South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 29 January 2019 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 18 December 2018**	Chair	**Paper**	8	To approve
4.	**9.40**	**Service User Story**	Director of Operations	**Verbal item**	10	To receive
5.	**9.50**	**Chair and Chief Executive's remarks**	Chair Chief Executive	**Verbal item** **Paper**	10	To receive
6.	**10.00**	**Risk and assurance**				
		6.1 Board Assurance Framework (BAF)	Director of Finance & Resource	**Paper**	15	To receive
		6.2 Corporate / organisational risk register (ORR)	Director of Finance & Resource	**Paper**	15	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		6.3 Contingency planning for “no deal” Brexit	Director of Human Resources, Organisational Development & Estates	**Paper**	10	To receive
7.	**10.40**	**Business developments**				
		7.1 NHS Long Term Plan	Director of Finance & Resources	**Paper**	10	To receive
		7.2 South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of Strategy	**Paper**	10	To receive
		7.3 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy	**Paper**	10	To receive
	11.10	*Break*			*10*	
8.	**11.20**	**Performance reports**				
		8.1 Integrated performance report (IPR) Month 9 2018/19	Director of Finance & Resource and Director of Nursing & Quality	**Paper**	45	To receive
9.	**12.05**	**Strategies**				
		9.1 Estates Strategy progress update	Director of Human Resources, Organisational Development & Estates	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
10.	**12.15**	**Governance items**				
		10.1 Operational plan 2019/20	Director of Finance & Resources	**Paper**	5	To approve
		10.2 Review of the Trust Constitution (including Standing Orders) and Scheme of Delegation	Director of Finance & Resources and Company Secretary	**Paper**	5	To approve
		10.3 Update to the Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)	Director of Finance & Resources and Company Secretary	**Paper**	10	To 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 8 January 2019 - Workforce & Remuneration Committee 18 December 2019	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 26 March 2019, Room 3/4, Laura Mitchell Health and Wellbeing Centre, Great Albion St, Halifax HX1 1YR	Chair	**Verbal**	4	To note
15.	**12.55**	**Questions from the public**	Chair	**Verbal**	10	To receive
	13.05	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 18 December 2018
Small conference room, Wellbeing & learning centre, Fieldhead, Wakefield

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Laurence Campbell (LC)	Non-Executive Director
	Rachel Court (RC)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Sam Young (SYo)	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 / Deputy Chief Executive
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
Apologies:	Nil	
In attendance:	Carol Harris (CH)	Director of Operations
	Sean Rayner (SR)	Director of Provider Development
	Salma Yasmeen (SY)	Director of Strategy
	Emma Jones (EJ)	Company Secretary (author)

TB/18/103 Welcome, introductions and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. There were no apologies. At the commencement of the meeting there were eleven members of the public in attendance including one governor, eight members of staff and two carers. AM reminded the 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/18/104 Declarations of interest (agenda item 2)

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

TB/18/105 Minutes of and matters arising 30 October 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 30 October 2018 as a true and accurate record with the correction of typographical errors.

Erfana Mahmood entered the meeting.

The following matters arising were discussed:

- TB/18/94ai Kirklees Health and Wellbeing Plan - Complete. Formal feedback provided to the Kirklees Health & Wellbeing Board.

- TB/18/94aii Wakefield Health and Wellbeing Plan - Complete. Formal feedback provided to the Wakefield Health & Wellbeing Board.
- TB/18/95a Integrated performance report (IPR) Month 6 2018/19 (prone restraint) - Complete. Number of service users now included.
- TB/18/96a Digital Strategy progress update (prioritisation on piloted areas) - Will be considered as part of the annual planning process. Action to be closed.
- TB/18/81a Appraisal / Revalidation Annual Board Report 2017/18 - In progress. Further guidance received from the Nursing & Midwifery Council (NMC), update back to the Board in January 2019.
- TB/18/52d General Data Protection Regulations (GDPR) update (report to Members' Council) - Can be considered for scheduling by the Members' Council Co-ordination Group post internal audit. Action to be closed.

TB/18/106 Service User Story (agenda item 4)

The Trust Board heard stories from John Laville, Chair of the Kirklees Carers' Forum, and Trisha Fisher about their experiences of being carers.

John talked about his experience caring for his wife. He described different levels of engagement including several changes to psychiatrists and the negative impact the transformation of services could have on a service user. He commented on the importance of carer support through the previous carers' dialogue group, which has since reformed as the Kirklees Carers' Forum. This is run by carers for carers, with fantastic support from the Trust, and a service user group has also been formed. The Forum had run workshops on communication and handovers and noted areas of best practice which are included in the Trust's procedures. However, he felt they were not being followed and suggested carers be invited to undertake an audit. He also recommended that the Trust align one of the Non-Executive Directors (NEDs) to be a carers' champion.

Trisha talked about her experience caring for adult children. She described her experience with crisis teams which she found uncomfortable as each time different staff attended her home. She described the difficulties she experienced being provided with information as a carer and some of the issues that had affected her family in receiving care from the Trust. She also highlighted the difficulty when service users are placed out of area as the Trust does not currently pay transport costs for carers to visit. Trisha had raised some of her concerns but did not feel she had an appropriate apology or resolution.

Rob Webster (RW) said sorry for the difficult experiences described by Trisha on behalf of the Trust and as the accountable officer. He noted the importance of maintaining services through transformation and that even when consent is not given by service users, it was possible to have a good and productive relationship with carers. This has improved in recent times, though more work is required. The Trust has processes in place, including a focus on continuous improvement that will ensure that this is the case. As part of the work under the West Yorkshire & Harrogate Health & Care Partnership, more focus will be placed on improving support for carers, recognising that there are over 260,000 carers across the area.

AM commented that normally the Board would have a discussion at this point of the meeting about any issued raised. Due to lack of time, AM asked the Board to provide their reflections and feedback on the stories so a collective response could be provided, and undertook to follow up personally with both carers.

Action: Angela Monaghan

The Board thanked the carers for sharing their stories.

It was RESOLVED to NOTE the Carers Stories and for Board members to feedback to the Chair. A further response would then be provided.

TB/18/107 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- The Board will be discussing the following items in private session today, which are considered as commercial in confidence:
  - Financial performance including draft financial sustainability plans.
  - Contracting plans for 2019/20.
  - Update on implementation of the new Clinical Records System (CRS).
  - Business developments in West Yorkshire and South Yorkshire including the Integrated Care Systems (ICSs).
  - Minutes of private partnership board meetings.

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 and highlighted the following:

- The national political landscape was having an impact on NHS and social care including the green paper. It was likely that the NHS Long Term Plan would be published in January 2019 however the Trust would be expected to take this into account as part of its plan for 2019/20.

Charlotte Dyson (CD) asked, in relation to the reported financial concerns concerning Interserve, if there was any impact on the Fieldhead masterplan. Alan Davis (AGD) commented that there was national guidance and advice to continue with the current arrangements including contingency plans. The risk would be in relation to the building of the new acute inpatient unit which is near completion and a lower risk than other developments nationally. SR commented that the situation was being monitoring closely and on the project risk register. AGD outlined the contingency arrangements in place.

CD asked in relation to the new websites for Barnsley and Kirklees Improving Access to Psychology Therapies (IAPT) services how the Trust ensures there is extra resource further along the pathway around core and enhanced should demand increase. Carol Harris (CH) commented that there was currently a hypothesis that there would be a higher level of demand and the Trust has asked SSG, who are working with the Trust on patient flow, to review the data with a report due at the end January 2019. RW commented that NHS benchmarking data showed that 1 million people nationally were using IAPT, with good levels of recovery. It was also important to consider the consequences of increasing access to care on other parts of the pathway. Conversations are taking place around how a "primary care mental health" offer could be developed to discuss with commissioners. CD commented that the outcomes of the report may be an area to consider as part of the Integrated Performance Report (IPR) indicators for 2019/20.

Rachel Court (RC) commented in relation to the Brexit update that it was good to see contingency planning taking place and asked if there was a deadline in relation to some areas such as pharmacy where decisions would be needed. AGD commented that contingency planning in relation to pharmacy was being coordinated nationally and there may be a decision to stockpile some items. More national guidance was expected shortly.

AM asked if there were areas that impact partners which may then impact the Trust, such as workforce. AGD commented that this issue was being looked at by the Yorkshire emergency planning group. The Trust was also discussing, as part of the West Yorkshire Mental Health Services Collaborative (WYMHSC), how we support staff who are European Union (EU) citizens to apply for the settlement scheme which is open to health care staff including potential payment of the fee. The Trust has sent out communications offering support to EU staff in applying for the settlement scheme.

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

TB/18/108 Performance reports (agenda item 6)

TB/18/108a Integrated performance report Month 7 2018/19 (agenda item 6.1)

Mark Brooks (MB) reported that, due to the earlier timing of meeting, the vast majority of metrics were only just being finalised now. Therefore the full Integrated Performance Report (IPR) for October 2018 (Month 7) has been provided and a presentation would be given on the information available to date for November 2018 (Month 8). The full IPR would be circulated to the Trust Board once complete.

Tim Breedon (TB) highlighted the following in relation to Month 8 data available:

- Children and Young People (CYP) in adult inpatient wards - Under 18 admissions to acute wards remain a concern and a cross-system escalation meeting had been scheduled. Admissions have been escalated to NHS England, conversation is taking place with Mid Yorkshire Hospitals NHS Trust about an individual situation, and the Medical Director for NHS England North would facilitate the cross-system conversation.
- Inappropriate out of area bed days. – 360 days recorded in the month
- Number of patient safety incidents resulting in death - Patient safety incidents involving moderate or severe harm or death. Initially the data shows 47 such incidents. The incidents need to be reviewed in more detail in line with our normal processes.
- Medicine omissions - further work to be done including the way information was being submitted.
- Percentage of prone restraint of three minutes or less. This has improved to 81.3%
- Safer staffing - full report on the agenda.

