rooms and work is on-going with the lighting. Room bookings continue to come up as an issue although space utilisation still seems low. A new reception desk has been designed for the Child and Adolescent Mental Health Service and this is due to be installed soon. The local building user groups are proposing further developments to the building including additional staff facilities and they continue to monitor room usage.

- Other Community Hubs are generally functioning well.

Disposal of Surplus Estate

- Two major disposals are planned for 18/19 and 19/20: Mount Vernon Hospital (MVH) and the Keresforth site. Plans for disposal of both are well advanced. However, the Keresforth disposal is part of the one Barnsley estate plan and includes adjoining land owned by the Local Authority and South Yorkshire Fire Service. The one Barnsley estate plan, whilst more complicated, is designed to provide the local population with greater facilities whilst maximising the value of the land.

- Other significant disposals for this year include Castle Lodge in Wakefield and Ossett Health Centre.

- Pressure on the estate is relatively high with little space available for expansion of services. Estates' planning has been strengthened for new service development, bids and tenders as vacant buildings and premises are no longer readily available.

- The disposals are exposing the Trust to a higher level of risk as the vacant sites have been targets for vandalism. A different approach to managing empty buildings is being investigated including the use of "property guardians" and demolition.

Capital Plan

- 2017/18 capital plan was more or less delivered against an altered internal target of £10 million (plan £10.75m). Minor works out turned at £72k, which was just below the original plan, and the major schemes were slightly below plan as well (£78k). There was a considerable amount of change within minor works due to operational changes in the year. This change was managed through the Estates TAG as shown below:

Minor Works		Plan	Actual	Variance
Heading	**Count**	**£k**	**£k**	**£k**
As Planned	21	830	760	(70)
Cancelled / Deferred	7	367	0	(367)
Balance 16/17 schemes	0	0	14	14
Total – Original	**28**	**1,197**	**774**	**(437)**
New Schemes	9	0	365	365
Total - Revised	**30 ***	**1,197**	**1,139**	**(72)**
Capitalisation of Salaries		200	249	49
Contingency		161	0	(161)
Total	**30**	**1,558**	**1,388**	

- 2018/19 will be a challenging year as capital availability is restricted with a large pre commitment for the Fieldhead Hospital site.
- A QIA process for non-approved schemes has been undertaken and is being reviewed by BDUs.

Facilities

- The housekeeper model adopted at Fieldhead for many years has been extended to Kendray and the Priestley unit and initial responses on the service have been positive in terms of quality. The savings predicted in the business case are being monitored.
- The PLACE scores for 2017-18 were far above the national average.

Sustainability

- The Trust is meeting its targets for carbon reduction overall.
- The Transport Plan is in consultation at the moment. Car parking at the main sites is being reviewed. The Trust continues to work with the bus companies to support the Transport plan.

Emergency Preparedness Resilience and Response (EPRR)

The Trust has undertaken a number of live exercises and activities to test its EPRR readiness including:

- Live exercises done including silver command involving the executive management team.
- Continuous review of on call arrangements and dissemination of good practice.
- Participation in another successful flu campaign.
- On-going review of Business Continuity Plans.

Overall the Trust is compliant with EPRR standards.

Health and Safety

- All the priorities in the Annual Plan were delivered in year.
- The Safety and Resilience TAG has proved successful with excellent BDU attendance.
- The use of lone worker devices in the BDUs remains low. A full review of the facility has been requested and will report through the OMG.

Fire Safety

- The Trust has met its target for fire training and has increased its training levels on inpatient wards.
- All Fire Risk Assessments are up to date.
- There is a focus this year on annual face to face fire safety training for inpatient units.

Security

- All Security assessments complete.
- New much improved external security contractor appointed in year.
- Car parking pressures at key sites are being managed within the team with a targeted cooperative approach.
- Car parking surveys used to aid transport plans.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 9.2

Title:	**Organisational Development (OD) Strategy action plan 2018-2019**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The Trust is facing significant challenges and the OD Strategy recognises to remain successful it is crucial that systems and resources are aligned and we continue to live our values.
Mission/values:	The aims of the OD Strategy is to enable the Trust to deliver its Mission and to Support Staff to Live the Values
Any background papers/ previously considered by:	The OD Strategy was approved by the Trust Board in October 2016. The OD Strategy links to the Workforce Strategy, Leadership and Management and Development Framework and Engagement Strategy. The Workforce and Remuneration Committee at its meeting on the 8 May 2018 considered and supported the OD action plan and recommended it should go to the Trust Board for approval.
Executive summary:	The Trust undertook an extensive engagement programme with Service Users, Carers, Staff and Partner Organisation to develop its Mission and Values. The Mission and Values are well embedded in the Trust as recognised in the Care Quality Commission (CQC) Well Led Review. This has provided a strong foundation for the on-going development of the Trust to enable it to remain successful given future challenges. The purpose and aims of the OD Strategy is to: ➢ Develop a clear sense of direction for the Trust ➢ Support effective change management ➢ Develop a workforce fit for purpose ➢ Alignment of systems and resources with the Trust priorities The Trust's definition of OD which was developed through the engagement of staff in the Trust is: **Working Together to Deliver the Mission and Live the Values,** which will require: alignment of resources and systems; a clear strategy and effective change management; and value based workforce development The OD Strategy uses a locally adapted version of the Mckinsey 7S model to develop a set of strategic objectives.

With all of us in mind.

	The 2018/2019 OD implementation plan has been developed in line with the annual planning timetable to ensure it accurately reflects the Trust's Strategy, and service and financial plans. A Quarter 1 update is included in the attached plan. **Risk Appetite** The OD action plan forms part of the control measures for the workforce risk which has a target of 8-12.
Recommendation:	**Trust Board is asked to APPROVE the OD action plan for 2018/2019.**
Private session:	Not applicable.

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Organisational Development Plan 2018/2019

With **all of us** in mind.

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Background

- Trust Board agreed a 2 year Organisational Development (OD) Strategy in 2016
- The purpose and aims of the OD Strategy were:
  - To develop a clear sense of direction for the Trust
  - Support effective change management
  - Develop a workforce fit for purpose
  - Alignment of systems and resources with Trust Priorities
- The OD Strategy is not designed to be an exhaustive list of development activities but a focus on the key areas for the Trust to ensure alignment of effort and resources

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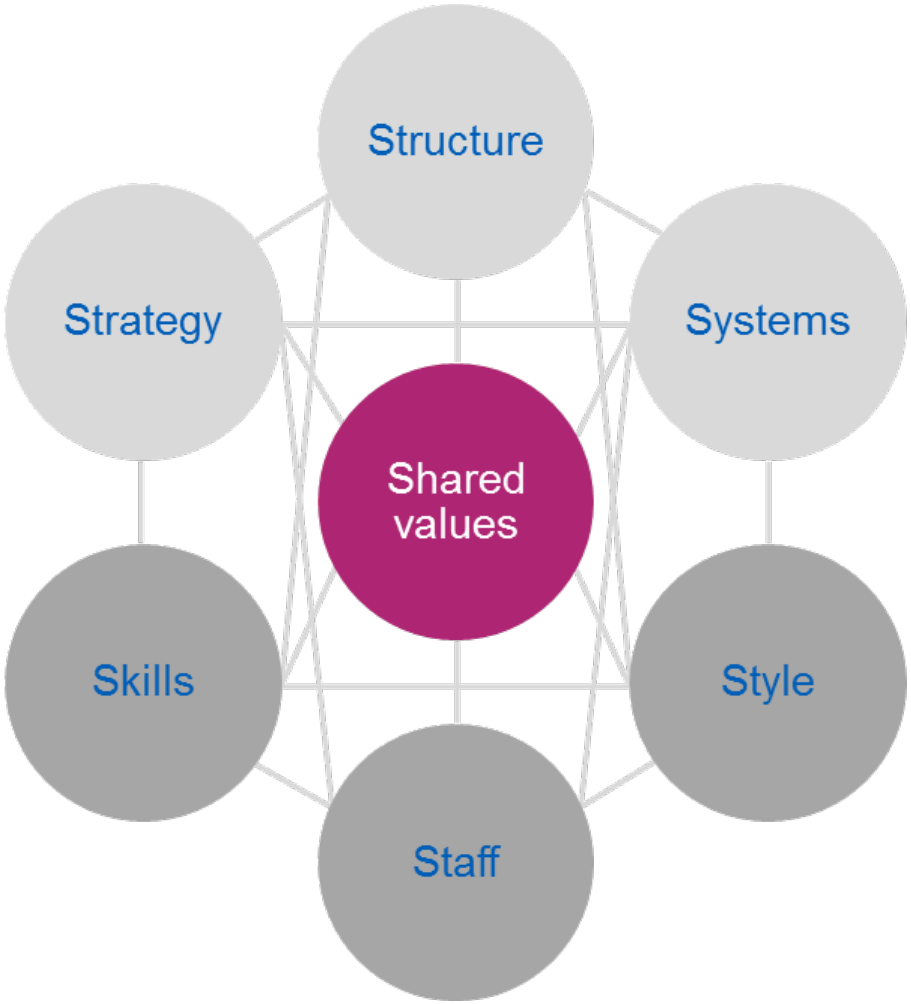
OD Framework

- The OD model used by the Trust is an adaptation of the McKinsey 7s
- The 7s model looks at the key internal factors an organisation needs to align for success
- The 7 factors can be broken down into 2 groups: hard and soft. Hard factors tend to be easier to define and generally influenced by management action, whilst soft ones are often less tangible and more influenced by culture
- The hard factors are: Strategy, Structure and Systems
- The soft factors are: Style, Staff, Skills and Values

McKinsey 7S model



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Trust's Adapted 7s OD Model: Definitions

7s Factor	Trust definition
Strategy	How we will achieve sustainable, safe and high quality services over the next 3 to 5 years
Structure	Clear, affordable collective management and leadership structures
Systems	Simple, understandable, effective and efficient systems
Style	Visible compassionate leadership which engages the workforce and is a strong system
Staff	Right people who are ready for today and relevant for tomorrow
Skills	Improve and be outstanding
Shared Values	Ensure we live our values

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2018/2019 OD Action Plan

Factor	High Level Actions
Strategy	• Update Trust Strategy and agree Priority Programmes for 18/19 • Agree and deliver Financial Recovery Plan • Clear and measurable objectives for the Chief Executive and Directors
Structure	• Review and update the Directors structure and portfolio • Agree and implement new operational management and leadership structure • Review corporate services to ensure they are affordable and aligned to new operational management arrangements
Systems	• Implement new clinical information system • Align corporate systems to the new operational management arrangements • Development of decision rights framework to support devolved decision making closer to the service user

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Draft 2018/2019 OD Action Plan con

Factor	High Level Action Plan
Style	• Implement new value based leadership and management framework • Roll out the Middleground programme on developing health teams • Visible and supportive leadership with the Integrated Care System at regional and place levels
Staff	• Clear change management programme to support new operational structures • Update clinical worker support strategy to include new roles and a zero approach to agency staff • Integrated workforce plan for the development and implementation of new roles linked to service and financial plans
Skills	• Agree and implement Trust's Quality Strategy • Agree implement a continuous development plan for the CQC Well Led standards • Ensure staff are equipped and able to maximise the benefits of the new clinical information system
Shared values	• Implement new value based appraisal system • Continue to develop the Freedom to Speak Up Guardian Network to support a culture of openness and safety • Develop a programme to tackle and reduce harassment and bullying at work

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2018/2019 OD Action Plan on a page

Strategy	Structure	Systems	
• Update Trust Strategy and agree Priority Programmes • Agree Financial Recovery Plan • Agree clear objectives for Chief Executive and Directors	• Review and update Directors Structure and Portfolios • Agree new Operational Management and Leadership Structure • Review Corporate Support Structures	• Implement new Clinical Information System • Align corporate support systems with the new operational arrangements • Development of decision rights framework to support devolved decision making	
Style	**Staff**	**Skills**	**Shared Values**
• Implement Value Based Leadership and Management Development Framework • Middleground Programme: Healthy Teams • Visible and supportive leadership within the Integrated Care Systems	• Change Management Programme to support new structures • Updated Clinical Support Worker Strategy including zero approach to agency • Workforce plan for the development and implementation of new roles	• Agree and implement Trust Quality Strategy • Agree continuous improvement plan for CQC Well Led review • Ensure staff are equipped and able to maximise the benefits of the new Clinical Information System	• Implement new Valued Based Appraisal System • Continued development of Freedom to Speak Up Guardian Network • Tackling Harassment and Bullying at work

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OD Strategy Action Plan 2018/2019

Quarter 1 Update

RAG Rating	
BLUE	Complete
GREEN	On target
AMBER	Off target at the present but with further action expected to hit the target date
RED	Off target and unlikely to hit the target date

Director Lead	
DoF	Director of Finance and Resources
DoS	Director of Strategy
DoN	Director of Nursing and Quality
DHR	Director of HR, OD and Estates
DoOp	Director of Operations
DoPD	Director of Provider Development
MD	Medical Director

Strategy

Action	Director Lead	Target Date	RAG rating	Comments
Update Trust Strategy and agree Priority Programmes for 18/19	DoS	Q1	BLUE	Agreed by Trust Board and EMT
Agree and deliver Financial Recovery Plan	DoF	Q2	GREEN	Director of Finance working towards September for the final recovery plan to be agreed by the Trust Board
Clear and measurable objectives for the Chief Executive and Directors	CE	Q1	BLUE	Chief Executive and Directors appraisals completed using value based appraisal model and objectives agreed

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Structure

Action	Director Lead	Target Date	RAG rating	Comments
Review and update the Directors structure and portfolio	CE	Q1	BLUE	New Directors Structure agreed and agreed implementation date 6th August 2018
Agree and implement new operational management and leadership structure	DoOp	Q3	GREEN	Single Director of Operations post agreed as part of new Director structure. Carol Harris to take up new role on 6th August 2018 and she will lead the development and implementation of the new operational management and leadership arrangements
Review corporate services to ensure they are affordable and aligned to new operational management arrangements	All Directors	Q2	GREEN	Cost Improvement Plans agreed for all Corporate Services for 18/19. Additional challenges for corporate services is to initially agree plans to ensure 18/19 expenditure is no greater than 17/18 and then look for a further 3% reduction

Systems

Action	Director Lead	Target Date	RAG rating	Comments
Implement new clinical information system	DoS	Q3	GREEN	Full programme management in place with governance systems well defined and support from the Integrated Change Team. Significant clinical engagement is happening and progress is reported through the Integrated Performance Report to the Trust Board. A recent internal audit has taken place. Assurance is provided to the Clinical Governance and Clinical Safety Committee and the Audit Committee
Align corporate systems to the new operational management arrangements	All Directors	Q4	GREEN	Director to review all corporate systems and structures to ensure they are aligned to new operational management and leadership arrangement
Development of decision rights framework to support devolved decision making closer to the service user	DoF	Q4	GREEN	This links to a review of corporate systems and the implementation of any new operational leadership and management arrangements

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Style

Action	Director Lead	Target Date	RAG rating	Comments
Implement new value based leadership and management framework	DoHR	Q1	BLUE	Leadership and management framework launched and a number of programmes underway including: Shadow Board, Mary Seacole, Moving Forward
Roll out the Middleground programme on developing health teams	DoHR	Q1-Q4	GREEN	Middleground launched with programmes schedule throughout the financial year. 2 programmes delivered to date
Visible and supportive leadership with the Integrated Care System at regional and place levels	DoPD/DoS	Q1-Q4	GREEN	Trust senior leaders are present, visible and actively contributing in all Place based and regional multi agency leadership partnerships. In Wakefield for example, the Trust has secured all Partners' agreement to taking forward a Provider Alliance in mental health services.

Staff

Action	Director Lead	Target Date	RAG rating	Comments
Clear change management programme to support new operational structures	DoHR	Q3	GREEN	To ensure that any new proposed operational leadership and management arrangements has clear staff engagement plans (including Staff Side), support effective change management in services and teams an
Update clinical worker support strategy to include new roles and a zero approach to agency staff	DoHR	Q3	GREEN	The clinical support worker strategy is being updated to include the development of new roles and a more flexible workforce. This will support the reducing agency spend on support worker roles
Integrated workforce plan for the development and implementation of new roles linked to service and financial plans	DoHR	Q4	GREEN	Annual BDU/ Directorate Workforce Planning workshops to be held in Q3 to ensure alignment of Service, Finance and Workforce Plans

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Skills

Action	Director Lead	Target Date	RAG rating	Comments
Agree and implement Trust's Quality Strategy	DoN	Q1	BLUE	Quality strategy and implementation plan approved by board and monitored by CGCS
Agree implement a continuous development plan for the CQC Well Led standards	DoN	Q1-Q4	GREEN	Action plan in place as part of CQC well–led review preparation (outcome Good rating) Implementation plan for Quality strategy in place and includes actions in relation to well-led domain.
Ensure staff are equipped and able to maximise the benefits of the new clinical information system	DoS	Q4	GREEN	Training approach developed with clinical and operational input. Support materials developed in partnership with Learning & Development. Training scheduling commenced and approach agreed by OMG

Shared Values

Action	Director Lead	Target Date	RAG rating	Comments
Implement new value based appraisal system	DoHR	Q1	BLUE	New appraisal system agreed and implemented
Continue to develop the Freedom to Speak Up Guardian Network to support a culture of openness and safety	DoHR	Q2	GREEN	Clinical Governance and Clinical Safety Committee to review current Freedom to Speak Up Guardian (FSUG) arrangements in September 2018. One day a week dedicated time provided for a FSUG to focus on the development of the role and a communication plan
Develop a programme to tackle and reduce harassment and bullying at work	DoHR	Q4	GREEN	Clinical network established to look at the harassment and bullying from Service Users/Carers/Visitors on Staff. New policy being developed in consultation with Staff Side and Equality Staff Network. Middleground programme as part of developing health teams includes tackling harassment and bullying at work

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018
Agenda item 10.1

Title:	**Equality and diversity annual report 2017/18**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To review equality and inclusion activity in 2017/18, as reported to the Equality and inclusion forum and areas for focus for 2018/19 as set out in this report and in the equality strategy.
Mission/values:	➢ This report provides evidence of an equality competent organisation with a well led culture that prioritises and champions equality ➢ Meeting the Trust's equality duties support an environment where everyone feels respected and valued. ➢ Valuing diversity in the communities that we serve and in our staff is fundamental to our value of person first and in the centre.
Any background papers/ previously considered by:	Equality and Diversity Strategy 2017-2020 Equality and Inclusion Forum meeting on 12 June 2018.
Executive summary:	This report has been received and considered by the Equality and Inclusion Forum on 12 June 2018. The Forum discussed that the format, conclusions and actions resulting were clear and easy to understand and support that the annual report be presented to the Trust Board in July 2018. Equality is about creating a fairer organisation in which everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. This report offers an overview of Trust activity in 2017/18. It highlights work to ensure an approach that is about culture not compliance, promoting an agenda of inclusivity and respect and valuing the diversity of the communities we serve and of the staff we employ. The report summarises work reported to the Equality and Inclusion Forum. The Forum's primary purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion into everything it does through promoting the value of inclusivity and treating people with respect and dignity. The Forum focusses on driving a values-based approach to equality and inclusion through the organisation rather than a traditional compliance-based approach. The Trust aims to ensure that services are designed and delivered, as far as possible, to respect and value difference and that services can adapt to meet the needs of individual service users and their carers. Equality of opportunity in employment and developing a workforce that

	reflects local communities will further enhance the quality of the services we provide. **Risk appetite** Risk identified –The development of the equality and diversity strategy implementation covers assurance for: ➢ **Compliance risk**: with CQC standards for reviewing healthcare deaths. This meets the risk appetite – low and the risk target 1-3. ➢ **Financial or commercial risks:** Reputational risks, negative impact on perceptions of service users, staff, commissioners. Cautious/moderate risk appetite and a risk target of 4-6 ➢ **Clinical risk** –risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-3. Key risks identified will be escalated to the organisational risk register as applicable and will be mitigated in line with our risk appetite and risk management strategy. This will be done through detailed action planning to underpin implementation activity.
Recommendation:	**Trust Board is asked to RECEIVE the Equality and Diversity Annual Report 2017/18.**
Private session:	Not applicable.

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Equality and Diversity Annual report

2017/18

With **all of us** in mind.

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Purpose of this report

To report progress on delivering the SWYPT Equality Strategy since approval in July 2017. The background to the strategy will be considered and progress in achieving the objectives and outcomes will reported.

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Equality strategy

The strategy is about treating everyone with fairness and understanding, not necessarily treating everyone the same. It aims to reduce inequalities in our services, including those linked to deprivation and those linked to the Equality Act protected characteristics.

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Equality strategy legal requirements

The Equality Act is the most significant piece of equality legislation and simplifies the law making it easier to understand. It also strengthens the law in important ways, tackling discrimination and inequality and making it easier for employers to understand their responsibilities. This approach brings together complex legislation and describes an approach which covers the groups offered protection from unfavourable treatment.

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Equality strategy legal requirements

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These protected characteristics 9 +1 are:

1. Disabled people
2. Men and women (gender)
3. People from different ethnicities and cultures and with different appearance
4. People of different ages
5. Straight, gay and lesbian people
6. People from different religions or people who do not have a religion
7. Women who are pregnant or who have a new baby
8. People who are married or who have a civil partner
9. Transgender people
10. People who are carers (In keeping with the type of services we offer, the Trust includes this additional characteristic – which is given the same importance as the other 9 characteristics).

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Equality strategy delivery is through

- The Public Sector Equality Duty (section 149 of the equality act) places a duty on public bodies to ensure that they consider the needs of all individuals in their day to day work, for example shaping polices or how they deliver services.
- Sets a standard to treat everyone, no matter what background or personal circumstances with dignity and respect.

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Equality Delivery System 2 (EDS2)

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- Department of Health, reviewed by NHS England
- Help the NHS measure equality performance.
- Assists the Trust to ensure it meets the Public Sector Equality Duty, includes 18 outcomes grouped into 4 goals.

Two of the goals are about services:

- Better health outcomes for all
- Improved patient access and experience

Two are about NHS staff:

- Empowered, engaged and included staff
- Inclusive leadership.

The Trust focused on one outcome for each of the 4 goals

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Workforce Race Equality Standards (WRES)

- Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS national contract
- The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
- This is important because studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

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Workforce Disability Equality Standards (WDES)

- Has been mandated through NHS standard contract
- Not live yet, Autumn 2018 publication is expected
- Proposed standards:-
  - Workforce representation
  - Reasonable adjustments
  - Employment experience
  - Opportunities

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Trust equality objectives

1. Promote a fair organisation – better health outcomes for all
2. Promote person centred care and equal access to pathways of care
3. Develop and sustain an equality competent organisation through inclusive leadership and ownership at all levels
4. Continue to improve equality of opportunity for staff and our volunteers

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Key headlines 2017/18

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There has been progress against the equality strategy objectives and the delivery and outcome.

- Progress is described mainly in qualitative terms rather than quantitative.

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Wider examples include:-

- We hosted some events and visited numerous of groups and forums including with seldom heard groups
- We have commenced work to refresh our commitment to carers
- We review satisfaction with services through analysis of feedback through customer services and patient experience processes
- We meet reporting requirements
- We have established a BAME network
- We are also setting up a network for staff who identify as having a disability and have started looking at networks for LGBT staff and staff who have caring responsibilities

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Wider examples include:-

- Our Trust Board participated in a pilot for the Insight Programme, which assists people from minority groups be represented on Trust Board
- Between1st April 2017 and 31st March 2018, 1799 staff undertook Equality, Diversity and Inclusion training
- There has been stakeholder involvement in EDS2 grading
- Produced a staff guide to support teams to help people who identify as lesbian, gay, bisexual, trans, questioning or intersex (LBGTQI) feel safe and welcome in Trust services

Examples of change

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- We established an arts café (with support from the Trust Charitable Funds) to offer social, educational and creative activities to adults with a learning disability
- We are setting up culturally sensitive memory cafes to meet the needs of people with dementia. We held a community dementia awareness event, with Kirklees Dementia Alliance
- We helped meet people's religious and spiritual needs by providing a multi-faith room at the Dales Unit in Calderdale
- Staff have undertaken training with the British Legion to raise awareness of the 'veteran' culture – enabling them to make adjustments to services as needed.

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Trust Strategy
Delivery and Outcome Measures

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Within the strategy the Trust identified seven delivery and outcome measures. The next set of slides will show some of the progress that has been made against each of the measures.

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Outcome 1

All services will have an Equality Impact Assessment (EIA) with annual review and delivery of actions monitored through BDU governance arrangements. All change programmes will be co-produced where appropriate and include equality considerations informed by EIA.

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- Services have developed EIA's
- Reviews and action plans need to be regularly monitored through governance groups
- Equality Impact Assessment(EIA's) quick guide is available to support staff
- We use EIA's to see whether our plans, strategies, policies and services affected some communities or groups of people differently and worked to address the impact of that difference

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Outcome 2

We will improve data capture and accuracy of recording in respect of protected characteristics

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- Incident data for violence and aggression identifies whether incident is racially or sexually motivated.
- Apparent suicides data collection has been added to Datix so this captures many of the protected characteristics
- Performance and information have produced dashboards to assist services in monitoring each of the 9 characteristics.
- SystemOne and RiO is available at service level: For Rio the total data collection and although improved from calendar year 2017 to financial year 2017/8 and there are a significant number of unknowns/ data gaps

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Outcome 3

Services will evidence equality considerations in support of Equality Delivery System (EDS2) to demonstrate how driving equality improvements can strengthen accountability to service users and the public

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- Business delivery units have developed action plans against the equality strategy and these include elements of EDS2
- Examples of work include:-
- Production of a range of material for ECT including a DVD, arranging supported visits.
- In patient carers group running at different times and different types of events –coffee evenings
- New carers booklet for in patients (Wakefield)
- Recovery college caring for carers course
- Improved disability access within Wakefield HUBs

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- The Trust return for May **2017** was completed for 17/18 of the outcomes. The 17/18 were graded developing –these are linked to workforce requirements, the remaining have not been graded.
- The **2018** return is showing that the Trust is achieving goal 1 and 2
  - Better health outcomes for all -achieving
  - Improved patient access and experience -Achieving
  - Empowered, engaged and included staff –Developing
  - Inclusive leadership –developing

- The 17/18 outcomes completed show an improvement of 2 achieved and 5 developing –these are linked to workforce requirements, the remaining have not been graded.
- This grading has been tested with stakeholder groups.

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- There has been numerous examples of services engaging with service users, carers, families and partners during the past year examples include:-
  - Perinatal mental health services launch events
  - speech and language for making information accessible and sharing service offer,
  - creative mind overviewing bids
  - Incontinence and urology with carers and people living with dementia
  - Interviews of Non executive Director

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Outcome 4

We will monitor any complaints and reported incident about access to services where discrimination was a factor

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- We adopt a person centre approach to complaint handling
- Customer services already monitor and report on these issues and collect information and at time of report it’s a nil return

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Outcome 5

An increase in positive stakeholder perceptions via Friends and Family Test and feedback via Customer Services and dedicated surveys

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- We review satisfaction with services through analysis of feedback through customer services and patient experience processes
- We helped over 5900 people give their views using the Friends and Family Test by providing survey materials in easy read and child friendly formats. We ask people to share their views about our services using a short postcard or a longer questionnaire
- This has been acknowledged as good practice by the Yorkshire and Humber Equality Leads Network. We also request equality data when people complete the test

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- Friends and family test “How likely are you to recommend services to friends and family if they required similar care or treatment”. There was also a 12% increase of response from 2016/17 to 2017/18

	White British	BAME
2016/17	97%	91%
2017/18	97%	100%

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Outcome 6

Our staff wellbeing survey results see improvements in feedback regarding equality of opportunity in training, support and career progression.

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- Our staff wellbeing survey results see improvements in feedback regarding equality of opportunity in training, support and career progression.
- NHS staff survey feedback will report increased staff satisfaction with equality of opportunity.
- The Trust asked staff their view on progress regarding Goal 3 by means of a confidential survey which asked 3 questions (the survey response rate showed a slight increase on last year):

‘**Do you feel that all Trust staff have equal access to career opportunities and skill development in the workplace?’**
Staff responded:
Yes 48.41% No 35.71% Don’t know 15.87 % (n = 252)

Do you feel the Trust has a fair recruitment and selection process?
Response - Yes 68.25% No 11.90% Don’t know 19.84% (n = 252)

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The Trust asked staff their by means of a confidential survey which asked 3 questions (the survey response rate showed a slight increase on last year):

‘**Do you feel that all Trust staff have equal access to career opportunities and skill development in the workplace?’**
Staff responded:
Yes 48.41% No 35.71% Don’t know 15.87 % (n = 252)

Do you feel the Trust has a fair recruitment and selection process?
Response - Yes 68.25% No 11.90% Don’t know 19.84% (n = 252)

Do you feel that the Trust deals effectively with harassment and bullying?
Response – Yes 28.17% No 23.41% Don’t know 48.41% (n = 252)

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Feedback from the survey included:

"Admin staff do not appear encouraged to access training and development other than mandatory training"

"Part time, lower graded staff do not have the same opportunities….."