Laurence Campbell (LC) asked for an update on the staff flu vaccination target. AGD commented that the current position was 68.8% with an extra 170 vaccinations needed to meet the target of 75%. RW commented that he had written to front line staff who had yet to receive their vaccination to further encourage them to have it.

CD asked, in relation to the serious incident figures for November 2018, if the detail on the areas and categories they relate to were known. TB commented that the areas where targeted reviews were needed was known, including an increase in aggression and violence and minor increase in relation to pressure ulcers. Pressure ulcer issues are now being considered as part of risk panel to ensure any trends are understood. There was also new guidance on inpatients who abscond.

Kate Quail (KQ) asked, in relation to the cross-system escalation meeting, whether the local authorities were included. TB commented not at this stage. The initial meeting would be to understand the current situation and any access issues to other services, then look at actions to take forward. Learning events with Barnsley and Wakefield have been agreed, which would include the local authorities.

KQ asked, in relation to structured judgment reviews, where 23% of risk assessments were rated as good or excellent if that meant the others aren't. TB commented that there were only a small number at the moment and the others were rated as satisfactory. The learning from deaths review was showing number of good or excellent ratings, with numbers to be reviewed. AM commented, in relation to the number of records with an up to date risk assessment, if there was a theme. TB commented that it related to a number that had not been reviewed and recorded within the agreed timescales. He suggested that there was evidence of updating risks in different parts of the record but that this was not always appropriately recorded in the risk assessment. Work was needed to improve with some training completed to assist. Further data was due in Quarter 4 2018/19.

LC asked if there had been an impact on customer services due to capacity. TB commented that additional staff from the Trust bank had been brought in to support the team due to staff sickness and an increase in the number of Freedom of Information (FOI) Act requests. The focus on resolving concerns at a local area has assisted and an internal audit has taken place to provide further insight. An independent advisor is also looking at the processes.

LC asked, in relation to the Friends & Family Test, if there were any themes or trends for those who responded as extremely unlikely to recommend. TB to confirm.

Action: Tim Breedon

LC commented, in relation to the Care Quality Commission (CQC) action plan, that more seemed to be RAG rated amber than reported in September 2018. TB commented that some have been moved into green/amber as they were off trajectory including some estates work which was delayed and the production of updated care planning advice which is taking place. TB reminded the Board what the different RAG ratings signified.

MB highlighted, in relation to Month 8 data available for the National Metrics, that the 7 day follow up target had been met. The IAPT target for people moving to recovery is not yet available but the target for the quarter may have been met, though by a small margin.

CH highlighted the following in relation to Month 8 data available for Locality:

- Neuro-rehab service beds that have been decommissioned by Barnsley CCG are being marketed nationally to match the income lost.
- Pulmonary rehab - performance notice received. MB commented that a joint investigation had been agreed with commissioners in relation to the target, with the outcome expected January/February 2019.
- Ward 18 - garden area reviewed for overall safety following a safety incident and currently there is restricted access.

CD asked CH if, through the new Director of Operations role, there were areas of learning that could be transferred through the different Business Delivery Units (BDUs). CH commented that the role provided the opportunity to work across pathways, working with deputies and trios to maximise the learning across the Trust. Inpatient teams working together on flow was showing benefit and the plan was to replicate that approach into the community teams.

RW commented that the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) had received national funding for capital developments. However the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) had not. One of the areas of funding requested by the SYBICS was in relation to stroke. This will impact on the location of services for a future pathway, but work on the approach will continue as commissioners have signalled that they want to look at the service provision differently.

RW commended the Wakefield and Barnsley systems for their work on reducing out of area placements, with both BDUs showing no out of area acute bed usage. Despite this, the November figures across the Trust showed the highest spend and focus needs to continue on areas where there are issues.

Salma Yasmeen (SY) highlighted the following in relation to Month 8 data available for the Priority Programmes:

- Older People's Services - Final business case shared with commissioners.
- Out of area - SSG have commenced their review of bed management processes, action plans, and opportunities.
- Clinical Records System - work is progressing including discussions on the go live proposal.

MB commented that there was a separate paper on the agenda in relation to Month 8 data for Finance.

AGD highlighted in relation to Workforce that there were some areas that were currently below target, including Information Governance (IG), Moving and Handling, Cardiopulmonary Resuscitation, and Aggression Management training. Work is taking place to review the figures and understand hotspots at the local level, taking action as appropriate.

LC asked what actions were taking place in relation to recruitment and retention. AGD commented that the Workforce & Remuneration Committee would receive a report in detail at their meeting in February 2019.

RW commented that areas of performance such as training and IG incidents may reflect pressure in the system. These are areas of focus for the Executive Management Team (EMT) and the Operational Management Group (OMG), as well as the need for focus on staff wellbeing and it was important for the Board to keep them in view.

It was RESOLVED to NOTE the Integrated Performance Report and COMMENT accordingly.

TB/18/108ai Finance report Month 8 2018/19 (agenda item 6.1i)
MB highlighted the following:

- Deficit in November of £80k.
- Highest monthly spend on out of area placements for 2018/19 of £417k
- Level of savings was primarily 300k on pay due to the level of vacancies.
- The cumulative position is £1m favourable to plan, but does include one-off asset disposal gains of over £0.6m
- Agency staffing costs were £536k in month and the full year projection of £6.4m is close to breaching the NHS Improvement cap by 25%. This would have adverse implications on our financial risk rating.
- Nuero-rehab currently running at a deficit with focus on selling beds no longer commissioned by Barnsley.
- The cash balance remains in relative health at £23.5m

Erfana Mahmood (EM) commented that the agency spend seemed to be going in the wrong direction, along with retention and sickness absence and asked what actions were taking place. AGD commented that a lot of the agency spend was in relation to medical locums and some posts that are very hard to recruit. In relation to the medical workforce, constructive conversations are taking place with the Child & Adolescent Metal Health Services (CAMHS) consultants and the wider workforce to ensure the service model is right

and to be able to recruit and retain staff in a competitive environment. The Workforce & Remuneration Committee are looking at other possibilities to improve recruitment, including potential of overseas recruitment and us becoming a GMC sponsor. The GMC sponsorship scheme would allow the Trust to recruit doctors from overseas and provide support and training for them whilst they work in the organisation. In relation to nursing, conversations continue with local universities and the possibility of different skill mix alternatives such as advanced clinical practitioners and trainee nurse associate roles. Dr. Subha Thiyagesh (SThi) commented that there are several factors that make people want to work with SWYPFT, such as cultural, financial and workload considerations. Discussions have taken place with research leads to understand what further the Trust could do to create a sustainable position in terms of our employment offer.

Sam Young (SYo) asked if the Board would be happy to accept a reduced financial risk rating from NHS Improvement and if there was anything further that could be done in the short-term to reduce agency spend. MB commented that the implication of the reduced rating would likely be more intense focus from NHS Improvement on the Trust's use of agency spend, based on what happened two years ago. RW commented that the positon of the Board was the Trust would not compromise safety over expenditure, including the use of agency staff. It was important to ensure processes were in place for the approval of the usage of staff which was subject to a previous internal audit. Where staff were essential to patient safety, they should be used.

LC commented that it would be good to have some overall Board visibility on the agency initiatives taking place. RW commented that the Board had to complete a self-certification in December 2016 and it might we worth using this to review progress made. This is an area that is reviewed by the Workforce & Remuneration Committee. RC suggested that an update is provided to the Board after the next Committee meeting in February 2019.

Action: Dr. Subha Thiyagesh / Mark Brooks

It was RESOLVED to REVIEW and COMMENT on the report.

TB/18/108b Serious Incident report Quarter 2 2018/19 (agenda item 6.2)
TB highlighted the following:

- Quarter 2 showed a slight reduction in the number of incidents reported.
- 88% of incidents are graded as low or no harm which is indicative of a positive culture of risk management.
- Violence and aggression continues to be the highest reported incident type. With physical aggression/threat (no physical contact) by patient the most reported category of these incidents.
- There have been no never events reported. The last never event reported was in 2010/11.
- The Clinical Governance & Clinical Safety Committee have considered this report as well as lessons learned which included blue light and green light alerts circulated, as well as a shared network drive to enable access; new SBAR (Situation, Background, Assessment and Recommendation) reports now included in Operational Management Group (OMG) reporting, additional work around safety huddles, a new clinical reference group, work taking place as part of the suicide prevention.

CD commented that the Clinical Governance & Clinical Safety Committee scrutinised the report ensuring any lessons learned are included in the strategy for action. The Committee has requested a specific report in relation to the use of prone restraint.

LC asked when the proposal to allow service users to use e-cigarettes would be introduced. CH commented that the vending machines in inpatient areas were being fitted in December 2018 and once complete and local processes confirmed it would go live. Service users and staff had had a lot of input into the changes. TB commented that the pilot would be monitored and reported.

KQ commented that the learnings from what could have happened earlier to prevent crisis, and shared learning from change and improvement, were helpful and felt very positive. KQ asked where any areas for improvement were included. TB commented that they are reported back to the OMG. CH commented that any areas identified by OMG were fed back into teams or requested for the governance group's review and feedback.

RW commented, as part of the complaints process, he has a monthly meeting with TB and SThi to look at themes and issues and whether they triangulate with any incidents.

LC commented that the report showed Barnsley community had the highest level of incidents and asked if there was a theme. TB commented that he believed these were in relation to tissue viability issues and pressure ulcers. TB to confirm.

Action: Tim Breedon

LC asked, in relation to suicide prevention, where any themes or areas for focus were being reviewed. TB commented that these areas were being picked up through the suicide prevention work and patient safety strategy.

It was RESOLVED to NOTE the quarterly report on incident management and the assurance provided from the Clinical Governance & Clinical Safety Committee.

TB/18/108c Safer staffing report (agenda item 6.3)
TB highlighted the following:

- The Trust currently meets its safer staffing requirement overall with staffing fill rates continuing to exceed 100%, although the planned levels of registered nursing staff are not always met.
- Certain inpatient areas continue to experience significant difficulties in meeting planned levels and, in such circumstances, the professional guidance tool is used to maintain safe levels.
- Important to note that underneath the data there are pressures in the system at different times and in some locations.
- An establishment review has been undertaken place the outcome of which will be incorporated into the workforce plan.
- New 'care hours per patient day' data is due to published in January 2019 and will show variations in the acute service. Some are due to how we plan and some due to ward size, which will feed into a transformation review.
- Continued work around community safer staffing report to enable reporting in Quarter 1 in 2019/20.

CD commented that the work on community safer staffing was really important to understand areas of pressure in the overall system.

LC asked why there was a higher fill rate of registered nurses on nights in comparison to days. TB advised it was due to vacancies rather than the rota.

CD asked if the peripatetic workforce could be utilised more in the community. AGD commented that they were now working directly on the wards. This initiative was originally aimed at nurses but utilised more for healthcare support workers. CH commented that by

having the services working more closely together it will enable staff to move between wards.

It was RESOLVED to:

- **RECEIVE the report as assurance that the organisation is meeting safer staffing requirements; and**
- **NOTE the assurance provided by the Clinical Governance & Clinical Safety Committee.**

TB/18/109 Business developments (agenda item 7)

TB/18/109a South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 7.1)

AGD highlighted the following in relation to the SYBICS:

- Performance measures are in place with the SYBICS performing well nationally. There are three mental health targets which are all currently RAG rated green with an amber on A&E overall, but Barnsley was performing well and the Trust was a major contributor to both.
- The SYBICS was now starting to work at a place level and look at areas of good practice. It is important that the Trust continues to be involved in those conversations.
- The Governance review is continuing and due to go out for consultation with stakeholders in January/February 2019.
- The SYBICS will be taking place in the national quit programme, with the Trust planning to be involved through the Yorkshire Smokefree service that it currently provides.

SY highlighted the following in relation to Barnsley:

- Work continues with partners and commissioner to develop integrated care, with a workshop held this month, which was positive.
- Work taking place on developing joined up care in neighbourhoods.
- The local authority had received a rating of 'Good' on their OFSTED inspection of children's services.

AM asked how discussions with mental health partners was progressing. RW commented in South Yorkshire the position in terms of priorities was slightly different as out of area placements were rare and suicide prevention received some additional resources centrally. Workforce and IAPT were areas of focus of how we can work collaboratively. The Memorandum of Understanding (MOU) for the West Yorkshire Mental Health Services Collaborative (WYMHSC) has been shared with partners in South Yorkshire and a meeting will take place with Chairs and Chief Executives on whether the same arrangements should be implemented in the SYBICS.. There was a strong sense that the governance review would identify that something separate was needed for mental health as well as acute providers. The SYBICS will have a stronger role in performance managing places and that approach is being adopted. With any proposed changes the discussion should start with 'what is problem are we trying to address collectively?'.

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

TB/18/109b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 7.2)
SY highlighted the following:

- Revised governance arrangements were moving forward with the Partnership Board selecting a Deputy Chair.
- The System Oversight and Assurance Group (SOAG) will act as the overarching group for assurance.
- A performance dashboard was in development.
- The unpaid carers' programmer was highly commended in the Health Services Journal Awards (HSJ).
- Funding confirmed to support the work streams, including the capacity to accelerate the good work that is happening.
- Wakefield went through a peer review process, with a full report on the outcome available. The other local places will also undergo a peer review.

SR commented, in relation to mental health programmes, two main areas that impact the Trust are: the business case for Learning Disabilities assessment and treatment units which Leeds & York Partnership NHS Foundation Trust is leading and which is due in March 2019; and a forensics new models of care, which this Trust is leading and should be available in January 2019, subject to financial information from NHS England.

RW commented that any remaining funding would be allocated to the public sector. Any capital works would need to be funded from existing resources or elsewhere, which is why an extra provision through the Provider Sustainability Fund (PSF) is important. NHS England North has announced that they will release £4.1m, with £1.5m for winter pressures to be allocated through A&E delivery boards and £2.6m for primary care development. National guidance on funding for next year was yet to be received, including towards suicide prevention.

SR commented that the Trust was part of a mental health provider alliance in Wakefield with the next key milestone the completion of a formal alliance agreement. A draft is expected for consideration by boards in February or March 2019.

KQ commented that the national Mental Health Act review mentioned funding for capital should be made available, highlighting that the estate in general was poor. RW commented that this was not the case in the Trust, which had delivered some significant investment, and it was important to keep commissioners aware of the state of our estate and associated capital charges.

It was RESOLVED to RECEIVE and NOTE the updates on the development of Integrated Care Partnerships and collaborations including:

- **West Yorkshire and Harrogate Health and Care Partnership**
- **Wakefield**
- **Calderdale**
- **Kirklees**

TB/18/110 Governance matters (agenda item 8)

TB/18/110a Assessment against NHS Constitution (agenda item 8.1)
EJ reported that the paper provided the self-assessment completed by EMT to provide assurance to Trust Board that the Trust meets the rights and pledges set out in the NHS

Constitution in relation to patients and staff. The Trust remains mindful of the commitments in the NHS Constitution in delivering, planning and developing its services.

EM commented that she felt the statement was helpful and asked what further information was available on how the Trust complies. TB commented that one of the key pieces of evidence was through the IPR and it may be helpful in future to map other key areas that are reported into the committees such as incidents, safer staffing, patient experience, financial, performance, and internal audit reports. MB commented another area that can be triangulated was the assurance and controls in the Board Assurance Framework (BAF). RW commented that visits to services either structured through quality monitoring visits or informally would also give a sense of how the Trust was performing against the rights and pledges.

RC asked, in relation to adherence to policies and procedures, whether there were any spot checks to see whether there was compliance. SThi commented that it was part of trainee doctors' supervision, Multi-disciplinary teams (MDT), and management process. AGD commented it was also part of the role of practice governance coaches.

KQ commented that it was important that staff are receiving messages and asked if their views were sought on internal communications such as "The Brief" monthly communication and "The View" weekly communication. AM commented that, at a recent staff side meeting, they said an app had been piloted in the Trust, which may be an easier way to communicate messages and asked about the status of this now.

Action: Salma Yasmeen

RW commented that staff surveys on the Trust's communications suggest that communication through "The Brief" and "The View" was significantly better than previously, however there was still further work to do to continue to improve.

RW commented that it was important to also recognise that there are some areas that are not constitutional standards such as wait times and access to services that the Trust wants to improve on.

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

TB/18/110b Operational plan 2019/20 (agenda item 8.2)

MB reported that the operational plan for 2019/20 was discussed as part of the Trust Board strategic session in November 2018. Guidance is yet to be fully received nationally; he understands the requirement for submission of a draft on 14 January 2019 will be activity for the acute sector.

KQ asked what would be the impact of the CQUIN change. MB commented that CQUIN has been halved for 2019/20, with half put into tariff and the other half available if the Trust can achieve metrics, with further details to come in the national guidance.

It was RESOLVED to:

- **NOTE the outline planning requirements and guidance for 2019/20; and**
- **REQUEST that the finance sub-group of the Board meets ahead of the current January 2019 draft submission with the results from that meeting communicated to and discussed with the full Trust Board ahead of the draft submission.**

TB/18/110c Emergency Preparedness, Resilience & Response (EPRR) Compliance (agenda item 8.3)

AGD reported that, when the initial self-assessment was submitted, the Trust was fully compliant in 45 and partially compliant in nine of the 54 standards which apply to mental health, learning disability and community trusts, resulting in partial compliance overall. Since then progress has been made, moving three further areas to fully compliant and resulting in a substantial assurance rating. For most of the remaining partially compliant areas, the Trust needs to work in partnership across the system. An important part of the process was the Trust's internal business continuity plans were tested to a high level.

EF asked who was the named officer responsible for compliance and suggested that it would be useful to note in the report the areas of partial compliance that are system wide. AGD advised that he was the named officer.

LC commented that, in relation to some areas, it looked like all providers were doing what they needed to do and asked why it was not rated as fully compliant. AGD commented that the report was triangulated with West Yorkshire partners and agreed that it should remain partial at this stage until all evidence was in place. AM asked where the Board could see the evidence against all the standards. AGD to circulate.

Action: Alan Davis

SYo asked when the Board discusses what their duties are under EPRR. AGD commented that most are day to day executive functions and the full Board would not need to get involved in these. The Board's role is assuring compliance, providing public facing leadership if required and a potential review of learning by the Clinical Governance & Clinical Safety Committee. The EMT took part in a mock scenario earlier in the year. MB explained that a genuine incident management would be expected to be overseen and led by operational managers and executive directors. Non-Executive Directors would of course be briefed and advised.

The Board discussed whether all members felt informed enough on future plans to provide challenge and requested:

- that the Health & Safety session planned for the Trust Board in March 2019 include EPRR and the communication process; and
- that the full copy of the plan be circulated to the Trust Board.

Action: Alan Davis / Salma Yasmeen

It was RESOLVED to RECEIVE the current EPRR update and to sign off the Trust's substantial compliance against the core standards.

TB/18/111 Receipt of minutes of partnership boards (agenda item 9)

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

- Barnsley Health and Wellbeing Board 4 December 2018 - SY commented that work was ongoing to review the Health and Wellbeing Board's role in the wider system.
- Kirklees Health and Wellbeing Board 22 November 2018 - TB commented that the Terms of Reference were being reviewed including membership organisations.
- Wakefield Health and Wellbeing Board 15 November 2018 - SR commented that the plan was approved and presented at the last Trust Board meeting. An "Early Help" Strategy was also presented and approved by the Health & Wellbeing Board. RW commented that the strategy links into CAMHS work in Wakefield.