"The Trust has put in place a 'Moving Forward' programme for BAME staff"

"The skill development and career opportunities I find are more nursing focussed"

" "Hearing stories from BAME staff certainly does not reflect this, but on the other hand we now have our very first BAME Director!"

"Sometimes people are put into jobs without the jobs being advertised"

"Yes, we recruit the best candidate for the job regardless of their protected characteristics"

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Feedback from the survey included:

"From my experience of recruitment it was open, fair and well organised" "No, the Trust does not deal fairly and openly with harassment and bullying choosing to hope the issue goes away rather than deal with the problem…"

"The Trust has a policy for staff and managers to follow and seeks to ensure issues have being effectively managed with appropriate response"

"There is always room for improvement but the message is clear and consistent on not tolerating this"

" "I don't know about the process because I've not experience harassment and bullying"

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Outcome 7

NHS staff survey feedback will report increased staff satisfaction with equality of opportunity.

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- KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion, this has worsened from 90% in 2016 to 86% in 2017 (86% is average compared to similar Trusts)

- KF10 Support from immediate managers scale summary has worsened very slightly to 3.87 in 2017 from 3.89 in 2016. (3.87 is average and the change from 2016 is not statistically significant)

- Harassment bullying and abuse from service users, carer and the public is above average although between staff is below average.

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Conclusion

Overall, the implementation of the equality strategy has resulted in real achievements and steady progress in meeting the strategy outcomes. However, the equality agenda features in different portfolios across various services in the Trust and delivery appears fragmented. The remaining two years of the strategy will require further strategic alignment and central co-ordination to ensure consistency in equality, diversity, inclusion and engagement across the Trust.

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Actions for 2018/19 include

1. Scope equality, diversity, inclusion and engagement activity across the Trust and report to EMT and E&I forum.
2. Finalise Equality strategy action plan for 2018/19.
3. Ensure there are quantitative and qualitative outcome measures for the action plan.
4. Ensure information and resources are easily accessible to services.

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Trust Board 31 July 2018
Agenda item 10.2

Title:	**Proposal for the use of e-cigarettes on Trust Premises**
Paper prepared by:	Director of Forensic, Specialist, Calderdale, Kirklees
Purpose:	This report seeks support from Trust Board in progressing the work to permit the use of e-cigarettes in Trust premises as part of our smoke free policy.
Mission/values:	This proposal supports people's health and wellbeing by allowing the use of e-cigarettes as a safer alternative to smoking, in line with Public Health England (PHE) and the Royal College of Psychiatrists (RCP) advice. The proposal aims to address a number of the concerns raised by staff, visitors and service users regarding breaches of the smoke free policy. It reduces the restrictions placed upon service users and promotes more positive therapeutic interactions with staff therefore putting people first and in the centre. The proposal is in response to service user engagement and reflects the feedback received.
Any background papers/ previously considered by:	The original smoke free policy was approved by Trust Board in March 2006 for implementation by December 2006. The current version of the policy attached was approved by the Executive Management Team (EMT) in November 2015.
Executive summary:	Following a series of concerns from breaches of the smoke free policy and incidents of fire, a working group was formed to review the implementation of the smoke free policy and the challenges that staff faced in implementing the policy in practice. The work led to the group providing a proposal to the Executive Management Team (EMT) in June 2018 to introduce allowing vaping/e-cigarettes into the existing smoke free policy. This proposal is supported by engagement with wider service managers and health and safety and fire safety managers as well as service users. It is also based on actions taken by similar Trusts. In addition to the health benefits of switching to e-cigarettes as set out by Public Health England and the Royal College of Psychiatrists, other benefits are expected to include: ➢ Reduction in the number of incidents of breach of policy. ➢ Reduction in the risk of fire. ➢ Improved therapeutic relationships by removing a known flashpoint in staff / service user interactions. ➢ Reduced risk of exploitation of vulnerable service users, by

	reducing the market for high-cost contraband or excessive pressure to share cigarettes. ➢ Improved use of therapeutic leave from the ward. EMT supported the proposal and recommended that approval is sought from Trust Board. If approved, the next steps will be for the working group to: ➢ Prepare a detailed implementation plan. ➢ Prepare the amendments to the current Trust Policy. ➢ Continue to report progress through EMT following approval from Trust Board.
Recommendation:	**Trust Board is asked to:** ➢ **SUPPORT the principle of allowing the use of e-cigarettes for service users;** ➢ **SUPPORT EMT to have oversight of changes to the policy and the implementation plan; and** ➢ **REQUEST assurance of effective implementation from the post implementation review at 6 months.**
Private session:	Not applicable.

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Proposal for the use of e-cigarettes on Trust Premises

Introduction

Following a series of concerns from breaches of the smoke free policy and incidents of fire, a working group was formed to review the implementation of the smoke free policy and the challenges that staff faced in implementing the policy in practice
This paper will attempt to:

- articulate the impact the Smoking ban has had on services and the service users;
- look at the current national opinion on e-cigarettes and how it has changed over time;
- consider the Health and Safety issues related to the smoking ban
- consider the success, or otherwise, of the smoking cessation work and look at the cost associated Nicotine Replacement Therapy (NRT).
- put forward a proposal for change.

Background and National Drivers

Smoking is the main cause of preventable illness and premature death. Currently in the UK, approximately 19% of adults smoke. People with a mental illness who smoke are more likely to be heavier smokers and more tobacco dependent than smokers in the general population. These high rates of smoking exacerbate the health inequality already experienced by those with mental illness. The largest positive impact on the health of people with mental health problems will come from increasing the focus on their smoking behaviour and through the routine provision of smoking cessation support.

Smoking causes a wide range of diseases and medical conditions, including cancers, respiratory diseases, and coronary heart disease. It also has a negative impact on mental health. Some smokers experience more severe mental health symptoms, require higher doses of psychotropic medication and spend more time in hospital compared to people with a mental illness who do not smoke. These interactions are caused by the components in the smoke (polycyclic aromatic hydrocarbons in the tar) and not the nicotine. Approximately a third of welfare benefits are spent on cigarettes and patients often prioritise buying tobacco over buying food, toiletries and spending on leisure activities.

People who stop smoking greatly reduce their risk of developing preventable disease and dying prematurely. Stopping smoking may also associated with a reduction in mental health symptoms for some people, as well as improved quality of life.

The Smoke-free Policy prohibits smoking in Trust premises i.e. buildings, grounds and Trust vehicles. South West Yorkshire NHS Partnership Foundation trust (SWYPFT) is committed to improving the health and wellbeing of patients, carers, staff and visitors. The historic image of mental health services is strongly associated with smoking. The Trust strives to change this to an image that positively promotes health and wellbeing for all. We will provide treatment to smokers who wish to quit and support smokers who do not want to quit but who must temporarily abstain from smoking whilst in Trust buildings

or grounds. We will provide a healthy environment to work in and create outside spaces that are conducive to nurturing wellbeing. The policy complies with Smoke-free legislation (Health Act, 2006), NICE Guidelines for Smoking: acute, maternity and mental health services (NICE, 2013a) and Smoking: harm reduction, (NICE, 2013b) and the NHS five year forward view (NHS England 2014).

The other drivers from a Health Service provider perspective is the Health and Safety at Work Act 1974, and the requirement that employers have a duty to 'provide and maintain a safe working environment which is, so far as is reasonably practical, safe, without risks to health and adequate as regards facilities and arrangements for their welfare at work'.

The aim of our Trust Policy is to ensure a smoke free Trust which:

- Protects and improves the health of staff
- Protects and improves the health of service users/patients, visitors and contractors
- Protects both smokers and non-smokers from the danger to their health of exposure to second-hand smoke
- Sets an example to other employers and workforces, particularly in health-related locations
- Supports and assists staff and service users/patients to quit smoking.

Our policy is also clear in the prohibition of e-cigarettes and vaporisers with cigarettes in our Trust properties, staff on home visits to patients in the community, and for our hospital-based staff, patients, carers and visitors.

Health, Safety and Security

Risk of fire is always a concern in a hospital environment. Measures have been put into place to ban the access to smoking paraphernalia in our services and therefore there is no need to have lighters or matches when people are not allowed to smoke. However, the smoke free policy has led to the subversive use of lighters or matches in bedrooms, bathrooms and toilets as well as communal areas and bedroom en-suites. There is also a practice of utilising the electric sockets and tin foil to make a spark to light cigarettes. These all increase risks of fire substantially and make the job of policing this activity an additional duty for staff and a source of conflict.

From the perspective of security, there have been occasions when both relatives and takeaway delivery staff have tried to smuggle cigarettes, tobacco and lighters into in-patient units. This is both dangerous and damages the relationship between the service user, staff, relatives and other visitors. If this can be reduced by the implementation of e-cigarette use, it would help maintain the security of the units and the relationships with these individuals.

E-cigarette use in mental health settings

The Care Quality Commission (CQC) recently published guidance on smoke free policies in mental health inpatient services where they clearly distinguished tobacco cigarettes from e-cigarettes. The guidance confirmed that blanket bans on tobacco cigarettes are justified but that blanket bans on e-cigarettes may not be. The guidance also highlighted the role of e-cigarettes in supporting smoke-free policies and referenced a briefing from the National Centre on Smoking Cessation and Training (NCSCT). The NCSCT briefing recognises that some people find e-cigarettes helpful for quitting, cutting down and/or managing temporary abstinence. Further information about E-cigarettes can be found at Appendix 1.

Smoking cessation

A thorough commitment was made to support all service users and staff who smoke to discuss and support smoking cessation across the Trust supported by Smokefree Yorkshire - SWYPFT, Calderdale, Barnsley, Wakefield, and Kirklees. Staff were trained up to offer ongoing support in all clinical services in preparation for the 'go live' date of the 1st December 2016.

Nicotine Replacement Therapy (NRT) was discussed and offered and prescribed where there was consent and capacity for service users who expressed an interest in trying to stop smoking.

The visit to Greater Manchester West Trust (GMW) indicated that the cost of NRT for their Forensic Services was averaging £7500 per month, this figure dropped to £500 - £600 after the introduction of e-cigarettes. The following table indicates the current cost of NRT in the Trust.

Month/ Service	Specialist (inc Forensic PLD)	Forensic	Calderdale/ Kirklees	Wakefield	Barnsley (MH)	Barnsley (Comm)	Support (Waste)
Dec 17 –May 18	£2,627.66	£16,394.49	£1,774.74	£5,098.28	£4232.28	£313.21	£242.40
Totals	£19,022.15		£11,105.30				
Grand total	**£30,967.25**						

- Trust-wide spend for NRT products held within and supplied by the Pharmacy department at Fieldhead hospital (FHH) for all Business Delivery Units (BDUs), excluding Barnsley where supplies are made by Lloyds pharmacy as per the current service level agreement

- The costs for the Psychiatric Learning Disability (PLD) wards and departments are within the columns headed SPECIALIST - this includes all costings for Low Secure Unit and Medium Secure Units Forensic PLD wards.

- Any costings displayed for SUPPORT are those absorbed by the Pharmacy department for breakages and expired stock.

As you can see from the table; the cost for NRT in the Forensic Services is very high. Where the vast majority of the service users are admitted for a significant length of time, (length of stay ranges from 12 weeks to 4 years), there were a number of patients who took up this programme for cessation; however there are a large number of service users who are now on NRT, who have chosen not to stop smoking but utilise NRT to support themselves on a daily basis in managing their craving.

Service user feedback

Service Users have voiced their opinion and perspective on the issues of e-cigarettes continuously in community meetings across the in-patient services, and other Service Users' forums, expressing dissatisfaction about the 'restrictive practice' of the blanket ban, and a request for the Trust to consider the use of e-cigarettes.

Service Users Comment – Forensic Services and Ward 18

"I would be very grateful if E-cigs could be allowed for us. I don't get what I need from the inhalators (NRT product available to Service Users), and an E-cig would really help me through the days".

"E-cigs would be good to be able to have on the wards as it would give us a choice and

an alternative to smoking, the lads wouldn't have to hide it anymore too which would be better for everyone"
"I would really like to be allowed an E-cig, it would make me feel like Services and staff have been listening to us (to complaints about smoking ban and the frustrations and perceived unjust nature of this), and are trying to do things for us and not to us all the time".
"We should be allowed to use E-cigarettes"
"Vaping works out cheaper than normal cigarettes"
"There should not be a designated vaping area"
"It would be preferred if vaping was allowed when in garden areas/areas off the ward and in bedrooms."
"Vaping should not be allowed in communal areas as not everyone wants to vape or be subject to passive vaping."
"The ward outside environment/garden area would be cleaner as currently tab ends are everywhere service users present expressed they were constantly trying to clean these up."
"If vaping outside/inside the smell doesn't linger like cigarette smoke"
"Good idea"
"Not sure about the disposable ones-are they safe?"

Local issues

The Forensic service has been a particular hotspot for the organisation with consistently high numbers of Datix (incident) reports for breaches of the smoke-free policy.

Managing the smoke-free environment in the external ground - Fieldhead site – has been a constant challenge – there are always a number of service users/visitors to be seen smoking around the site and the 'confidence' from many staff to challenge them is low.

The acute wards have opted to manage service user pressure by having escorted leave to the hospital grounds at appointed times for cigarette breaks. This outwardly looks very unpleasant and does not promote the positive image that the Trust would like to display. The ward manager has received complaints about this – "**It's lovely to inhale smoke from 30 cigarettes first thing on a morning**" as a member of staff walked by a large group of patients that were smoking at the main entrance. There are also concerns about service users sitting on the kerb with their legs in the road.

The statistics would indicate that this issue is not limited to the Fieldhead site. Other units are located on property owned by other organisations, with different local policies. Mid Yorkshire Hospital NHS Trust's Nicotine Management Policy states 'Therefore the use of e-cigarettes outdoors in the hospital grounds is permitted …' and 'The Trust's fire safety/risk management team recommends that e-cigarettes must not be used in MYHNHST property. Additionally, e-cigarettes must not be charged in any Trust premises.'

Consequences of Smoke Free policy

The impact of banning smoking in inpatient settings have 3 main areas of concern; (whilst the focus of this work came from the Forensic services, the implications and effect are likely to be common across any inpatient setting in the organisation.)

Effect on Therapeutic Relationships

The restriction appears to have an influence on the way that services are creating and maintaining boundaries as well as how these boundaries translate into the formation of positive, collaborative therapeutic relationships. As we know, it is within these

boundaries and relationships that service users and staff feel safe enough to engage in therapeutic interventions aimed at eliciting and empowering change.