- West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group 19 November 2018 and 17 December 2018.
- West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive 6 November 2018 and 4 December 2018.

It was RESOLVED to RECEIVE the updates provided.

TB/18/112 Assurance from Trust Board Committees (agenda item 10)

Clinical Governance & Clinical Safety Committee 20 November 2018

CD highlighted the following:

- Patient Safety Strategy - whether staff are engaged, was it making a difference for service users, and workstreams. Good evidence provided.
- Ligature - key point was how the Trust audits processes for identifying and managing ligature risks, with plans in place for each service.
- Safer Staffing - as included on the Trust Board agenda.
- CQC Action Plan - included in the IPR on the Trust Board agenda.
- Serious Incidents - as included on the Trust Board agenda.
- Restraints - the Committee has requested a further report.
- CAMHS - top level benchmarking data showed the Trust was an outliner on referral to treatment and progress on actions scrutinised.
- Minutes of the previous Committee meeting held on 18 September 2018 (attached to Trust Board papers)

RW asked if the Committee looked at benchmarking data on the use of restraint. CD commented that it did and they have requested the Deputy Director of Nursing & Quality for further information in relation to reporting and learnings that can be used to further reduce prone restraints.

CH commented, in relation to CAMHS, as part of the work on recruitment and retention the CAMHS consultants have agreed to take on leadership in a particular area, which is a positive development. The areas include care pathways and reducing waits to the service.

Mental Health Act Committee 13 November 2018

KQ highlighted the following:

- Committee being briefed on the use of the legislative framework in CAMHS. Positive message around the good compliance with Community Treatment Orders (CTOs).
- CQC visits – how the Trust can improve performance management and a refreshed escalation process.
- Ethnicity recording - will be looked at further by the Equality & Inclusion Forum.
- Section 49 requests - impact on the workload of staff.
- Sharing of information with Approved Mental Health Professionals (AMHPs) (Local Authority)
- Minutes of the previous Committee meeting held on 28 August 2018 (attached to Trust Board papers).

RW commented that the Trust was seeing significant additional pressure around the decisions to detain people within parameters set down by law. TB commented that it would be reiterated to partners as part of learning lessons events.

It was RESOLVED to RECEIVE the updates provided.

TB/18/113 Use of Trust Seal (agenda item 11)

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

TB/18/114 Trust Board work programme 2018/19 (agenda item 12)

It was RESOLVED to NOTE the work programme.

TB/18/115 Date of next meeting (agenda item 13)

The next Trust Board meeting held in public will be held on Tuesday 29 January 2019, Small conference room, Wellbeing & learning centre, Fieldhead, Ouchthorpe Lane, Wakefield.

TB/18/116 Questions from the public (agenda item 14)

There were no questions received from the public.

Signed: **Date:**

NHS
South West Yorkshire Partnership
NHS Foundation Trust

TRUST BOARD 18 DECEMBER 2018 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 18 December 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/106 Service User Story	AM commented that normally the Board would have a discussion at this point of the meeting about any issued raised. Due to lack of time, AM asked the Board to provide their reflections and feedback on the stories so a collective response could be provided, and undertook to follow up personally with both carers.	AM		
TB/18/108a Integrated performance report Month 7 2018/19	LC asked, in relation to the Friends & Family Test, if there were any themes or trends for those who responded as extremely unlikely to recommend. TB to confirm.	TB		Since 1 April 2018 the Trust has received 5,290 responses to the F&FT. Of these, 105 were 'Extremely unlikely' (2%). The main 2 themes coming out of the free text responses from these 105 are: - Waiting times / access to services - Staff attitude – generally issues with individual members of staff
TB/18/108a Finance report Month 8 2018/19	LC commented that it would be good to have some overall Board visibility on the agency initiatives taking place. RW commented that the Board had to complete a self-certification in December 2016 and it might we worth using this to review progress made. This is an area that is reviewed by the Workforce & Remuneration Committee. RC suggested that an update is provided to the Board after the next Committee meeting in February 2019.	SThi / MB	March 2019	
TB/18/108b Serious Incident report Quarter 2 2018/19	LC commented that the report showed Barnsley community had the highest level of incidents and asked if there was a theme. TB commented that he believed these were in relation to tissue viability issues and pressure ulcers. TB to confirm.	TB		TB confirmed that the service reports all pressure ulcers (Pus) they observe, for any patient under the care of Neighbourhood nursing service – e.g. whether in the home, care home, attributable to SWYPFT care or not, this includes all categories of PU. This accounts for high level of reporting.

Min reference	Action	Lead	Timescale	Progress
TB/18/110a Assessment against NHS Constitution	KQ commented that it was important that staff are receiving messages and asked if their views were sought on internal communications such as "The Brief" monthly communication and "The View" weekly communication. AM commented that, at a recent staff side meeting, they said an app had been piloted in the Trust, which may be an easier way to communicate messages and asked about the status of this now.	SY		
TB/18/110c Emergency Preparedness, Resilience & Response (EPRR) Compliance	LC commented that, in relation to some areas, it looked like all providers were doing what they needed to do and asked why it was not rated as fully compliant. AGD commented that the report was triangulated with West Yorkshire partners and agreed that it should remain partial at this stage until all evidence was in place. AM asked where the Board could see the evidence against all the standards. AGD to circulate.	AGD		
	The Board discussed whether all members felt informed enough on future plans to provide challenge and requested: ➢ that the Health & Safety session planned for the Trust Board in March 2019 include EPRR and the communication process; and ➢ that the full copy of the plan be circulated to the Trust Board.	AGD / SY	March 2019	Separate briefing session scheduled for the Trust Board in March 2019.

Outstanding actions from 30 October 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/93a Strategic overview of business and associated risks	The Board discussed whether the level of detail within the report was useful and requested the following areas be considered: ➢ Whether enough was being done to capitalise on the strengths and opportunities that were in the Trust's control. ➢ Highlight key areas on the front cover, including what would be done as a result of the analysis and any actions identified. ➢ Inclusion of the last review date within the report.	SY	April 2019	

Min reference	Action	Lead	Timescale	Progress
	➢ Whether data sharing in relation to the Clinical Records System and safety issues from the CQC inspection were prominent enough, as raised by the Shadow Board. ➢ Further areas to be reflected in the report including universal credit rollout, legal regulatory framework through the Health & Safety Executive with a focus on managing aggression and violence (MAV) and manual handling, changes to NHS England and NHS Improvement. ➢ Importance of horizon scanning and whether the external stakeholder survey could be refreshed and repeated to assist with providing an external view.			
TB/18/93c Corporate / organisational risk register (ORR)	RC suggested that more information be referenced on the front cover in relation to the work that committees are doing to manage risks.	MB	January 2019	Complete. Updated paper on the agenda for Trust Board meeting on 29 January 2019.
	RC asked in relation to Risk ID 1212, regarding the risk that the impact of re-commissioning on staff morale leads to sub-optimal performance and increased staff turnover, whether it should be reviewed by the Workforce & Remuneration Committee as a workforce issue rather than the Audit Committee.	MB/AGD	January 2019	Complete. Risk realigned to Workforce & Remuneration Committee. Note, currently managed within risk appetite.
	REQUEST that Risk ID 1368, in relation to children and younger people requiring a CAMHs bed are temporarily located in a bed designated for adults, be looked at in detail.	CH	January 2019	Complete. Updated paper on the agenda for Trust Board meeting on 29 January 2019.

Outstanding actions from 25 September 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/78 Chair and Chief Executive's remarks (Chief Executive's	AM commented that she had seen new legislation had recently been brought into effect which meant stiffer sentences for people who assault emergency workers, including NHS staff. AGD commented that the guidance would be reviewed to ensure the Trust had the right tolerance level and balance within the services it provides.	AGD	January 2019	

Min reference	Action	Lead	Timescale	Progress
report)				
TB/18/81a Appraisal / Revalidation Annual Board Report 2017/18	AM asked who would form part of the new group and who would have oversight. SThi commented that work was taking place on the terms of reference and the proposal was for it to be a supporting group to be established to look at informal concerns. RW commented that it was important that the appropriate oversight was in place during the year if there was a decision taken that an appraisal was not acceptable against the standards rather than waiting for an annual report. *Update 30 October 2018:* Alan Davis (AGD) commented that work was in progress and an update was expected to come back to the Executive Management Team (EMT) in November 2018 then an update would come back to Trust Board. *Update 18 December 2018:* Further guidance received from the Nursing & Midwifery Council (NMC), update back to the Board in January 2019.	AGD / SThu	January 2019	
TB/18/81c Health & Safety Annual Report 2017/18	MB commented that there was a lot of legislation that the Trust needs to comply with and it was important for the Board to receive assurance that all areas were covered. AGD commented that previously Capsticks had provided some specific training to the Board which could be scheduled again.	AGD	March 2019	Complete. Briefing session scheduled for Trust Board in March 2019.
	RW commented that the report provided a sequential view however the new priorities were being received formally half way through the financial year. RW asked if the Board could consider the priorities annually in March. AGD commented that the action plan could be separated from the annual report.	AGD	March 2019	

Outstanding actions from 31 July 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/67a	LC asked if there had been an assessment of the	AGD	January 2019	Complete. Updated paper on the agenda for Trust

Min reference	Action	Lead	Timescale	Progress
Estates Strategy update	community hubs as part of a post project implementation review. AGD commented that they had been completed and would be reported to the EMT and could be included in the next update to Trust Board.			Board meeting on 29 January 2019.
TB/18/68b Proposal for the use of e-cigarettes (agenda item 10.2)	The Trust Board requested assurance of effective implementation from the post implementation review at 6 months. *Update 25 September 2018:* To be added to work programme for April 2019.	CH	April 2019	Complete. Added to the work programme for 2019-20.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 5

Title:	**Chief Executive's report**
Paper prepared by:	Chief Executive
Purpose:	To provide the strategic context for the Trust Board conversation.
Mission/values/Objectives:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers/ previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.
Executive summary:	➢ This is a more detailed paper than usual, given the lack of an edition of The Brief in late December 2018. ➢ The paper sets out national developments on Brexit, the NHS Long Term Plan and associated work. ➢ The paper sets out how Integrated Care Systems (ICS') fit into this context. ➢ The paper emphasises the importance of our leadership at this time.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019
Chief Executive's Report

Purpose of this paper

1. This paper describes the strategic and operational context within which we operate. The Board is asked to:

    a. Note national, regional and local developments
    b. Discuss any points that relate to strategic ambitions and risks

National developments

2. **The political agenda is dominated by Brexit discussions with the possibility of a "no deal" scenario still in play.** As described in the last Chief Executive's report, this has triggered national contingency planning arrangements on issues for the NHS like workforce and drug supply. Matthew Swindells, deputy Chief Executive of NHS England is overseeing the arrangements. He is supported on operational matters by Professor Keith Willets. A set of governance arrangements covering the country through NHS England's 7 Regions is in place. This links in turn to Local Resilience Fora coordinated through councils and local stakeholders. Our nominated lead for planning is the Director of Human Resources, Organisational Development and Estates. An update on the latest position is included on the Board agenda. Check

3. **The Long Term Plan for the NHS has been published, alongside 5 year allocations for Clinical Commissioning Groups (CCGs) and draft financial control totals for NHS Trusts and Foundation Trusts.** This plan has been cautiously welcomed by many commentators and national stakeholders. A full briefing on the plan and associated papers is included in the Board papers. The Board will note the breadth of the commitments in the plan, including on mental health services, community services, wellbeing and services for people with a learning disability. **Overall, the plan is significantly aligned with the strategy of the Trust.**

4. **Funding for Mental Health, Primary and Community services will increase in line with CCG allocations.** Across our CCGs, the overall growth in allocations is 5.8% cash, which should set the "investment standard" for these services. Our expectation should be that some funds will flow into new services and to meet significant demand pressures in our Trust. The Board is aware that trust budgets have been reducing in recent times and that there is no guarantee of additional resources until commissioning intentions have been set and contracts have been negotiated.

5. **Allocations to CCGs have been amended this year, with an improved and more accurate formula for Community and Mental Health services.** This means our local CCGs will have resources allocated that more accurately reflect need. It has been of

concern to us for some time that the previous formula appeared to show unlikely variations in morbidity between places such as Bradford and Wakefield. This in turn impacted on need adjusted benchmarking data.

6. **There is still a level of detail missing from the planning guidance, including the allocation of targeted funds to support some developments.** This is likely to follow to inform the five year plans that will be coordinated by our two Integrated Care Systems (ICS) in West Yorkshire and Harrogate (WY&H) and South Yorkshire and Bassetlaw (SY&B). The timescales for this are for guidance in the Spring and plans to be finalised by the Autumn.

7. **Despite Brexit consuming most parliamentary time, there are some legislative changes that the Government has agreed to make in principle.** These are aimed at ensuring collaboration is strengthened within the system, with greater powers for regulators to direct NHS Foundation trusts, for example.

8. **Concern remains that important funding streams and strategic developments on Local Government, Social Care and Workforce remain unclear.** The much awaited Social Care green paper has yet to emerge. The workforce budgets for the NHS, alongside other central budget for the Department of Health and Social Care, will not be settled until the spending review later this year. Most commentators are clear that this will cause a problem with effective planning. In my media engagements on the Today Programme and in national media, I have made the same points.

9. **Julian Hartley, Chief Executive of the Leeds Teaching Hospitals Trust, has been seconded to NHS Improvement to oversee the development of the Workforce Strategy for the NHS.** Over the next ten weeks he will develop a plan that will address the issues we face as workforce is the biggest single rate limiting factor for implementing the plan. This will be familiar to Board members from the work done at Board and in the Workforce and Remuneration Committee. The Board should also be aware that WY&H ICS has published a local workforce strategy https://www.wyhpartnership.co.uk/our-priorities/workforce and the SY&B ICS has a similar set of considerations in play.

10. **The national bodies continue to develop their new operating model and the long term plan confirms that CCGs face 20% cuts in management costs.** Several new roles have been appointed to in national bodies https://www.england.nhs.uk/2018/12/nhs-england-and-nhs-improvement-announce-new-senior-leadership-posts/ including the movement of Health Education England's reporting lines into NHS Improvement https://www.hee.nhs.uk/news-blogs-events/news/public-statement-health-education-england-nhs-improvement. This consolidation of national organisations and reporting lines should help coherence in planning and oversight of local systems and organisations.

11. **The focus on digital solutions for the NHS continues.** The secretary of state for health and social care, Matt Hancock, continues to promote technological solutions to NHS problems. This is right, given the opportunities that exist in this field. To help, a technology panel has been created made up of industry experts https://www.gov.uk/government/news/health-technology-expert-panel-meets-for-

the-first-time. WY&H ICS hosted Non-Executive Directors from NHS England, NHS Improvement and NHS Digital last week. The two day visit included a range of sessions showing how the partnership works; the impact of digital developments in Leeds and Wakefield; and significant opportunities for digital developments in WY&H that deliver economic benefit.

12. **Data on the Workforce Race Equality Standard (WRES) have been published.** https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/workforce-race-equality-standard-2018-report/**.** Improvements in equality, diversity and inclusion are being mandated in the long term plan, with an initial focus on the WRES. In governance terms, the Equality and Inclusion forum has a role to play. In terms of leadership, we can point to a Board that has appointed 7 people since I arrived in post, with 6 of them being female and 3 from a BAME (Black, Asian and Minority Ethnic) background. In addition our BAME network has a new leadership, with Afsana Aslam and Cherrill Watterson now picking up the chair and vice chair roles. This leadership now needs to help change the culture in the organisation to one where BAME staff feel the improvements that we have made in processes around recruitment, selection and training are changing their experiences and expectations.

WY&H, SY&B and place based developments

13. **Integrated care systems have a bigger role in planning and delivery.** This is apparent in 2019/20 plans, that now need signing off by the ICS' locally, as well as the lead role ICS play in the development of new 5 year plans. Changes to the national bodies and to the commissioning landscape mean that staff may be more aligned to ICS roles. For example, commissioning support units should be better aligned to the functions of ICS'. This work is progressing in both WY&H and SY&B. Given the differing approaches in each ICS, there will be different solutions that emerge. What is clear is that the movement of commissioning towards three different levels is accelerating:

    a. Greater capacity in integrated providers at a local level
    b. Joint capacity with councils in each of the places within an ICS
    c. Some functions shared across the ICS footprint.

14. **This is playing out in each of our local places.** There is a report in the Board papers that covers this in more detail.

15. **At this stage, as ICS leader in WY&H, I am constantly reminding people that the ICS is a system with a partnership function that provides effective support on a shared agenda.** This ethos is important. The ICS is our partnership that we have created with others to serve our interests. If we treat the ICS as an organisation that covers WY&H or SY&B we risk recreating hierarchical ways of working that undermine subsidiarity as a principle.

16. **Our two integrated systems remain influential and are developing their capacity and impact.** The importance given to ICS by the national bodies is evident from the

paragraphs above and the commitment in the long term plan to have ICS' covering the whole country by 2021. The Board papers include updates on our two ICS' in detail.

17. **There have been a number of leadership changes across the system locally**. The importance of relationships across our ICS' cannot be underestimated. This was a theme of a recent session with the Kings Fund and the WY&H ICS. It is worth noting that:

    a. **Amanda Bloor** has become the joint accountable officer for three CCGs in North Yorkshire, having previously looked after Harrogate and Rural District CCG.
    b. **Clive Kay** has been appointed to the role of CEO of Kings College Hospitals London and will depart his role as CEO of Bradford Teaching Hospitals Trust.
    c. **Yvette Oade** will act as CEO of Leeds Teaching Hospitals Trust in the absence of Julian Hartley.
    d. **Bradford Teaching Hospitals NHS Foundation Trust and Mid Yorkshire Hospitals NHS Trust** are both seeking new chairs**.**
    e. **Diana Terris** will be stepping down as CEO of Barnsley Council later this year.

18. **Strategic developments continue in each of our places.** This is reflected in the paper to the Board. It is worth noting that the importance of primary care networks, joined up care in each place and effective commissioning arrangements between councils and NHS trusts is apparent everywhere. Developments like the provider alliance in Wakefield and New Care Models for specialist services are a firm foundation for the future.

Trust issues

19. **The integrated performance report demonstrates progress against our strategic priorities and operational plan.** The Trust continues to make significant progress on a number of fronts. Strategic and operational risks are being managed and are set out in the Board Assurance Framework and Risk Register. The degree of risk being carried is significant.

20. **In this context, we are strengthening capacity and focus in key areas.** This includes the appointment of external capacity on managing out of area placements and changes to the operational structure. On the latter, Chris Lennox has been appointed as the Deputy Director with responsibility for inpatient mental health beds across the Trust. This will help standardisation of good practice. Chris will be appointing to a new clinically led structure.

21. **We are into the planning process for next year, which will inform prioritisation of capacity and our delivery challenges**. This in turn will be informed by contract conversations with our commissioners and support from our key partners.

22. **This is all taking place in the heart of winter, with service pressures and regulatory scrutiny higher than usual.** The impact of all of this on our staff and leadership is being offset by a strong focus on health and wellbeing. It is especially pleasing to see that we have exceeded our flu target for the year, with around 76% of staff vaccinated. This is only a small component of our #AllofUs campaign. A presentation that describes our

work and its impact has been shared with Board members separately. This shows that with appropriate insight, capacity, creative flair and focus, we deliver results.