- Staff members have described feeling powerless to act when they have found service users smoking on ward areas and in the grounds.
- Staff have to weigh up the consequences of challenging service users and the potential outcome of the confrontation verses safety.
- Service users then see staff as "prison guards" who are employed to enforce rules with any sense of collaboration being lost as punitive responses take away our freedom to have adult-to-adult conversations with service users.
- Service users feel 'punished' and 'restricted' for something that is legal.
- With an aim to 'Reduce Restrictive Practices' – this ban feels restrictive and punitive.
- Service users who have restrictions on their movements, access or leave allowances are unfairly discriminated against as they have no opportunity to smoke or vape.

Rehabilitation

Therapeutic activities are at the heart of our service users' recovery, for example community access via Section 17 leave allows our service users to practice valuable life-skills such as: budgeting, shopping, exercise and identifying means of social support beyond the hospital. In some instances the smoking restriction has influenced engagement in these activities.

- Many service users are utilising their periods of leave for the sole purpose of smoking. This has made rehabilitative activities increasingly more difficult as service users are smoking in lieu of, for example, going to the shop to collect ingredients for a self-cater meal.
- In addition to this, this activity is being recorded as therapeutic leave in service users' notes, for example in their 25 hours activity on Rio.
- Service users have also been known to refuse to participate in activities that occur off the ward if they are unable to smoke.
- Service users have 'binged' on cigarettes while out on leave which has caused them to become physically unwell.
- Service users are not being accepted by "move-on" services due the risks they pose by smoking on the ward.

The preceding points demonstrate the impact that the smoking ban has on our service users' recovery as it is likely to interfere with the quality of the care we provide. Safety is also compromised as the restriction of therapeutic activities related to our approach to the smoking restrictions can leave people feeling stuck and frustrated. It is therefore in our best interests to think about how our practices influence recovery and identify alternative means of implementing this restriction in a way that support positive messages about health and recovery and a harm reduction approach.

Relational Security

We feel that it is important to consider how the smoking restrictions impact on the service user dynamics on our wards and how this may impact on care and safety. Important service user dynamic problems have been/are likely to be:

- Vulnerable service users may be exploited both financially and emotionally.
- Service users who do not have Section 17 leave, and who cannot procure their own cigarettes have relied on others to subvert ward rules and bring smoking materials onto the ward.
- A black-market has emerged in which service users are charging upwards of £50 per cigarette.

- Service users have been pressured into bringing smoking materials onto the wards for others, which puts their own recovery at risk if the consequences of doing so is to lose their leave.
- Manufacturing a 'light' from electrical plug sockets.

Health behaviour change is more likely when people see it as a choice rather than an imposition and that some people may be at different stages of stopping, requiring alternatives to purely abstinence interventions.

This could also take into account that some service users do not want to give up smoking which we should respect. Coercive approaches have wealth of literature reviews re lower levels of treatment efficacy.

Hospitals and Prisons

A number of acute hospitals, secure services and prisons have started to permit the use of e-cigarettes in and on their premises. (See appendix 2)

All of the information we know currently indicates that a number of other organisations are allowing the use of e-cigarettes; however they are not allowing them to be used to charge the rechargeable versions. If visitors can take home the equipment and recharge and return the items, or use portable charging devises, this may be a possibility at a later date.

Mental health secure services and prisons have only opted for non-rechargeable/disposable e-cigarettes.

Conclusion and Proposal

After careful consideration and consultation it has been concluded that e-cigarettes may support compliance with SWYPFT's smoke free policy and help some smokers manage their nicotine dependence. However, it is important that e-cigarettes do not simply replace cigarettes and a culture of facilitating e-cigarette breaks for groups is avoided.

In the site visit undertaken, the need for managing staff time for facilitating smoke breaks is mitigated by allowing use of e-cigarettes in designated internal spaces – i.e. bedrooms, internal courtyards.

We believe that e-cigarettes may help some smokers move away from using harmful burnt tobacco towards a cleaner form of nicotine delivery. E-cigarettes are not recommended as a first line treatment option, and cannot be used by patients who are under 18 years or pregnant women. They should be considered after smokers have rejected all other options set out in the Trust's Tobacco Dependence Treatment Pathway. All e-cigarette users must have in place a risk assessment and care plan that details how the smoker will be supported to use his/her device.

Trust Board is asked to

- Support the principle of allowing the use of e-cigarettes for service users.
- Support EMT to have oversight of changes to the policy and the implementation plan.
- Request assurance of effective implementation from the post implementation review at 6 months.

If approved, the next steps will be for the working group to:

- Prepare a detailed implementation plan
- Prepare the amendments to the current Trust Policy
- Continue to report progress through EMT following approval from Trust Board.

Appendix 1

Electronic cigarettes – Everything you need to know!

To charge or not to charge?

There is a huge range of e-cigarettes available on the market – broadly speaking they fall in to one of two categories:

Rechargeable e-cigarettes – contain a rechargeable lithium battery that requires a regular power charge, via USB port, connection to a computer, or other power source. The biggest thing to remember is that e-cigarettes do not randomly catch fire – the two main factors behind vape explosions are the quality of your device components and how you maintain your equipment. In fact, it's not the vape as a whole that is behind fires or explosions – the most common cause is the battery

Disposable e-cigarettes – self-contained unit, single use, which can be disposed on in appropriate battery bins following use.

N.B. - for the purpose of this proposal we are only considering the use of disposable single use e-cigarettes

What are electronic cigarettes (e-cigarettes)?

E-cigarettes are battery powered devices that deliver nicotine via inhaled vapour. Devices come in many shapes or forms, sometimes resembling cigarettes, but others resemble pens or gadgets. They commonly comprise a battery-powered heating element, a cartridge containing a solution principally of nicotine in propylene glycol or glycerine, water (frequently with flavouring), and an atomizer that when heated vaporises the solution in the cartridge enabling the nicotine to be inhaled (it should be noted however that some e-cigarettes do not contain nicotine). E-cigarettes can be disposable, rechargeable or refillable. E-liquids come in various different volumes, concentrations and flavourings. An estimated 2.8 million people in the general population in Great Britain currently use e-cigarettes, the vast majority of whom are smokers or recent ex-smokers . Recent reports from Public Health England (PHE) and the Royal College of Psychiatrists (RCP) have summarised the evidence on the impact of e-cigarettes on smoking in England. These reports concluded that e-cigarettes appeared to be effective when used by smokers as an aid to quitting smoking. E-cigarettes offer a much less harmful alternative to tobacco for dependent smokers.

Are electronic cigarettes safer than ordinary cigarettes?

As e-cigarettes do not contain tobacco and are not burnt, they do not result in the inhalation of cigarette smoke which contains about 4000 constituents, around 70 of which are known to cause cancer. E-cigarette vapour contains far fewer chemicals and those that are found have much lower levels than in cigarette smoke. E-cigarettes are therefore regarded by most experts as much safer delivery devices for nicotine. This does not mean that they are completely safe, but they are envisaged to be much less harmful than cigarettes. The Royal College of Physicians (RCP) recently indicated that the hazard to health arising from e-cigarettes was unlikely to exceed 5% of the harm from smoking tobacco.

Do e-cigarettes help smokers to stop?

There is evidence from a Cochrane review which assessed two randomised controlled trials that e-cigarettes may help some smokers to stop, corroborated by surveys and case reports. A large cross-sectional analysis of a representative sample of the English population found that those who used e-cigarettes in their quit attempts were more likely to report that they had stopped, than those who used a licensed nicotine replacement product over-the-counter or no cessation aid. More recent data from the same survey indicated that changes in prevalence of e-cigarette use in England have been positively associated with the success rates of quit attempts, and estimated that e-cigarettes may have contributed about 18,000 additional long-term ex-smokers in 2015. There is some

evidence that the newer generation e-cigarette devices are more helpful for smoking cessation compared with some of the older disposable models. This is likely to be due to improved efficiency of delivering nicotine in the newer devices. Two small pilots of e-cigarettes (first generation devices) with people with serious mental illness were positive regarding reduction/cessation of cigarette smoking and without an exacerbation in psychopathology.

What concerns have been raised by e-cigarettes?

E-cigarettes were first introduced onto the market in the UK in 2004 so there have been no long-term health studies. However a recent study examined levels of known toxins in urine of e-cigarette users who had used them exclusively for around 17 months and found much lower levels of these substances compared to cigarette smokers, and e-cigarette users had similar levels to a group of long term users of nicotine replacement therapy.

There have been other concerns that:

- E-cigarettes resemble ordinary cigarettes and therefore re-normalise smoking. The Public Health England (PHE) and RCP reports found that there is currently no evidence to support this as smoking prevalence continues to decrease, both among adults and youth, in the UK and other countries such as US where e-cigarettes are prevalent;
- Simply replacing some cigarettes with e-cigarettes may confer little benefit. Some dual use is inevitable, but the toxins study reported above, did indicate that e-cigarette users who also smoke did not have significantly lower levels of toxins, so an important message is that e-cigarette users need to give up smoking completely as soon as possible;
- Some e-cigarettes are produced by the tobacco industry – this is indeed true. Whilst e-cigarettes were developed originally by a smoker wishing to stop smoking, and independent companies, the tobacco industry is increasingly involved in this area;
- They are not tightly regulated in terms of their content and delivery. From May 2017, all e-cigarettes on the UK market need to comply with an EU regulation on electronic cigarettes (see below).
- There is a potential fire risk that these devices may present, for example if an incorrect charger is used or if the device is left charging for longer than recommended. It is important however to recognise that the fire risk from tobacco cigarettes is much higher and the fire risk caused by other commonly used devices such as mobile phones and MP3 players is similar.
- E-cigarettes must not be used near naked flames or oxygen.

How are e-cigarettes regulated?

Since 20 May 2017 all e-cigarettes in England on the consumer market need to be compliant with new regulations introduced through the European Union tobacco products directive. These regulations include controls on content and packaging, such as child resistant/tamper proof packaging, must be protected against breakage and leakage and capable of being refilled without leakage, must deliver a consistent dose of nicotine under normal conditions, must contain a health warning, and tanks and cartridge sizes must be no more than 2ml in volume and nicotine strengths of liquids must be no more than 20mg/ml.

Manufacturers can apply for a Medicines & Healthcare products Regulatory Agency (MHRA) licence for e-cigarettes which will allow them to be used for smoking cessation, and confers other benefits, such as enabling them to be prescribed, be advertised and make health claims in line with other medicinal products.

After careful consideration and consultation it has been concluded that e-cigarettes may support improved compliance with SWYPFTs smoke free policy and help some smokers manage their nicotine dependence. However, it is important that e-cigarettes do not

simply replace cigarettes and a culture of facilitating e-cigarette breaks for groups is avoided. Evidence from services visited indicated the need for managing staff time for facilitating smoke breaks is mitigated by allowing use of e-cigarettes in designated internal spaces – i.e. bedrooms.

The Trust believes that e-cigarettes may help some smokers move away from using harmful burnt tobacco towards a cleaner form of nicotine delivery. E-cigarettes are not recommended as a first line treatment option, and cannot be used by patients who are under 18 years or pregnant women. They should be considered after smokers have rejected all other options set out in the Trusts Tobacco Dependence Treatment Pathway. All e-cigarette users must have in place a risk assessment and care plan that details how the smoker/vaper will be supported to use his/her device.

Appendix 2

Further analysis on NHS Mental health trusts replies to Committees correspondence (questions outlined below). For the earlier replies, please see ECG0102.

1. **Have you banned the use of electronic cigarettes in your facilities?**
2. **If you ban or restrict the use of e-cigarettes, do you have any plans to review that position given the advice from Public Health England?**
3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
Trust 1	When the Trust originally committed to becoming smokefree in the summer of 2016, a decision was made to not allow electronic cigarettes within our mental health inpatient units. At the time, there were concerns regarding the safety of these devices and the potential associated risks for patients and staff. Therefore at this point, they were not included within the policy as a treatment option. However a further review was undertaken 12 months later as local intelligence and patient/carer feedback suggested a demand for these products, as many patients has used them before admission.	We do allow the use of e-cigarettes as outlined in question 1 and have seen increased compliance with our smoke free policy as a result.	Yes. We also took into consideration the review of underpinning evidence(McNeill et al, 2015) commissioned by Public Health England.	Yes. We will continue to monitor this and ensure we deliver our services in line with national evidence base and best practice.

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4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
	The licensed Nicotine Replacement Therapy products were not accepted by all patients, so we looked at the least restrictive practice in relation to provision of nicotine replacing products for mental health in- patients within the Trust. With the benefit of shared experiences from other Trusts and taking into consideration the evidence review (McNeill et al, 2015) commissioned by Public Health England, a decision was taken to allow one specific brand of disposable e- cigarettes as a nicotine dependency treatment option. We commenced providing the choice of Nicotine Replacement Therapy or disposable e- cigarettes in December 2017.			
Trust 2	Only disposable devices with prefilled cartridges may be used (see Appendix B). Rechargeable devices of this type are not permitted due to	N/A	E-cigarettes are battery powered devices that deliver nicotine via inhaled vapor. Since e- cigarettes do not contain tobacco and are not	E-cigarette use should only be permitted in discrete places and never be permitted in areas where patients and staff congregate.

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3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
	the risks associated with charging. E- cigarette use is only permitted for patients, visitors and contractors in designated areas e.g. hospital grounds and courtyards, but **not** in communal indoor areas or bedrooms.		burnt, they do not result in the inhalation of cigarette smoke they are therefore regarded by most experts as much safer delivery devices for nicotine. This does not mean that they are completely safe, but they are envisaged to be much less harmful than cigarettes.	
Trust 3	We have not banned the use of e-cigarettes and are following the advice from PHE and the CQC about their benefits to support service users who are dependent on nicotine. E- cigarettes are in the repertoire of Nicotine Replacement Therapies we support for the people who use our services.	We have currently banned the use of e-cigarettes in our High Secure Service, which is consistent with the other two HSS Trusts. However, we are meeting to review this decision to clarify the clinical, risk and/or security grounds which inform this decision. We may also review the decision in the light of service users' experience in using e- cigarettes in our medium and low secure services or if other appropriate products become available.	The Trust considered, and is supportive of, the harm reducing potential of e-cigarettes and recognises they may be of assistance to enable some smokers to move away from using harmful burnt tobacco towards a cleaner form of nicotine delivery, and may ultimately help them to give up smoking in the longer term if they make this decision. In addition, the Trust strongly supports service users' choice and preferences in their recovery, and our service users informed us that having e-cigarettes as an available option would allow them to	The Trust will continue to review its position on e- cigarettes, including if any risks are identified in future as new evidence and guidance emerges. This will include regular reviews, as it would any other new aspect of practice and care, to ensure the Trust, its staff and the people we serve are kept fully informed by contemporary findings and safety information so that we continue to support best practice and safe care in this developing area.