Conclusion

23. **This is a critical time for the Trust.** We exist to help people fulfil their potential and live well in their community. To achieve our mission, we must continue to live our values; join up care with our partners; put safety first, and know quality counts; use our resources wisely; and, above all support our staff. The Board's leadership will be tested on this in the coming months. We need to be ready to make some tough choices and hold our nerve on things we know will make a difference in this period of flux and political uncertainty.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 6.1

Title:	**Board Assurance Framework (BAF) Quarter 3 2018/19**
Paper prepared by:	Director of Finance & Resources
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives.
Mission / values:	The assurance framework is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.
Any background papers/ previously considered by:	Previous quarterly reports to Trust Board.
Executive summary:	**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. In terms of development of the BAF there are two areas of improvement agreed with Internal Audit that will be put in place in

readiness for the next review of the BAF at Trust Board. These developments will highlight whether assurances are positive or negative and which are provided externally.

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

Our six strategic priorities		
Improving health	**Improving care**	**Improving resources**
Working in partnership	Safety first, quality counts and supporting our staff	Ready for tomorrow: Operational excellence

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

Strategic objective	**Strategic risk (abbreviated)**	**Assurance level**		
Strategic objective	**Strategic risk (abbreviated)**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**
Improving health Working in partnership	1.1 Differences in published local priorities could lead to service inequalities across the footprint	**Y**	**Y**	**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**	**Y**	**Y**
	1.3 Differences in the services may result in inequitable services offers across the Trust	**Y**	**Y**	**Y**
Improving care Safety first, quality counts and supporting our staff	2.1 Lack of suitable and robust information systems leading to lack of high quality management and clinical information	**Y**	**Y**	**Y**
	2.2 Inability to recruit and retain skilled workforce leading to poor service user experience	**Y**	**Y**	**Y**
	2.3 Failure to create learning environment leading to repeat incidents	**Y**	**Y**	**Y**
	2.4 Increased demand for and acuity of service users leads to a negative impact on quality of care	**Y**	**A**	**A**
Improving resources Ready for tomorrow: Operational excellence	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to deliver capital programme	**A**	**A**	**A**
	3.2 Failure to develop commissioner relationships to develop services	**Y**	**Y**	**Y**
	3.3 Failure to deliver efficiency	**A**	**A**	**A**

	improvements / CIPs			
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	G	G	G

The following changes have been made to the BAF since the last Board report in October 2018:

Strategic objective	Areas updated
Improving health Working in partnership	Strategic risk RAG ratings reviewed and remain unchanged.
	Key added for control and assurance inputs following recommendation from internal audit. (I=Internal, E=External, P=Positive, N=Negative)
	Rational for current assurance level updated.
	Strategic risk 1.1 - Gap in assurance completion dates updated and narrative included.
	Strategic risk 1.2 - Gap in assurance completion dates updated and narrative included.
	Strategic risk 1.2 - Gap in control completion dates updated and narrative included.
	Strategic risk 1.3 - Gap in assurance completion dates updated and narrative included.
Improving care Safety first, quality counts and supporting our staff	Strategic risk RAG ratings reviewed and remain unchanged.
	Key added for control and assurance inputs following recommendation from internal audit: I=Internal, E=External, P=Positive, N=Negative
	Rational for current assurance level updated.
	Strategic risk 2.1 - Gap in assurance completion dates updated and narrative included.
	Strategic risk 2.2 - Gap in control completion dates updated and narrative included.
	Strategic risk 2.2 - Gap in assurance completion date updated and narrative included.
	Strategic risk 2.3 - Gap in control completion dates updated and narrative included.
Improving resources Ready for tomorrow: Operational excellence	Strategic risk RAG ratings reviewed and remain unchanged.
	Key added for control and assurance inputs following recommendation from internal audit: I=Internal, E=External, P=Positive, N=Negative
	Rational for current assurance level updated.
	Strategic risk 3.1 - Gap in assurance completion dates updated and narrative included.
	Strategic risk 3.2 - Gap in assurance completion dates updated and narrative included.
	Strategic risk 3.3 - Gap in control completion dates updated and narrative included.
	Strategic risk 3.3 - Gap in assurance completion dates updated and narrative included.

Recommendation:	**Trust Board is asked to:** ➢ **NOTE and the controls and assurances against the Trust's strategic objectives for Quarter 3 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, DO=Director of Operations, DPD=Director of Provider Development

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.

Controls and Assurance inputs: I=Internal, E=External, P=Positive, N=Negative

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 - Working in partnership	1.1 Differences in published local priorities could lead to service inequalities across the footprint	4	A	Y	Y	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	Y	Y	
	1.3 Differences in the services may result in inequitable services offers across the Trust	10	Y	Y	Y	Y	
Improving care - Safety first, quality counts and supporting our staff	2.1 Lack of suitable and robust information systems leading to lack of high quality management and clinical information	13	Y	Y	Y	Y	
	2.2 Inability to recruit and retain skilled workforce leading to poor service user experience	15	Y	Y	Y	Y	
	2.3 Failure to create learning environment leading to repeat incidents	18	Y	Y	Y	Y	
	2.4 Increased demand for and acuity of service users leads to a negative impact on quality of care	20	N / A	Y	A	A	
Improving resources - Getting ready for tomorrow: operational excellence	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to deliver capital programme	23	A	A	A	A	
	3.2 Failure to develop commissioner relationships to develop services	26	A	Y	Y	Y	
	3.3 Failure to deliver efficiency improvements / CIPs	28	A	A	A	A	
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	30	Y	G	G	G	

Strategic Objective:	Lead Director(s)	Key Board or Committee	Overall Assurance Level			
1. Improving health - Working in partnership	As noted below	EMT, CGCS, MHA	Q1	Q2	Q3	Q4
			Y	Y	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)

- 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 involvement and engagement with West and South Yorkshire Integrated Care Systems.
- Trust involved in development of place based plans and priority setting.
- Involved in development of Integrated Care Partnerships in Barnsley (establishment of Integrated Care Partnership Group), Calderdale, Kirklees and Wakefield (establishment of Mental Health Provider Alliance).
- 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 8 out of area beds – red, children and young people accommodated on an adult inpatient ward – red, 7 day follow up– green, physical health – green, % clients in settled accommodation - green.
- 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. (I)	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. (I)	C02	DO	1.1
Senior representation on West Yorkshire mental health collaborative and associated workstreams. (I)	C03	DPD	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. (I,E)	C04	DS	1.1, 1.2
Annual business planning process, ensuring consistency of approach, standardised process for producing businesses cases with full benefits realisation. (I)	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. (I)	C06	DFR	1.1, 1.2
Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	C07	DS	1.1, 1.3
Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	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. (I,E)	C09	DO	1.1, 3.3
Engagement and representation on South Yorkshire integrated care system mental health work streams and partnership group. (I,E)	C77	DS	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. (I)	C78	DO	1.1, 1.3

Gaps in control - what do we need to do to address these and by when?	**Date**
Impact on services as a result of local authority cuts – actions identified on the Organisational Risk Register. (Linked to ORR Risk ID 275, 1077)	Ongoing
Impact of local place based solutions and Integrated Care System initiatives – recognition that some of this is out of our control and ensure engagement takes place in each area impacted. (Linked to ORR Risk ID 812)	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. (P,N) (I)	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.(P) (I)	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. (P) (I)	A03	DNQ	1.1

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**
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. (P) (I)	A04	CEO	1.1
Independent PLACE audits undertaken with results and actions to be taken reported to Executive Management Team (EMT), Members' Council and Trust Board	Service users and Directors involved in assessments. (P) (I, E)	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 evaluation plan 2018/19 taken to CG&CS Committee June 2018. (P) (I)	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). (P) (I)	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 reported to Trust Board when available with associated plans. (P, N) (I, E)	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. (I)	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. (P, N) (I)	A10	DO	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. (P) (I)	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	Annual unannounced and planned visits programme in place and annual report is now received directly by the CG&CS Committee. The annual report for 2017/18 was received by the CG&CS Committee in June 2018. (P, N) (E)	A12	DNQ	1.1, 1.2, 2.4
Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement	Operational plan for 2018/19 approved at Trust Board April 2018. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. (P, N) (I)	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. (P) (I)	A14	DFR	1.1, 1.3, 2.4
Rolling programme of staff, stakeholder and service user/carer engagement and	Communication, engagement and involvement strategy 2016-2019	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**
consultation events	(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 service user & carer engagement events across the year plus Annual Members' Meeting September 2018. Engagement through Members' Council. Stakeholder engagement through involvement in new models of care in each place. (P) (I, E)			

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. (Linked to ORR Risk ID 812). *(Note, expected completion date changed from Dec 2018 to Jan 2019 as publication of national guidance and long term plan has been delayed)*	Jan 2019
Assessment of place based plans in each Integrated Care System. (Linked to ORR Risk ID 812). *(Note, expected completion date changed from Dec 2018 to Feb 2019 as plans will be completed once plans have been complete following publication of the long term plan)*	Feb 2019

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 agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I,E)	C04	DS	1.1, 1.2
Annual business planning process, ensuring consistency of approach, standardised process for producing businesses cases with full benefits realisation. (I)	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. (I)	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. (I, E)	C10	DNQ	1.2
Governors' engagement and involvement on Members' Council and on working groups, holding Non-Executive Directors (NEDs) to account. (I)	C11	DFR	1.2
Partnership Fora established with staff side organisations to facilitate necessary change. (I)	C12	DHR	1.2
Priority programmes supported through robust programme management approach. (I)	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. (I)	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. (I,E)	C16	DS	1.2, 2.2

Gaps in control - what do we need to do to address these and by when?	**Date**
Agreement and development of implementation plan for Trustwide operational management arrangements due October 2018 complete. Implementation of new arrangements for leadership of the inpatient wards due April 2019.	April 2019