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4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
			make positive improvements in both their physical and psychological well-being. We consider collaboration and choice to be an essential component of our least restrictive and co-produced approach to care within the Trust.	
Trust 4	No	N/A	Yes	We believe the potential for harm reduction through supporting the use of e-cigarettes to far outweigh any concerns regarding exposure to secondhand vapour. The NCSCT's Electronic cigarettes briefing indicates that "some studies have found traces of toxicants in secondhand vapour, but at such low levels that they do not pose a health risk to bystanders. There is no evidence that secondhand vapour is dangerous to others; however, it helps to be respectful when using e- cigarettes around

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3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
				others, especially non-smokers." We have taken this evidence into consideration in our smokefree policy. We do ask our patients and staff not to use e-cigarettes in communal spaces limiting such exposure and normalisation of their use.
Trust 5	No	N/A	Yes and we included them in our revised policy	No
Trust 6	No, we encourage their use.	We only restrict the use of some models of e- cigarette for reasons of fire safety.	Yes, based on strong research evidence of harm reduction.	No, but we discourage use in shared areas so as to not affect others at all.
Trust 7	Yes we have banned the use of electronic cigarettes in our facilities after careful consideration. We are an out-patient facility and the majority of our patients are children, young people and families. Our patients are on our premises for short periods to attend out - patient appointments. We banned the use of electronic	Yes, our smoke free policy (May 2017) will be reviewed in May 2018 on the basis of an updated review of current evidence including PHE advice.	Yes, we did and we encourage and support staff and patients to take up interventions to stop or reduce smoking tobacco through appropriate means including switching to electronic cigarettes as a substantially safer alternative for when they are not on Trust premises.	Yes.

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3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
	cigarettes as we did not wish our young patients and families to see patients, staff or visitors using any form of cigarette which might imply our condoning this behaviour.			
Trust 8	Staff and visitors – yes. Patients – Yes in the Trust's Forensic Service Division No in the Trust's Local Partnership Division (in- patient mental health units]. Use is restricted to just one type of disposable e- cigarette called E- burn due to unique safety features and the fact that numerous other Trusts and some prisons are allowing their use.	Yes our position will be under constant review and decisions will be made according to guidance and the emerging evidence-base.	Yes	We are guided by PHE advice, 2016 "the constituents of cigarette smoke that harm health – including carcinogens – are either absent in e-cigarette vapour or, if present, they are mostly at levels much lower than 5% of smoking dose (mostly below 1% and far below safety limits for occupational exposure)"
Trust 9	In our facilities we do not permit the use of electronic cigarettes indoors. We do allow the use of electronic cigarettes among	On 1 October 2017 CPFT banned smoking and the use of all electronic cigarettes and vaporisers on our premises. This	The harm reduction potential of electronic cigarettes was a factor in our decision to allow electronic cigarettes and	At the moment there is no evidence to suggest that electronic cigarettes or vaporisers cause harm to non-

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2. **If you ban or restrict the use of e-cigarettes, do you have any plans to review that position given the advice from Public Health England?**
3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
	service users in ward gardens and allow staff members to use electronic cigarettes outdoors during break times.	policy was amended in December 2017 to allow for the use of electronic cigarettes and vaporisers in outdoor areas in light of feedback from staff on our wards. The decision to allow the use of electronic cigarettes and vaporisers in outdoor areas was reflective of the evidence and recommendations presently available from Public Health England. The CPFT Smoke Free policy will be monitored and amended as additional evidence becomes available.	vaporisers on our grounds. As noted above, the Trust will continually monitor our Smoke Free Policy as additional evidence becomes available from Public Health England around the risks and benefits of electronic cigarette use.	users. As we have restricted the use of electronic cigarettes and vaporisers to outdoor areas only we do not currently have any concerns around the potential for secondary harm to service users or staff. We welcome updates from Public Health England around the second-hand risks of electronic cigarettes as research in this field progresses.
Trust 10	SWLSTG NHS Trust has adopted an interim E- cigarette Protocol to support patients to manage their nicotine dependence whilst hospitalised. Patients wishing to use e-cigarettes as part of their nicotine management programme can bring/purchase the brand of their choice as long as those are disposable and non-rechargeable e-cigarette devices. Patients are allowed to use e-cigarettes in	We are currently reviewing our existing e- cigarette protocol to ensure that it is in line with the new PHE and NICE recommendations. However, we also take into consideration the needs and views of our service users, carers and staff.	Despite the limited evidence on the long term health effects of e-cigarettes, there's been some evidence that vaping is 95% less harmful than smoking. Our inpatients are being professionally supported to manage their nicotine dependence with the method of their choice whether this is NRT or disposable e- cigarettes. We combine either method with behavioural support.	We have considered the very few evidence of the effects of second-hand vaping on bystanders which does not support this possibility but also does not entirely dismiss the potential effects. Hence, our balanced decision to allow the use of e- cigarettes in open-air areas i.e. courtyards but not in communal indoor rooms.

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3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
	designated areas of the wards i.e. their individual bedrooms and courtyards but should refrain from vaping at indoor communal areas. The protocol prohibits the use of e- cigarettes in any other areas of the Trust grounds and/or buildings. E-cigarettes use by outpatients, staff and visitors is currently prohibited across Trust premises.			
Trust 11	E-cigarettes use or 'vaping' must occur only outside, at no time inside any buildings.	This [e-cigarette policy] is currently under a review with our Smoking Steering Group. The e-cigarette section is part of that review and in particular the disposable and re- chargeable items.	Yes	Yes
Trust 12	In line with Lincolnshire Partnership NHS Foundation Trust(LPFT) Smoke Free Premises Policy (attached), we adhere to the following guidance: Restrictions on usage of e-cigarettes on LPFT Trust Premises.	LPFT has not banned E-cigarettes. Our current LPFT Smoke Free Premises Policy is scheduled for review in June/July 2018. We will reappraise our position at this time, taking into account PHE guidance and we will continue to work closely with	Our vision at LPFT is to make a difference to the lives of people with mental health and learning disabilities. To promote recovery and quality of life through effective, innovative and caring services.	The evidence base is still limited and products are changing rapidly. At LPFT we support the belief that E-cigarettes are less harmful than conventional cigarettes and we will support our patients at every stage of their smoking

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3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
	E-cigarettes can only be used in outside areas away from exits and entrances. They should not be used in proximity to other people who choose not to use them. E-cigarettes should only be recharged using approved devices and methods. Recharging should be under the supervision of staff within a specific designated safe charging area away from sources of ignition and accelerants such as oxygen supplies. Once recharging is complete the device should be promptly disconnected and returned to safe storage. Staff should be aware that fire risks whilst recharging e-cigarettes relate largely to:- - Use of incorrect or malfunctioning charger - Battery defects or overtightening of the battery - Overcharging of the product.	our experts by experience, carers and staff to ensure our policies are evidence based, robust and usable.	We encourage smoking cessation and harm reduction through the use and availability of nicotine replacement therapy. We support the use of E-cigarettes rather than conventional cigarettes.	cessation journey.

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3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
	E-cigarettes contain batteries and must be disposed of in a designated bin as electronic waste.			
Trust 13	We have banned them on our inpatient wards at the moment.	We have reviewed this decision – in light of the advice and new products that are now available. Plan is that we will pilot use with a particular brand of e cigarettes. We are working with patients on this pilot. The Pilot will be active within the next couple of months with short cycle before rolling out across all inpatient areas.	When the initial decision was made to ban e- cigarettes there was no guidance available. At the time there was concern about safety of the models available. However with the introduction of safe models to use on wards, the advice from public health and the fact that our patients are asking for them has meant that we have revisited our decision and are about to embark on a short pilot in one of our low secure wards with the aim to roll out across all services. Smoking cessation – encouraging their use as a proven aid to stop smoking	We do not believe that there will be an increasing risk of second hand harm to patients by use of e- cigarettes. They are hazardous waste and need to be disposed of safely but we have plans in place to ensure that this happens.

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2. **If you ban or restrict the use of e-cigarettes, do you have any plans to review that position given the advice from Public Health England?**
3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
Trust 13	The Trust does not have a ban on the use of electronic cigarettes, they are however restricted. They cannot currently be used inside Trust Buildings. This includes Inpatient wards.	The Trust is currently considering its position on the use of e-cigarettes, particularly with regard to the implementation of Smoke Free NHS. This is both in the light of the advice provided from PHE and also as a result of the shared learning from a number of Trusts who are successfully managing the use of e-cigarettes. Additionally, the Trust has secured support from these Trusts in the reviewing of our position. This includes Trusts who have successfully managed this for mental health inpatient facilities. The advice and information from PHE together with the shared learning from these examples of successful implementation will contribute to the Trust's review of its position with regard to e- cigarettes. The collation of this information for Board level discussions with regard to the way forward is currently being prepared.	The Trust considered this in formulating our initial decisions, however at that time the picture with regard to a wider variety of associated risks was significantly less clear than it now is. Genuine considerations such as fire/charger safety and unregulated products were also considered together with the unknown longer-term risks of e-cigarette use. As new and reliable information and experience has now been made available, the Trust is in a good position to consider our current approach. The health harm reduction benefits of e-cigarettes for individuals over tobacco cigarettes are now explicitly clear. The PHE advice and information with regard to this has been very helpful. Additionally, many of the other potential risks are far better understood now. The Trust feels this gives us an excellent base from which to consider and update our approach where	The Trust considered any and all potential risks when developing its original position with regard to the use of e-cigarettes. This included any potential second-hand harm and tangential consequences(not only health related). The Trust will include any updated knowledge and information regarding these considerations as part of the review of our position. Our understanding of the current information and knowledge available is that there is not strong evidence of significant health harms from secondary 'smoke' as it is vapour and is not produced from a tobacco product, nor is it ignited as such. We are aware however of issues such as large clouds of strong smelling vapour being unpleasant for some people and possibly distressing to some people under some circumstances. We are also aware of the potential

Further analysis on NHS Mental health trusts replies to Committees correspondence (questions outlined below). For the earlier replies, please see ECG0102.				
1. Have you banned the use of electronic cigarettes in your facilities? **2. If you ban or restrict the use of e-cigarettes, do you have any plans to review that position given the advice from Public Health England?** **3. Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?** **4. Are you concerned with any second-hand harm caused by e-cigarettes?**				
Name of trust	**Question 1**	**Question 2**	**Question 3**	**Question 4**
			appropriate.	emergence of secondary markets associated with e-cigarettes (as there is with tobacco cigarettes). The Trust will remain vigilant with regard to this, particularly with our more vulnerable populations.We also remain vigilant about the possibility of e-cigarettes being implicated in fire setting (deliberate or accidental) and the very obvious second-hand harm that could bring. We are aware however of the significantly increased safety profile of these devices now over earlier, unregulated models.
Trust 14	No, we permit these within our smoke-free policy	N/A	Yes, this is why we allow them	We only allow outdoor use; any second hand harm is likely to be small by comparison with either the direct or second hand effects of actual smoke.

Further analysis on NHS Mental health trusts replies to Committees correspondence (questions outlined below). For the earlier replies, please see ECG0102.

1. **Have you banned the use of electronic cigarettes in your facilities?**
2. **If you ban or restrict the use of e-cigarettes, do you have any plans to review that position given the advice from Public Health England?**
3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
Trust 15	No, selected e cigarettes are allowed	NTW has already agreed to supply a limited number of e-cigarettes on admission and allow purchase in hospital shops thereafter. We are modifying our policy and procedures accordingly.	Yes	We wish to avoid non-smokers being exposed to nicotine vapour so will restrict vaping in communal areas. We have concerns about possible long term effects of exposure to nicotine and/or excipients.
Trust 16	No	Yes as per policy	Yes	Monitoring please see policy about this
Trust 17	The Trust currently has no ban in place. The draft smoke free policy which is in development does not exclude the use of electronic cigarettes, the policy stipulates that the devise must be a sealed unit identified by the Trust.	Currently we do not have a ban.	Yes this is under consideration by the smoke free steering group.	Yes this is under consideration by the smoke free steering group.

Further analysis on NHS Mental health trusts replies to Committees correspondence (questions outlined below). For the earlier replies, please see ECG0102.

1. **Have you banned the use of electronic cigarettes in your facilities?**
2. **If you ban or restrict the use of e-cigarettes, do you have any plans to review that position given the advice from Public Health England?**
3. **Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?**
4. **Are you concerned with any second-hand harm caused by e-cigarettes?**

Name of trust	Question 1	Question 2	Question 3	Question 4
Trust 18	On review of the Trust's smoke free policy it clearly states that we are mindful of common law and statutory duties to protect the health and safety of all our employees and therefore we do not support the use of e-cigarettes in the workplace. It is expected that staff treat e-cigarettes in the same way as other types of smoking. However, there are expectations to this in regard to patients as to whether special arrangements need to be made so that the person may be permitted to smoke on a trust site. I am aware that for inpatients the wards have no ban in place in regard to the use of e-cigarettes or vapes and this is encouraged for those individuals who wish to give up smoking. The ward environments treat e-cigarettes	At the present time there are no plans to review this position as our policy has been recently updated, however this will be kept under review to ensure any national guidance is reflected.	Physical health monitoring and promotion of positive physical health forms an important aspect of the work undertaken by our inpatient staff in supporting and promoting the physical health and wellbeing of our inpatients. As part of this the use of e- cigarettes or vapes is supported for those mental health patients who wish to give up smoking, alongside the use of other nicotine replacement products.	There does not appear to be evidence that second hand damage should be less of that than other types of smoking as the likelihood of individual harm is reduced. However, within the clinical environment there may be concern of different risks unrelated to the vapour that is expelled.

Further analysis on NHS Mental health trusts replies to Committees correspondence (questions outlined below). For the earlier replies, please see ECG0102.				
1. Have you banned the use of electronic cigarettes in your facilities? **2. If you ban or restrict the use of e-cigarettes, do you have any plans to review that position given the advice from Public Health England?** **3. Did you consider the harm reducing potential of e-cigarettes compared to conventional cigarettes in your decision?** **4. Are you concerned with any second-hand harm caused by e-cigarettes?**				
Name of trust	**Question 1**	**Question 2**	**Question 3**	**Question 4**
	the same as normal cigarette and requests that patients use the outside areas to use these. It is expected that patients comply with this for the comfort of other patients. However the use of electronic cigarettes within our facilities is banned for staff.			
Trust 18	No, we allow the use of e cigarettes in outdoor spaces following our journey to "Tobacco Smoke Free" in April 2018.	N/A	Yes, in collaboration with our PH colleagues and supporting evidence.	We only allow the use of e-cigarettes in outdoor spaces.
Trust 19	Solent NHS Trust allows the use of disposable e- cigarettes, but not rechargeable vapes.		We did consider the harm of e- cigarettes, but compared it to the harm of normal tobacco and the implications on our patients.	In relation to second hand harm of e- cigarettes, this is minimised by only allowing their use in our open gardens.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018

Agenda item 11 – Receipt of public minutes of partnership boards

Calderdale Health and Wellbeing Board

Date	9 August 2018 (last update from meeting 21 June 2018)
Non-Voting Member	Medical Director / District Director – Forensic, Specialist, Calderdale and Kirklees
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=26408

Barnsley Health and Wellbeing Board

Date	7 August 2018 (last update from meeting 5 June 2018)
Member	Chief Executive / District Director - Barnsley & Wakefield
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Wakefield Health and Wellbeing Board

Date	26 July 2018
Member	Chief Executive / District Director - Barnsley & Wakefield
Items discussed	➢ West Yorkshire and Harrogate Health and Care Partnership Update - Integrated Care System ➢ Refresh of the Wakefield Health and Wellbeing Plan ➢ General Practice Performance and Development: Draft Strategic Objectives and Project Plan ➢ Healthy Hearts ➢ Suicide Prevention Strategy ➢ Proposal to re-launch Children and Young People Partnership Board
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

Kirklees Health and Wellbeing Board

Date	28 June 2018
Invited Observer	Chief Executive / District Director – Forensic, Specialist, Calderdale and Kirklees
Items discussed	➢ Confirmation of Deputy Chair ➢ Plans to respond to Secretary of State letter

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	➢ Integrated Care System (ICS) in Development ➢ Developing the Kirklees Health and Wellbeing Plan ➢ Learning from winter 2017-18 across Kirklees
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 July 2018

Agenda item 12 – Assurance from Trust Board Committees

Audit Committee

Date	10 July 2018
Presented by	Laurence Campbell, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ SystmOne implementation - assurance level • workstream risk mapping • deadlines • Trust Board sign off of design • key decisions intra gateways • transitional system during cutover ➢ Delivering service change - need to review some projects at points before formal Gateways. ➢ Risk register – growing/emergent risks such as acuity and out of area bed risk ➢ Board Assurance Framework (BAF) revision – changes supported but more input on strategic risks needed ➢ Triangulation report – gaps against BAF required in future ➢ Recognise progress on Information Commissioners Office (ICO) and General Data Protection Regulation (GDPR) audits (both closed) ➢ Counter fraud plan 2018/19
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 10 April 2018 (attached).

Nominations Committee

Date	16 July 2018
Presented by	Angela Monaghan, Chair (Chair of the Committee)
Key items to raise at Trust Board	➢ Recommended appointment of Non-Executive Directors (NEDs) to Members' Council. ➢ Sub-group to be established to review the Chair and NED remuneration.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 20 June 2018 (attached).

Workforce and Remuneration Committee (previously Remuneration and Terms of Service Committee)

Date	3 July 2018
Presented by	Rachel Court, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Middleground programme - now being delivered with a focus on developing healthy teams.

	➢ Sickness/Absence – positive trend in the first two months and Trust currently below target. ➢ Recruitment and Retention : • Recruitment and retention action plan agreed • Agency Spend – reviewed current level of agency spend and noted particular pressures in Children & Adolescent Mental Health Services (CAMHs) medical staffing ➢ Directors structure - confirm arrangements for Deputy Chief Executive (attached). ➢ Risk Register reviewed – agreed that the equality and diversity and Workforce Race Equality Standards (WRES) need to be linked to the work of the Equality & Inclusion Forum as well as the Workforce & Remuneration Committee
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 8 May 2018 (attached).

West Yorkshire Mental Health Services Collaborative Committees in Common

Date	30 July 2018
Presented by	Angela Monaghan, Chair (member of the Committee)
Key items to raise at Trust Board	➢ Verbal update to be provided at the Trust Board meeting on 31 July 2018
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 30 April 2018 (to follow).

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Audit Committee held on 10 April 2018

Present:	Laurence Campbell	Chair of the Committee
	Chris Jones	Non-Executive Director
	Rachel Court	Non-Executive Director
Apologies:	Members	
	Nil	
In attendance:	Rob Adamson	Deputy Director of Finance
	Mark Brooks	Director of Finance (lead director)
	Tony Cooper	Head of Procurement
	Alan Davis	Director of HR, OD & Estates
	Elaine Dower	Clinical Quality Lead, 360 Assurance
	Leanne Hawkes	Deputy Director, 360 Assurance
	Caroline Jamieson	Manager, Deloitte
	Emma Jones	Company Secretary
	Richard Norman	Change Governance Manager (items 1 – 4.4)
	Ed Reid	Programme Director, Clinical Records System (items 1 – 4.4)
	Olivia Townend	Assistant Anti-Crime Manager, Audit Yorkshire
	Julie Williams	Interim Senior IM&T Manager
	Jane Wilson	PA to the Director of Finance (author)

AC/18/27 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Laurence Campbell (LC) welcomed everyone to the meeting. There were no apologies.

AC/18/28 Declaration of Interest (agenda item 2)

There were no further declarations over and above those made in the annual return to Trust Board in March 2018 or subsequently.

AC/18/29 Minutes from the meeting held on 9 January (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meeting held on 9 January 2018 as a true and accurate record.

AC/18/30 Matters arising from the meeting held on 10 October 2017 and 9 January 2018 (agenda item 4)

AC/18/30a Action log (agenda item 4.1)

The action log was noted.

AC/18/30b AC/17/63a Internal Audit (KPMG) progress report 2016/17 (Data Quality – Clinical Record Keeping (agenda item 4.2)

Laurence Campbell (LC) asked for an update in respect of the follow up to the internal audit relating to the embedding of team dashboards and how effectively they were being used. Mark Brooks (MB) explained that team dashboards are available and being used by Intensive Home Based Treatment and Adult Acute inpatient teams. In terms of the development of the

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data warehouse the project status and shorter term actions are being re-assessed in light of the move to SystmOne for Mental Health. Further focus will be applied in the shorter term to developing the knowledge of internal staff and expanding the reports available into other teams.

Chris Jones (CJ) commented that the previous action from 9 January 2018 had not been dealt with and the metrics needed to be added to show that data quality has improved. This item will remain on the agenda for meeting to be held on 10 July 2018. Julie Williams (JW) offered to provide copies of data quality reports that are taken to the Improving Clinical Information Group (ICIG) at a future Audit Committee.

ACTION: Tim Breedon

AC/18/30c Delivering service change update (agenda item 4.3)

Richard Norman (RN) presented an update on status of recommendations arising from the delivering service change internal audit dated April 2017. LC requested assurance that the new integrated change framework gateway process is working and delivering. A schedule of when gateways for projects occur to be circulated at the July Committee meeting. LC suggested the committee review one of the projects that has reached 'business as usual' when possible. Following a question it was also highlighted that the Audit Committee does not have responsibility for closing actions on the internal audit, but that this needed to be agreed by Trust management. LC requested that this item remain as a standing item at future meetings. **ACTION: Salma Yasmeen**

AC/18/3d AC/18/13 SystmOne implementation risks and milestones (agenda item 4.4)

At the meeting on 9 January 2018, the Audit Committee had requested clarity between key milestones associated with the project and the risk associated with each of these key milestones. Ed Reid (ER) reported that the programme had the controls and mechanisms in place to manage the risks of delivering the programme and that these were under regular review. ER confirmed the comments section in the risk register report had been updated accordingly.

Rachel Court (RC) commented that some of the likelihood scores seemed unusually high and asked if it this was presenting the right balance of risk. ER stated that the risks are currently high largely due to the fact we remain in early phases of the project. He explained for example that at this point in time he does not have assurance that staff will be released for training. RC felt that if this was the case then the project would not go live. MB stated that this initiative has been identified as a key priority by the Trust Board and that there is Board commitment to ensure staff can be released for training.

Chris Jones (CJ) commented that he felt the report was very difficult to understand and there was further work to do to articulate what is actually happening. ER commented that the key area of focus is training and the issues around this being resolved to achieve the go live date of January 2019. The Clinical Records System (CRS) team are continually liaising with Bradford District Care Trust who are also going through SystmOne implementation, and further ahead in the process. LC raised the point that he had expected to see the report identify key milestones, what has been achieved to date, what risks there are to each milestone and contingency plans. He was also concerned about the 'big bang' approach to live, and the lack of prototyping. ER took some time to explain the governance processes and the fact that the Trust already uses SystmOne for Community Services and a number of other Trusts have either undergone or are in the process of undertaking a similar implementation.

The Committee advised that based on the information provided they were not assured the project is doable in time available and will report this back to Trust Board. LC requested this remain as a standing item at future meetings.

ACTION: Salma Yasmeen/Ed Reid

Leanne Hawkes noted that some internal audit time has been set aside to focus on the implementation in the 2018/19 internal audit plan, which is being discussed later in the meeting.

It was RESOLVED to NOTE the update.

AC/18/31 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 (ORR) that had been aligned with the Audit Committee, with a summary on any changes since the Audit Committee meeting on 9 January 2018. All risks from the trust-wide ORR graded 15 and above were reported to the Trust Board on 30 January 2018. There were five potential risks that have been assessed as relevant to the work of the Audit Committee and were currently exceeding the risk appetite of the Trust. Seven new risks have been added to the ORR which are allocated to the Audit Committee. These were risks ID 1196, 1212, 1213, 1214 1215, 1216 and 2217, the details of each risk was included in the paper.

EJ confirmed that the report went to Trust Board in January 2018 and that it is continually being reviewed. An updated version of the report will be presented at the next Trust Board on 24 April 2018. MB explained that all risks have been reviewed and updated at EMT over the past quarter and these updates will be included in the report to Trust Board in April. He further explained that the most significant change to the scoring of a number of risks was the consequence of the Trust losing business as a result of tendering. CJ felt this would be worthy of further discussion at the Trust Board meeting.

ACTION: Mark Brooks/Emma Jones

It was RESOLVED to NOTE the current Trust-wide Corporate/Organisational level risks relevant to this Committee.

AC/18/32 Triangulation of risk, performance and governance (agenda item 6)

The Committee noted that the report which covered the triangulation of risk, performance and governance was helpful. MB felt that the report highlighted that there should be a risk added to the risk register in respect of out of area (OOA) beds. A discussion followed with respect to the timing of recognition of risks. LC suggested the triangulation report is typically backward looking and more focus could be applied to future potential risks. LC suggested this should be incorporated in the regular EMT reviews. MB added that the Organisational Management Group (OMG) and Executive Management team (EMT) have a focus on OOA beds.

It was RESOLVED to RECEIVE the report as part of the evidence of assurance on the operation of risk processes within the Trust.

AC/18/33 Agreement of draft final accounts timetable and plans (agenda item 7)

Rob Adamson (RA) advised the Committee that the timetable for the 2017/18 financial year-end and associated review, approval and reporting requirements and been updated with two date changes. 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. An informal meeting has

been arranged with Trust Board members on 24 April to keep them appraised of progress on the year-end accounts and audit and that this had been built into the timetable. MB confirmed a draft set of accounts would be available early next week for the NEDs who attend the Audit Committee so they can review ahead of the meeting on 24 April.

ACTION: Mark Brooks

It was RESOLVED to RECEIVE the report and NOTE progress made.

AC/18/34 Review of annual accounts progress (agenda item 8)

RA confirmed that the accounts for 2017/18 have now been closed with the Trust meeting its control total. As previously noted a set of draft accounts are expected to be available week commencing 16 April 2018.

It was RESOLVED to RECEIVE the report and NOTE progress made.

AC/18/35 Update of actions from ICO audit (agenda item 9)

Julie Williams (JW) 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. Recruitment still remains a challenge and JW is currently looking at interim resource to help out with General Data Protection Regulation (GDPR). Two actions have been completed since December 2017 with a further two are due to be completed by the end of April 2018. The deadlines for Assessing Legality, Risks and Benefits and for Information Sharing and Logs actions will be completed by 30 April 2018 and will form part of the GDPR Plan, which will provide timely delivery of the training prior to the GDPR implementation. Further focus to be applied to the data sharing actions that involve training other staff on the standards for data sharing and assessing privacy impact. Both will become mandatory requirements under the GDPR so it is essential the learning is implemented before enforcement in October 2018. JW confirmed it was vital to hold quarterly meetings with asset owners. A copy of the ICO response following on from their review of actions that was embedded in the report to be forwarded to audit committee members.

ACTION: Mark Brooks/Julie Williams

It was RESOLVED to RECEIVE the report and NOTE progress made.

AC/18/36 Review of other 'risk' Committees' effectiveness and integration – Committee Annual Reports 2017/18 (agenda item 10)

The Committee received the annual reports of each Committee and noted the additional points highlighted.

Clinical Governance and Clinical Safety Committee

- Terms of reference are still being updated.

Mental Health Act Committee

- More use of data reports, one of BDU Directors present.
- Engagement with external partners is key.
- Capture quality assurance work that takes place, examples of work within BDUs that would help committee.

Remuneration and Terms of Service Committee

- Greater focus on key risk issues, in more in depth.

- The work of the committee is being reviewed to ensure the focus on workforce is clear and will be renamed the Workforce and Remuneration Committee.

It was RESOLVED to RECEIVE the annual reports from the committees to provide assurance to the Trust Board on 24 April 2018 in terms of the effectiveness and integration of risk committees and that risk is effectively managed and mitigated through:

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

AC/18/37 Approval of internal audit plan (agenda item 11)

Leanne Hawkes (LH) advised 180 days had been allocated for this work. LH reported that Cyber security had not been allocated any time. Following discussion the committee agreed in conjunction with MB and Alan Davis (AD) that the time allocated for recruitment and retention would be reallocated to cyber security. This is based on the fact the Trust is working with NHS Improvement on retention and can take other sources of assurance in this respect. LH reported there was also nothing in place for General Data Protection Regulation (GDPR). The use of contingency for this will be looked at during the year. MB suggested the requirements for independent assessment of the clinical record system readiness be discussed in the private session. With regard to the audit on performance management the scope needs to be agreed and the Audit Committee members would be interested in seeing this scope.

ACTION: Mark Brooks/Leanne Hawkes

It was RESOLVED to REVIEW and NOTE progress made.

AC/18/38 Counter fraud annual plan (agenda item 12)

Olivia Townend (OT) presented the draft report to the Committee. It was confirmed this would be agreed subject to any changes being made that may arise through nationally mandated requirements. It is unlikely these would be significant. The final plan will be taken to the 22 May 2018 meeting for formal sign off.