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. (P,N) (I)	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. (P) (I)	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. (P) (I, E)	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 evaluation plan 2018/19 taken to CG&CS Committee June 2018. (I)	A06	DNQ	1.1, 1.2, 1.3
Strategic priorities and programmes monitored and scrutinised through	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT).	A07	DS	1.1, 1.2, 1.3, 2.1,

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**
Executive Management Team (EMT) and reported to Trust Board through IPR	(P) (I)			3.4
Service user survey results reported annually to Trust Board and action plans produced as applicable	NHS mental health service user survey. Results are reported to Trust Board when available with associated plans (P,N) (I, E))	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. (P) (I)	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. (P, N) (I)	A10	DS	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. (P) (I)	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 (P,N) (E)	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	Operational plan for 2018/19 approved at Trust Board April 2018. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. (P, N) (I)	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 (P) (I)	A16	DHR	1.2
Update reports on WY and SY ICS progress	Routine report into EMT and Board (P) (I)	A17	DS	1.2
Reports from Transforming Care Board and Calderdale, Kirklees and Wakefield Partnership Board	Update reports into EMT (P, N) (I)	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. (P, N) (I)	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. (P, N) (I, E)	A20	DFR	1.2, 3.1, 3.2, 3.3
Monthly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to Trust Board (P, N) (I)	A21	DFR	1.2, 3.1, 3.2, 3.3

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**
development activity				
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. (P, N) (I)	A22	DO	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**
Improved commissioning intentions intelligence required. *(Note, expected completion date changed from Dec 2018 to Jan 2019 due to publication of national guidance and long term plan has been delayed)*	Jan 2019
Benchmarking data unavailable for some services and limited number of statistically similar organisations.	Ongoing

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. (I)	C07	DO	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. (I)	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. (I)	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. (I)	C18	MD	1.3
Clear Trustwide policies in place that are agreed by the Executive Management team.(I)	C19	DS	1.3
Implications of Carter report for services considered at OMG and actions identified. (I)	C20	DO	1.3
Participate in national benchmarking activity for mental health services and act on areas of significant variance. (I)	C21	DFR	1.3
Director of operations post developed to lead operational delivery across the Trust. (I)	C78	DO	1.1, 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. (Linked to ORR Risk ID 812)	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. (P, N) (I)	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. (P) (I)	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. (P) (I, E)	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 evaluation plan 2018/19 taken to CG&CS Committee June 2018.(I)	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).(P) (I)	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 are reported to Trust Board when available with associated plans.(I, E)	A08	DNQ	1.1, 1.2, 1.3, 2.3, 2.4
Transformation change and priority programme plans monitored and	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT).	A09	EMT	1.1, 1.2, 1.3, 2.4,

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**
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 to delivery EMT. Quarterly report to Audit Committee and CG&CS Committee re. quality impact. (P) (I)			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. (P) (I)	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 May & June 2018, various engagement events across the year plus Annual Members' Meeting September 2018. (P, N) (I, E)	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. (P, N) (I)	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. *(Note, expected completion date changed from Dec 2018 to Jan 2019 as publication of national guidance has been delayed.)*	Jan 2019
Impact of medical workforce retention / turnover in certain specialities and assessment through recruitment and retention strategy. This is linked to the Trust Recruitment and Retention strategy with an ongoing action plan.	*(Dec 2018) Complete*

Strategic Objective:	Lead Director(s)	Key Board or Committee	Current Assurance Level			
2. Improving care - Safety first, quality counts and supporting our staff	As noted below	EMT, WRC, CGCS	Q1	Q2	Q3	Q4
			Y	Y	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**	A

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 8 shows: Friends & Family Test MH green, F&F Test Community amber, safer staff fill rates green, IG confidentiality breaches red, people dying in their place of choosing - green
- 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. (I)	C22	DFR	2.1
Digital strategy in place with quarterly report to Executive Management Team (EMT) and half yearly report to Trust Board. (I)	C23	DFR	2.1
Programme established for implementing new clinical record system. (I)	C24	DS	2.1
Risk assessment and action plan for data quality assurance in place. (I)	C25	DFR	2.1
Customer services reporting includes learning from complaints and concerns. (I)	C26	DNQ	2.1, 2.2, 2.3
Datix incident reporting system supports review of all incidents for learning and action.(I)	C27	DNQ	2.1, 2.2, 2.3
Integrated change management arrangements focus on co-design. (I)	C28	DS	2.1, 2.3
Patient Safety Strategy developed to reduce harm through listening and learning. (I)	C29	DNQ	2.1, 2.2, 2.3
Weekly risk scan where all red and amber incidents are reviewed for immediate learning. (I)	C30	DNQ/MD	2.1, 2.2, 2.3
Quality Improvement network established to provide trustwide learning platform. (I)	C31	DNQ	2.1, 2.2, 2.3
Quality Strategy achieving balance between assurance and improvement. (I)	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. (I)	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.	Quarter 4
Limited use of reports generated using the data warehouse tool with resource currently focused on SystmOne implementation.	2019
Limited data on caseload, real time waiting list issues, face to face time.	2019

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. (P) (I)	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.(P) (I)	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. (P) (I)	A07	DS	1.1, 1.2, 1.3, 2.1, 3.4
Business cases for expansion/change of services approved by Executive	Contracting risks, bids & tenders update standing item on delivery EMT agenda.	A10	DS	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**
Management Team (EMT) and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework	Report to Board bi-annually. (P, N) (I)			
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.(P) (I)	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 (P, N) (I)	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. (P) (I)	A24	DNQ	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. (P) (I)	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. (P) (I)	A26	DFR	2.1
Customer service reports to board and CGCS	Monthly reports to board/EMT and bi-monthly into CGCS (P, N)	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 (P) (I)	A28	DS	2.1 2.2 2.3
Quality strategy implementation plan reports into CGCS	Routine reports into CGCS (I)	A29	DNQ	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. (P) (E)	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 audit report on SystmOne implementation governance arrangements.	Quarter 3
Development plan and implementation to more extensively generate and use management reports using the data warehouse. *(Note, expected date of completion changed from Quarter 3 as this is on hold given the focus of the team on the SystmOne implementation)*	2019
Follow up of actions identified in data quality internal audit (Note, all actions from internal audit have been completed)	*Quarter 3 Complete*
Completion of review of decision-making framework (Scheme of Delegation) to inform delegated authority at all levels (to Audit Committee).	Quarter 4
CIP delivery is currently behind plan and there is an overspend in relation to out of area bed placements.	Quarter 4
Delivery of 17/18 financial control total was only been achieved through a range of non-recurrent means. 18/19 financial forecast includes a number of non-recurrent measures.	Quarter 4
Internal audit reports with partial assurance management actions agreed by lead Director.	As per Audit report
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 I, E)	C16	DS	1.2, 2.2
Customer services reporting includes learning from complaints and concerns (I)	C26	DNQ	2.1, 2.2, 2.3
Datix incident reporting system supports review of all incidents for learning and action (I)	C27	DNQ	2.1, 2.2, 2.3
Patient Safety Strategy developed to reduce harm through listening and learning (I)	C29	DNQ	2.1, 2.2, 2.3
Weekly risk scan where all red and amber incidents are reviewed for immediate learning (I)	C30	DNQ/MD	2.1, 2.2, 2.3
Quality Improvement network established to provide trustwide learning platform (I)	C31	DNQ	2.1, 2.2, 2.3
Quality Strategy achieving balance between assurance and improvement (I)	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 OMG, EMT and Trust Board (I)	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 (I)	C34	DHR	2.2
Annual learning needs analysis undertaken linked to service and financial meeting. (I)	C35	DHR	2.2
Education and training governance group established to agree and monitor annual training plans (I)	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 (I)	C37	DHR	2.2
Mandatory clinical supervision and training standards set and monitored for service lines (I)	C38	DHR	2.2
Medical leadership programme in place with external facilitation as and when required	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 (I)	C40	DHR	2.2
Recruitment and Retention action plan agreed by EMT (I)	C41	DHR	2.2
Recruitment and Retention Task Group established (I)	C42	DHR	2.2
Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs) (I)	C43	DHR	2.2
Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures (I)	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 (I)	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 (I)	C46	DO	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. (Linked to ORR Risk ID 905, 1151). Ongoing - Director of HR, OD & Estates and Director of Nursing & Quality are having regular meetings with local university.	Ongoing
Exit interviews and questionnaire have a poor response rate and therefore Trust does not have a complete picture of why staff are leaving. Recruitment and Retention Task group streamlining process and monitoring response rate including medical workforce. Complete - New arrangements in place and response rate significantly increased.	*Sept 2018 Complete*
Support needed for a tailored medical leadership / talent development programme. Currently capacity issues exist to support this.	Jan 2019
Lack of clear comms / branding for advertising medical posts with clarity on local facilities, relocation package and benefits gained by working for the trust. To be addressed as part of recruitment and retention strategy linked to medical workforce strategy. *(Note, expected completion date changed from Dec 2018 to Dec 2019 in terms of developing the comms and branding to support the recruitment retention strategy this will need to be agreed as a priority as it is a significant piece of work)*	Dec 2019

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. (P, N) (I)	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. (P) (I)	A02	DFR	All
Customer service reports to board and CGCS	Monthly reports to board/EMT and bi-monthly into CGCS (P, N) (I)	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 (P) (I)	A28	DS	2.1 2.2 2.3
Quality strategy implementation plan reports into CGCS	Routine reports into CGCS (I)	A29	DNQ	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 (P) (I)	A31	DHR	2.2
Appraisal uptake included in IPR	Monthly IPR goes to the Trust Board and EMT (P) (I)	A32	DHR	2.2
ESR competency framework for all clinical posts	Monitored through mandatory training report (P) (I)	A33	DHR	2.2
Mandatory training compliance is part of the IPR	Monthly IPR goes to the Trust Board and EMT (P) (I)	A34	DHR	2.2
Recruitment and Retention performance dashboard	Quarterly report to the Workforce and Remuneration Committee (P, N) (I)	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 (P)	A36	DNQ	2.2
Workforce Strategy performance dashboard	Quarterly report to the Workforce and Remuneration Committee (P) (I)	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.	Feb 2019
Sustainable workforce plan for CAMHS services. Complete - Developed an action plan with consultants to increase their leadership role including them supporting the development of a sustainable workforce. Further work will be developed through workforce planning workshops in January and February. This is also linked to the Trust Recruitment and Retention strategy.	*Dec 2018 Complete*
Impact of a no deal Brexit is currently unknown.	Mar 2019