ACTION: Olivia Townend

It was RESOLVED to APPROVE the draft report subject to any changes

AC/18/39 Reference costs – approval of methodology (agenda item 13)

RA updated the Committee on progress and commented that there were minimal changes this year. It was agreed that RA would update the committee on progress at the meeting on 10 July 2018 meeting prior to formal submission at the end of July 2018. The Committee asked if there was any benchmarking available. MB confirmed he would bring a summary of what is provided i.e. headlines to the July 2018 meeting.

ACTION: Mark Brooks/Rob Adamson

It was RESOLVED to APPROVE the update.

AC/18/40 GDPR update (agenda item 14)

Julie Williams (JW) presented the GDPR update reporting that the Trust continues to make progress against its own action plan and the internal audit recommendations in preparation for the introduction of GDPR in May 2018. JW commented that capacity within the Information Governance (IG) team remains a risk but that an appointment to the vacant Data Protection officer role had been made. The GDPR compliance plan is to be presented to EMT on 16 May 2018. JW emphasised the need to work with corporate services to ensure readiness. JW was asked what is the biggest risk to compliance, and responded that resources across the Trust systems to review consent/re-consent required is the main risk.

ACTION: Mark Brooks/Julie Williams

It was RESOLVED to RECEIVE the report and NOTE the progress made

AC/18/41 Review of risk appetite statement (agenda item 15)

MB reported that following the Trust Board strategy session in February 2018, EMT was asked to develop a recommendation for any updates to the Trust risk appetite statement. This was based on the fact the existing risk appetite statement had been running for over a year and it was appropriate to re-assess effectiveness. It was identified that given the consequence of a number of risks they could not fit within the current risk thresholds and a more considered view was required. In respect to clinical risk, Dr Adrian Berry had provided input into what was appropriate. This is recognised in the recommended threshold of 1-6 for clinical risk. At EMT, it was agreed to recommend different thresholds for financial and commercial risks.

Chris Jones (CJ) commented on the need for clarity around how this is used in Business Development Unit (BDUs) structures and also how this is communicated throughout the organisation.

The Committee agreed that an updated statement would be presented at Trust Board on 24 April 2018. LC suggested rewording of 'compromise' under background paragraph.

ACTION: Mark Brooks/Emma Jones

It was RESOLVED to SUPPORT the approach and update to the Trust's Risk Appetite Statement.

AC/18/42 Procurement update (agenda item 16)

Tony Cooper (TC) presented an update advising that 12 major contracts were let with a value of £1.4m. 10 major contracts are currently in progress including the supply of temporary medical locums and the provision of out of area beds. £498k CIP (Cost Improvement Plan) savings have been identified to date with a further £142k cost avoidance savings. It was confirmed that 38 Service Line Agreements (SLAs) have currently been signed. TC confirmed there had been a reduction in waivers, which is down by some 75% due to change in thresholds and increased market testing.

LC acknowledged the cost savings achieved and also commented that there had been good progress made on SLAs.

It was RESOLVED to RECEIVE the report and NOTE the progress made

AC/18/43 Treasury management update (agenda item 17)

RA confirmed that all funds remain within the Governance Banking Service (GBS) unless invested with the National Loan Fund and the Trust continues to not make external investment. There are currently no funds invested. Forecast interest receivable is currently £61k. This is £17k more than previous forecast given the cash position and change in interest rate.

It was RESOLVED to NOTE the update.

AC/18/44 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:

- Additional Pay Spend Control Framework (agency) which provided limited assurance. A full copy of the report was shared report with Audit Committee.
- Payroll which provided significant assurance.
- Information Governance Toolkit which provided significant assurance.
- Mental Health Act Governance which provided significant assurance.
- Learning from deaths which provided significant assurance

Recommendation tracker to be amended.

The audit of agency staffing controls focussed on nursing/medical. Part of the reason for the limited assurance opinion was the fact it was hard to gather evidence. The process is devolved and MB noted that with respect to community nursing the Trust has gone live with using Sugarman since the audit was conducted. This was not embedded at the time of the audit. He also added that he had spoken with Dr Berry regarding the points made regarding medical locums. Having spoken with a number of staff he felt the audit was fair. This report to go to the Remuneration and Terms of Service Committee to be reviewed in more detail. TC added that there will be a tender for medical locums to go out later this month.

Audit Committee to ask EMT how they can provide assurance that this is being driven. CJ requested assurance that there will be clear director responsibility for co-ordinating and delivering against these recommendations.

A draft Head of Internal Audit Opinion was included in the papers to provide an early sight of what it will look like. Any updates will be incorporated in the final version and provided to the May Audit Committee.

ACTION: Mark Brooks

AC/18/45 Counter fraud progress report (agenda item 19)

Olivia Townend (OT) presented the update to the committee and reported that the annual self-review tool has been completed and submitted. MB reviewed this submission before it was sent. There were a number of ambers on the report and OT advised that this could be improved next year with increased awareness. OT also explained that the fraud awareness programme continues.

ACTION: Olivia Townend

AC/18/46 External audit update (agenda item 20)

Caroline Jamieson (CJa) advised the report was based on Q3 data so slightly out of date. Work on year end will commence on 23 April 2018. CJa confirmed Deloitte will be in position to report back to Committee on 10 July 2018. LC stated that he felt the report was very helpful and useful and asked for it to be circulated to all Trust Board members

ACTION: Emma Jones

It was RESOLVED to RECEIVE the update.

AC/18/47 Losses and special payments report (agenda item 21)

RA reported that the Trust has made payments of £12,281 since the last report to Committee. This included £9,976 relating to Employment Tribunals. Alan Davis (AD) confirmed that learning from appeals and tribunals are conducted on a regular basis and feeds back into WRC.

LC queried the approach to staff over-payments and recovery. AD and RA confirmed that the process continues to be reviewed and learning adopted. Increase in volume linked to salary sacrifice recovery for leavers. The detailed spreadsheet detailing all payments made in the year to be circulated to Committee members

ACTION: Rob Adamson

It was RESOLVED to NOTE the losses and special payment report.

AC/18/48 Any other business agenda item 22 (agenda item 22)

No other business was raised.

AC/18/49 Consideration of any changes to 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/18/50 Items to report to Trust Board (agenda item 24)

These were agreed as:

- SystmOne implementation – assurance level
- Delivering Service change – need to review some projects at points before business as usual
- Risk Register – growing/emergent risks
- Agency Controls Internal audit - Limited Assurance
- Out of area bed risk
- Risk appetite recognise progress on ICO and GDPR
- Draft Head of internal audit opinion
- Internal Audit Plan 2018/19
- Counter Fraud Plan 2018/19

AC/18/51 Work programme (agenda item 25)

There were no further changes to work programme.

It was RESOLVED to NOTE the work programme.

AC/18/52 Date of next meeting (agenda item 26)

The next meeting of the Committee will be held on Tuesday 22 May 2018 at 14.00 in Room 49/50, Folly Hall, Huddersfield.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Nominations' Committee held on 20 June 2018

Present:	Angela Monaghan	Chair of the Trust (Chair of the Committee)
	Marios Adamou	Staff elected governor, medicine and pharmacy
	Jackie Craven	Lead Governor (Publicly elected governor, Wakefield)
	Ruth Mason	Appointed governor, Calderdale and Huddersfield NHS Foundation Trust
	Rob Webster	Chief Executive
Apologies:	Nasim Hasnie	Publicly elected governor, Kirklees
In attendance:	Alan Davis	Director of Human Resources, Organisational Development and Estates
	Emma Jones	Company Secretary (author)

NC/18/17 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Angela Monaghan (AM) welcomed everyone to the meeting and advised that Rob Webster (RW) would be late to the meeting. The apologies above were noted.

NC/18/18 Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return at Trust Board in April 2018 and Members' Council in April 2018 or subsequently.

In relation to agenda item 4 Non-Executive Director (NED) recruitment - shortlist, RW advised that he had worked closely in the past with one of the candidates recommended for shortlisting. He had not taken part in the preliminary interview process. The remaining Committee members confirmed they had no close personal or professional connections with the shortlisted candidates.

NC/18/19 Minutes of and matters arising from previous meeting held on 10 April 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the meeting on 10 April 2018. All matters arising from the meeting were complete.

NC/18/20 Committee Annual Report including review of Terms of Reference (agenda item 5)

AM reported that under its Terms of Reference the Committee is required to formally report annually to the Members' Council. At this time it was also recommended that the Committee review and approve any changes to its Terms of Reference for final approval by the Members' Council.

With all of us in mind.

Committee annual report

The Committee reviewed the draft annual report. MA suggested that a table showing the number of meetings attended by members be included. EJ commented that attendance at committees was included in the Trust's Annual Report and Accounts and could also be added to this report. The Committee supported this amendment.

Action: Emma Jones

Committee Terms of Reference

The Committee reviewed the draft amendments to its Terms of Reference and discussed the number of meetings held in accordance with the frequency of meetings section. The Committee requested that the wording to be updated to state "In the absence of any other meetings, the Committee should meet a minimum of once per year to ensure a regular review of the structure, size and composition of the Board is undertaken, at a time which fits with the business cycle of the Trust Board."

Action: Emma Jones

It was RESOLVED to APPROVE the:

- **Committee Annual Report 2017/18; and**
- **update to the Committee Terms of Reference which will go to Members' Council for final approval.**

NC/18/21 Non-Executive Director (NED) recruitment - shortlist (agenda item 4)

Alan Davis (AGD) reported that the shortlisting report attached with the papers provided an update on the processes undertaken to date and candidates recommended for shortlisting for the Committee's consideration. Also attached were sample interview questions and a draft for each of the three focus groups/stakeholder panels and final interview panel. AGD highlighted the following:

- The Trust had previously used external recruitment consultants to support the recruitment process. However, it was decided on this occasion to manage the recruitment process in-house using past successful processes and at a considerable financial saving.
- The advertisement for two Non-Executive Directors was advertised nationally in the Guardian and Yorkshire Post online in the week beginning 26 March 2018 and promoted through networks.
- In support of the recruitment process, prospective applicants were invited to four recruitment/information events, attended by members of the Trust Board in Calderdale (Halifax), Kirklees (Huddersfield), Wakefield and Barnsley. Also a number of interested people, who could not make the open events, were offered the opportunity for an informal telephone conversation. Feedback received on the events was very positive.
- The closing date for applications was the 7 May 2018 and a total of 39 applications were received.
- A longlist of candidates was established against the person specification and criteria within the advertisement, seeking to balance with the skills on the Board. From the 39 applications received, 13 candidates were longlisted (Category 1: Recommended Candidates).

- Longlisted candidates were invited to two 20-minute matrix interviews on 29 May 2018 with AGD / Charlotte Dyson (CD), Deputy Chair/Senior Independent Director and Mark Brooks (MB), Director of Finance and Resources (lead Director for Corporate Governance) / AM. These preliminary interviews explored the candidates' CVs in detail and the requirements of the NED role to further understand the candidates' career history and motivations.
- The report, attached with the papers, details the longlisting process and makes recommendations on the shortlist for the formal interviews on the 13 July 2018. The recommendation is for 7 candidates to be shortlisted for the final interview process from the initial 13 at longlisting (Category 1: Recommended). Only 1 of the candidates recommended for shortlisting had a financial background and while it was part of succession planning to replace one of the current NEDs, Chris Jones (CJ), it was noted that it was not essential to appoint a NED with a financial background as current NED Laurence Campbell was a qualified accountant.

Marios Adamou (MA) commented that this year's process felt more transparent than previously, that there seemed to be a lot of candidates with legal background and perhaps in future recruitment could target candidates with a science background. AM commented that legal experience was one of the areas identified for targeting this time, along with financial expertise, workforce/human resources; IT/digital technology, and health and social care. The reason for seeking candidates with legal experience was to recognise nationally and locally the complex situation and collaborative working arrangements. There are currently three clinicians on the Board who would have science backgrounds as part of their qualifications.

Ruth Mason (RM) commented that she felt there was a strong field of candidates which also look to be from diverse backgrounds which was positive. AGD commented that the advertisement welcomed applications from all aspects of society, including people from BAME communities, people with disabilities, younger people, service users and carers. This was supported through networks and the recruitment events which allowed for potential candidates to come to the Trust and talk to current members of the Board. Jackie Craven (JC) commented that the attendance at the Wakefield recruitment event was higher than previous years and very positive.

The Committee noted and supported the robust process that had taken place for the longlisting and agreed that further discussion was not needed on candidates that had been placed in Categories 2 (Strong marginal), 3 (Marginal) and 4 (Not recommended).

The Committee discussed two longlisted candidates from Category 1 who were just below the cut off for shortlisted candidates. AGD advised that the candidate who was rated equal seventh had a very similar background to two candidates who had been recommended for shortlisting and they did not demonstrate as much motivation for the role.. The next rated candidate had a similar background to two higher-rated candidates and did not demonstrate strong value based answers or a real commitment to the Trust in their approach. The Committee confirmed their support for the 7 candidates recommended for shortlisting for the final interview process.

Rob Webster entered the meeting.

AM updated RW on the discussion in relation to the process and recommended shortlist. RW commented that he was happy with the process and supported the candidates recommended for shortlisting.

The Committee thanked the Human Resources staff and Corporate Governance staff for their support of the process and CD and MB for assisting with the longlisting and preliminary interviews.

Final interview process

EJ advised that draft questions for the final interview process were based on the process and questions used for the previous NED and Chair recruitment. They had been reviewed with Sandy Stone, Human Resources Manager and were provided for the Committee to review at this draft stage. The final questions may be updated in discussion with the panel facilitators.

The Committee discussed and agreed that they did not need to go into the detail of deciding the questions and it was noted that the final interview questions may be enhanced based on the feedback from the stakeholder panels. AGD outlined the stakeholder panel process and how the feedback would be summarised and provided to the final interview panel in line with previous recruitment processes.

It was RESOLVED to:

- **NOTE the update provided; and**
- **AGREE the seven shortlisted candidates for the final interview process**

NC/18/22 Any other business (agenda item 6)

Committee Terms of Reference

RW requested in relation to agenda item 5 Committee Annual Report including review of Terms of Reference, that an update be made to the Terms of Reference under the Authority section to ensure requests are in line with its duties. AM commented that she believed the current wording used was standard across all committees' Terms of Reference, and that this could be updated in future. The Committee requested that the wording be updated to state "The Committee is able to seek any information it requires from any employee in line with the duties of the committee and all employees should co-operate with any request made by the Committee."

Action: Emma Jones

NC/18/23 Issues and items to bring to the attention of Trust Board / Members' Council (agenda item 7)

Items were identified as:

- Non-Executive Director recruitment update
- Non-Executive Director recommendation

NC/18/24 Date of next meeting (agenda item 8)

The next meeting will be held on Monday 16 July 2018 from 10.00am to 11.30am in Room 7, Block 7, Fieldhead, Wakefield.

MA, RM and RW gave their apologies for this date.

Director portfolios

July 2018

South West Yorkshire Partnership NHS Foundation Trust

	Deputy CEO / director of nursing & quality *	Director of operations	Medical director *	Director of finance & resources *	Director of HR, OD & estates *	Director of strategy	Director of provider development

Portfolio	• Deputy CEO
	  • EMT meeting co-ordination
	  • Complaints sign-off
	  • Implementation of portfolio & structure changes
	• Patient safety
	• Patient experience
	• Customer services
	• Quality improvement
	• Clinical governance
	• CQC/NICE compliance
	• Non-medical student placements
	• Safeguarding
	• Infection prevention & control
	• Professional lead for nursing, AHPs & psychology
	• Equality & diversity
		• Operational delivery
		• Local delivery partnerships
		• Recovery development
		• Flow and out of area beds
		• Workforce productivity
		• Cost improvement programme monitoring
			• Medical workforce planning
			• Pharmacy services
			• Professional lead for doctors & pharmacists
			• Medical education
			• Clinical legislation services - Mental Health Act
			• Research & development [i]
				• Finance
				• Commercial development
				• Procurement
				• Contracting
				• Business planning
				• IM&T
				• Performance & information
				• Information governance
				• Corporate governance
				• Membership
				• Risk management
				• NHS Improvement compliance
					• Organisational development (OD)
					• Workforce
					• HR services
					• Learning & development
					• Estates
					• Health & safety
					• Fire
					• Sustainability
					• Emergency planning & business continuity
						• Strategy
						• Change & transformation
						• Clinical record system implementation
						• Innovation
						• Library
						• Charity
						• Stakeholder management
						• Marketing & communication
						• Engagement & involvement
						• Volunteering
						• Digital
							• Integrated care
							• New models of care
							• Provider Alliance Wakefield
							• West Yorkshire mental health programmes
							  • Beds
							  • CAMHS
							  • Suicide
							  • Forensics [v]
							  • ED
							  • ASD

Designated role	• Director of infection prevention & control • Caldicott guardian • Designated senior manager – whistleblowing		• Responsible officer [i] • Guardian of safe working hours [ii]	• Accounting officer • Senior information risk owner • Company secretary [iv]	• Health & Safety • Fire • Emergency planning		
Board and committees	• Clinical governance & clinical safety committee • Equality & inclusion forum • Executive management team	• Operational management group	• Mental Health Act committee • Drugs & Therapeutics sub-committee • Clinical governance & clinical safety committee	• Trust Board • Members' Council • Audit committee • Nominations committee • Extended EMT	• Workforce & remuneration committee	• Charitable Funds committee • Transformation board	• West Yorkshire Mental Health Services Collaborative Committees in Common
External committees	• Calderdale Health & Wellbeing Board • Kirklees Health & Wellbeing Board • Safeguarding boards • Quality boards • Director of nursing forums	• A&E delivery boards	• Local medical committees • West Yorkshire STP clinical forum • South Yorkshire and Bassetlaw clinical forum [iii] • Director of Medical Education / Heads of School Meeting • Medical Directors' Network • West Yorkshire Locality – Medical Leaders Implementation Group	• Contract boards	• South Yorkshire & Bassetlaw Integrated Care System	• Barnsley Health & Care Together partnership / delivery board • Barnsley Health & Wellbeing Board • Overview & scrutiny committees	• Wakefield connecting care board • Wakefield new models of care board • West Yorkshire & Harrogate Health & Care Partnership • Wakefield Health & Wellbeing Board

Key / notes:

*	Voting director role
[i]	Delegated to Dr Adrian Berry
[ii]	Delegated to Dr Richard Marriott
[iii]	Delegated to Dr Suresh Chari
[iv]	Director lead, role filled by Emma Jones
[v]	Supported by Dr Adrian Berry

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Workforce and Remuneration Committee held on 8 May 2018

Present:	Rachel Court	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Rob Webster	Chief Executive
Apologies:	Charlotte Dyson	Non-Executive Director
In attendance:	Alan Davis	Director of Human Resources, Organisational Development & Estates
	Janice White	PA to Director of HR, OD and Estates (author)

WRC18/18 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Rachel Court (RC) welcomed everyone to the meeting. An apology was received from Charlotte Dyson.

WRC/18/19 Declaration of Interests (agenda item 2)
There were no further declarations over and above those made in the annual return to Trust Board in March 2018 or subsequently.

WRC/18/20 Minutes of the meetings held on 26th March 2018 (agenda item 3)
It was RESOLVED to APPROVE the minutes of the meeting held on 26th March 2018 subject to the following amendment: *Gender Pay Gap (agenda item 7),* change of date from June 17/18 to June 18/19.

WRC/18/21 Matters arising (agenda item 4)
The Committee discussed the schedule of matters arising and the following points were made:

- RTSC/18/18 Directors Remuneration Benchmarking and Link to Performance Related Pay (PRP)
  The Committee agreed to keep Directors Performance Related Pay under review and include it in the Work Programme.
  Action: Alan Davis
- RTSC/17/51 (item 4b) Recruitment of NEDS to sit on Appeals and Consultant Recruitment Panels
  Alan Davis (AGD) confirmed that he has had a conversation with Subha Thiyagesh (ST), Medical Director regarding Consultant appointments and the membership of the panel and agreed it was an opportune time to review the recruitment process. The Committee discussed broadening the number of people to be able to sit on these panels and a suggestion was to involve Governors. AGD agreed to speak to Subha and Emma Jones (EJ), Company Secretary regarding this. Rob Webster (RW)

With all of us in mind.

suggested the possibility of also opening it up to Members as well as Governors as this seems to have worked well in other Trusts.

Action: Alan Davis

- RTSC/17/58 Workforce Strategy 2017/18 (item 5b) – Staff Survey and Action Plan
  Rachel Court (RC) suggested leaving this as an open action as a reminder to the Committee there will be an updated action plan in February/March that will come to the Workforce and Remuneration Committee (WRC) then Trust Board.

Action: Alan Davis

- RTSC/17/58 (item 5a) Middleground
  AGD mentioned that the first Middleground session is due to commence the second week in May. It was confirmed that Trust Board members will be involved in a question and answer session as in previous Middleground programmes.

WRC/18/22 Workforce Strategy: 2018/2019 Action Plan (agenda item 5)

AGD introduced the report and mentioned the three areas Workforce Development, Staff Wellbeing and Engagement and Leadership and Management Development within the Workforce Strategy are all designed to provide an integrated work programme. He mentioned that there was a lot of building the foundations in year 1 and year 2 is more about implementation. He said the action plan is not an exhaustive list of actions and that there are a lot of other things still being done to support the Strategy.

The Committee felt that the development of Clinical Support Workers and the introduction of new roles e.g. Physicians Associates and Trainee Nurse Associates were important initiatives the Trust needs to take forward. They felt it would be good to have trajectories to see how these progress against the plan.

Action: Alan Davis

The Committee were concerned about the career pathways into Nursing for Health Care Support Worker (HCSW) following the removal of the bursaries. AGD said it has become more difficult for HCSW to move directly into nurse training given the removal of bursaries but there were now other routes into nursing rather than direct entry to University e.g. the Trainee Nurse Associates are designed to provide a pathway into Nursing and Nursing Apprenticeships are being explored.

RW felt that it was important that we link with the Local Workforce Action Board (LWAB), particularly on the development of new roles and nurse training.

Action: Alan Davis

The continued development of staff networks this year was seen as an important part of the Trust's commitment to Equality and Diversity. It was noted that the Disability Staff Network has progressed well and that there is strong support for establishing lesbian, gay, bisexual and Transgender (LGBT) and Carers networks.

The Committee discussed the key action in some depth and felt the plan provided a good framework to monitor progress and ongoing developments.

It was RESOLVED to NOTE and COMMENT on the Workforce Strategy 2018/2019 Action Plan.

WRC/18/23 Organisational Development Strategy 2018/2019 Action Plan

AGD introduced the action plan and said it follows the adapted 7S model agreed in the Organisational Development (OD) Strategy. He said that the key purpose of the OD action

plan is to effectively align resources and systems to maximise the performance and potential of the Trust.

AM asked whether it should be the WRC or the Trust Board who approve the action plan. It was agreed that the OD Strategy was much broader than workforce, although it was recognised as a significant component, and therefore the Trust Board should be responsible for its approval. The Committee felt that it was nice to see the OD plan on a page and it gave a good structure to alignment of key programmes of work.

The Committee agreed that a quarterly update be provided to the Trust Board and to put this on the Trust Board agenda.

Action: Alan Davis

It was RESOLVED to SUPPORT the Organisational Development Action Plan for 2018/2019 and that it should go to the Trust Board for approval and a quarterly update will be provided.

WRC/18/24 Strategic Workforce Plan Update

AGD introduced the Strategic Workforce Plan update and said that it was a refresh following the Workforce Planning workshops held with the BDUs in November. The executive summary attached reflected feedback from each of the BDUs and linked to the Trust's annual and financial plans. BDUs have been clearer this year about their service plans and the workforce implications and the alignment with the financial plan has been strengthened.

RW felt that the age profile was striking and it was very positive to see the increase of young people in the workforce but also at the other end there is a worrying number of people within 5 years of retirement. He felt stability rates looked good and that the focus on retention is clearly a key issue for the Trust.

The Committee felt that in future workforce plans we need to cover the gender pay gap and what actions the Trust is taking to reduce it.

Action: Alan Davis

The Committee considered the plan in some depth and felt it was important to have regular updates against the plan. It felt if possible we should look to see how it could be built into the performance dashboard.

Action: Alan Davis

It was RESOLVED to CONSIDER and SUPPORT the Strategic Workforce Plan and SUPPORT the recommendations.

WRC/18/25 HR Exception Reports

Workforce Strategy Dashboard: Prototype

AGD introduced the paper and said that the Workforce Strategy included a series of Key Performance Indicators (KPIs) based on the NHSI and Dr Michael West list of workforce performance measures. The NHSI and Dr West's measures rely heavily on the NHS Staff Survey but also takes account of other evidence base measures. He said this was very much a prototype which will be developed over the next 12 months and welcomed feedback from the Committee.

The Committee felt it was a good start but would like to see:

- Stronger link to the Robertson Cooper survey

- Bank and agency broken down further
- Stronger link developed with the Integrated Performance Report

It was RESOLVED to NOTE the report and that quarterly reports will come to future meetings.

Action: Alan Davis

WRC/18/27 Clinical Excellence Award Scheme

AGD informed the Committee that following the last meeting he has sought clarification from NHS Employers whether the backdating of awards is contractual or not. The view of NHS Employers was that it was not contractual but it is likely the BMA have a different view.

AGD mentioned he had discussed the backdating of the Clinical Excellence Awards with Subha and both felt given the importance of retention it would be seen very positively by Consultants. The Committee supported backdating the CEA but asked that the values are a key part of the application process.

RW mentioned that it was worth noting that we had an approach from Abdullah Kraam to support an application for a national award but this was only received the day before and he felt it was submitted too late for him to support.

It was RESOLVED to NOTE the update.

WRC/18/29 Workforce Risk Register

The Committee considered the risk register and discussed key issues around Equality and Diversity, Agency Spend and potential decommissioning of services. The Committee felt the risk register appropriately reflected the key workforce risks.

Action: Alan Davis

It was RESOLVED to AGREE the risk register.

WRC/18/30 Annual Work Programme

The Committee asked for Review of the Committee's Effectiveness to be added to the Annual Work Programme.

Action: Alan Davis

WRC/18/31 Matters to report to the Trust Board and other Committees

- Workforce Strategy: 2018/2019 Action Plan
- Organisational Development Strategy 2018/2019 Action Plan
- Strategic Workforce Plan – Executive Summary
- HR Exception Report – Workforce Strategy Dashboard; Prototype

WRC/18/32 Terms of Reference

It was RESOLVED to NOTE the Terms of Reference.

WRC/18/33 Date and Time of next meeting

The next meeting will be held at 14:00 on 3rd July 2018 in the Chair's office, Block 7, Fieldhead Hospital.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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	✘	✘	✘	✘	✘	✘	✘	✘
STP / ICS developments	✘	✘	✘	✘	✘	✘	✘	✘
Integrated performance report (IPR)	✘	✘	✘	✘	✘	✘	✘	✘
Assurance from Trust Board committees	✘	✘	✘	✘	✘	✘	✘	✘
Receipt of minutes of partnership boards	✘	✘	✘	✘	✘	✘	✘	✘
Question from the public	✘	✘	✘	✘	✘	✘	✘	✘
Quarterly items								
Corporate/organisational risk register	✘		✘		✘		✘	
Board assurance framework	✘		✘		✘		✘	
Customer Services quarterly report (now patient experience report included in IPR from quarter 1)	✘		✘		✘		✘	
Guardian of safe work hours (now included in IPR)	✘		✘		✘		✘	
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 (private session)	✘				✘			
Safer staffing report	✘				✘			
Digital strategy (including IMT) update	✘				✘			
Estates strategy update			✘				✘	
Annual items								
Draft Annual Governance Statement	✘							

With **all of us** in mind.

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Audit Committee annual report including committee annual reports	✘							
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘							
Review of Risk Appetite Statement	✘							
Annual report, accounts and quality accounts - update on submission		✘						
Health and safety annual report		✘						
Customer Service 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						✘		
Eliminating mixed sex accommodation (EMSA) declaration								✘
Information Governance toolkit								✘
Strategic objectives								✘
Trust Board annual work programme								✘
Operational plan (two year) *(next due in December 2018 - date to be confirmed by NHS Improvement)*						✘		
Policies and strategies								
Constitution (including Standing Orders) and Scheme of Delegation							✘	
Risk Management Strategy							✘	
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)							✘	

Policies/strategies for future review:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(reviewed as required)*
- Membership Strategy *(next due for review in April 2019)*
- 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)*
- Customer Services Policy *(next due for review in June 2020)*
- Equality Strategy *(next due for review in July 2020)*

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
• Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in October 2020)* • Learning from Healthcare Deaths Policy *(next due for review in October 2020)* • Digital Strategy *(next due for review in January 2021)* • Quality Strategy *(next due for review in March 2021)* • Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in March 2021)* • Estates Strategy *(next due for review in July 2022)*								

	Business and Risk (includes quarterly performance reports and quarterly reports to Monitor/NHS Improvement)
	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.	