Supply of a range of professions including doctors and nurses is insufficient to meet demand. (Linked to ORR ID 1151).	Ongoing

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 (I)	C26	DNQ	2.1, 2.2, 2.3
Datix incident reporting system supports review of all incidents for learning and action (I)	C27	DNQ	2.1, 2.2, 2.3
Integrated change management arrangements focus on co-design (I)	C28	DS	2.1, 2.3
Patient Safety Strategy developed to reduce harm through listening and learning (I)	C29	DNQ	2.1, 2.2, 2.3
Weekly risk scan where all red and amber incidents are reviewed for immediate learning (I)	C30	DNQ/MD	2.1, 2.2, 2.3
Quality Improvement network established to provide trustwide learning platform (I)	C31	DNQ	2.1, 2.2, 2.3
Quality Strategy achieving balance between assurance and improvement (I)	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 (I)	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 (I)	C46	DO	2.2, 2.3
Learning lessons reports, BDUs, post incident reviews (I)	C47	DNQ	2.3
Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training (I)	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 (I)	C49	DNQ	2.3

Gaps in control - what do we need to do to address these and by when?	**Date**
Monitoring of implementation of action plans linked to SI reports.	Ongoing
Quality Improvement approach launched – progress to implement improvement methodology to be evaluated by December 2019.	*(Dec 2018) Complete*

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. (P, N) (I)	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. (P) (I)	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 are reported to Trust Board when available with associated plans. (I, E)	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	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to	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**
undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation	EMT, Clinical Governance & Clinical Safety Committee and Trust Board. (I)			
Customer service reports to board and CGCS	Monthly reports to board/EMT and bi-monthly into CGCS. (P, N) (I)	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. (P) (I)	A28	DS	2.1 2.2 2.3
Quality strategy implementation plan reports into CGCS	Routine reports into CGCS. (P) (I)	A29	DNQ	2.1 2.2 2.3
Weekly risk scan update into EMT	Weekly risk scan update into EMT. (P, N) (I)	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	Routine report to each CG&CS Committee of risks aligned to the committee for review. (P) (I)	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**
Impact of information governance (IG) training and action plan on IG hotspots. (Linked to ORR Risk ID 852, 1216)	Jan 2019

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. (I)	C50	DO	2.4
Out of area bed reduction joint action plan with CCG. (I, E)	C51	DO	2.4
Performance management process and IPR at various levels of the organisation. (I)	C52	DFR	2.4
Safer staffing policies and procedures in place to respond to changes in need. (I)	C53	DNQ	2.4
TRIO management system monitoring quality, performance and activity on a routine basis. (I)	C54	DO	2.4
Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	C55	DO	2.4
Waiting list management improvement plan in place to support people awaiting a service/treatment. (I)	C56	DO	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. (P, N) (I)	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. (P) (I)	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 reported to Trust Board when available with associated plans. (I, E)	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. (P) (I)	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 2018/19. (E)	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. (P) (I)	A14	DFR	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**
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 May & June 2018, various engagement events across the year plus Annual Members' Meeting September 2018. (P) (I)	A15	DHR, DS, DMCEC	1.1, 1.3, 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. (P, N) (I)	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	Routine report to each CG&CS Committee of risks aligned to the committee for review. (P, N) (I)	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. (E)	A40	DNQ	2.4
Staff wellbeing survey results reported to Trust Board and/or Remuneration and Terms of Service Committee and action plans produced as applicable	Results will be reported when available. (P, N) (I)	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. (P) (I)	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**
Impact upon patients and families of out of area placements. (Linked to ORR 1319)	Mar 2019
Outcome of community mental health transformation programme review.	Jan 2019
Impact of waiting list in CAMHS services.	Jan 2019

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

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 deficit is higher than the reported number 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.
- CIP identification is below the required level for 2018/19.

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. **(I)**	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. (I)	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. (I)	C57	DFR	3.1
Standardised process in place for producing business cases with full benefits realisation. (I)	C58	DFR	3.1
Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities. (I)	C59	DFR	3.1
Annual financial planning process CIP and Quality Impact Assessment (QIA) process. **(I)**	C60	DFR DNQ	3.1, 3.3
Financial control and financial reporting processes. **(I)**	C61	DFR	3.1, 3.3
Regular financial reviews at Executive Management Team (EMT) including monthly focus when non-executive directors are also invited. (I)	C62	DFR	3.1, 3.3
Service line reporting / service line management approach. (I)	C63	DFR	3.1, 3.3
Weekly Operational Management Group (OMG) chaired by Director of Operations providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks. (I)	C64	DO	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 (Linked to ORR Risk ID 1077, 1214).	Ongoing
Risk of inability to achieve transitions identified in our plan (Linked to ORR Risk ID 695, 1114).	Ongoing
Trust has a history of not fully achieving its recurrent CIP targets (Linked to ORR Risk ID 1076).	March 2019
Reduction in Local Authority budgets negatively impacting on financial resource available to commission staff / deploy social care resource (Lined to 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 (Linked to ORR Risk ID 275).	Ongoing
All financial risk for out of area bed costs currently sits with the Trust (Linked to ORR Risk ID 1335).	March 2019
Increased risk of redundancy / lack of ability to redeploy if services are decommissioned at short notice (Linked to 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. (P, N) (I)	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. (P) (I)	A02	DFR	All
Business cases for expansion/change of	Contracting risks, bids & tenders update	A10	DS	1.1, 1.2,

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**
services approved by Executive Management Team (EMT) and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework	standing item on delivery EMT agenda. Report to Board bi-annually. Scheme of delegation. Reports to Audit Committee. (P, N) (I)		DFR	2.1, 3.1 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. (P) (I)	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	Operational plan for 2018/19 approved at Trust Board April 2018. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. (P) (I)	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. (P, N) (I)	A20	DFR	1.2, 3.1, 3.2, 3.3
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) and twice yearly to Trust Board (P, N) (I)	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. (P, N) (I)	A22	DO	1.2, 3.1, 3.3
Attendance of NHS Improvement at Executive Management Team (EMT) and feedback on performance against targets	NHS Improvement hold Quarterly Review Meetings with EMT. (P) (E)	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. (P) (I)	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. (P) (I)	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. (P, N) (I)	A45	DFR	3.1
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 last 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. The next review is scheduled for 2019. (P) (I)	A46	DFR	3.1
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. (P, N) (I)	A47	DO	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). Will reduce some levels of approval.	Quarter 4
CIP delivery is currently behind plan and not fully identified. Ongoing review of potential upsides and mitigations. *(Note, expected completion date changed from Quarter 3 to March 2019 as remains behind plan requirement, but has improved since previous quarter)*	March 2019
Internal audit reports with partial assurance management actions agreed by lead Director. Review of high and medium priority recommendations to be undertaken quarterly.	As per Audit reports
There is a significant increase in spend on out of area bed placements and an overspend against budget. Requesting non-recurrent financial support for 2018/19. *(Note, expected completion date changed from Quarter 3 to March 2019 as position will be further reviewed in Quarter 4 with commissioners)*	March 2019
Cash position is largely dependent on us delivering a surplus.	Ongoing
Balanced financial plan for 2018/19 not yet in place. Development of a financial sustainability plan. *(Note, expected completion date changed from Quarter 3 to March 2019. Wwork on the financial sustainability plan has commenced with an initial paper taken to December Trust Board. Further work scheduled for quarter 4.)*	March 2019

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. (I, E)	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. (I)	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. (I)	C65	DS	3.2
Forums in place with commissioners to monitor performance and identify service development. I, E)	C66	DO	3.2
Independent survey of stakeholders perceptions of the organisation and resulting action plans. (I, E)	C67	DS	3.2
Strategic Business and Risk Report including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power. (I)	C68	DS	3.2
Quality Impact Assessment (QIA) process in place. (I)	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. (Linked to ORR Risk ID 1077)	Ongoing
Level of tendering activity taking place. (Linked to ORR Risk ID 1214)	Ongoing
Refresh of actions to support the stakeholder engagement plans. *(Note, expected completion date changed from Oct 2018 to Dec 2018, work ongoing).*	Dec 2018

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. (P, N) (I)_	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.(P) (I)	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. (P) (I)	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. (P, N) (I)	A20	DFR	1.2, 3.1, 3.2, 3.3
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) and twice yearly to Trust Board (P, N) (I)	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. (P) (I)	A44	DS	3.1, 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**
Attendance at external stakeholder meetings including Health & Wellbeing boards	Minutes and issues arising reported to Trust Board meeting on a monthly basis.(P, N) (I,E)	A48	DO	3.2
Documented update of progress made against comms and engagement strategy	Monthly IPR to Executive Management Team (EMT) and Trust Board. (P, N) (I)	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. (*Note, expected completion date changed from Oct 2018 to Dec 2018, work ongoing)*	Dec 2018
Assessment of updated commissioning intentions. *(Note, expected completion date changed from Dec 2018 to Jan 2019 as publication of national guidance and long term plan has been delayed)*	Jan 2019
Assessment of place based plans within the Integrated Care Systems. *(Note, expected completion date changed from Dec 2018 to Feb 2019 as will be completed once plans have been complete following publication of the long term plan)*	Feb 2019

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. (I, E)	C09	DO	1.1, 3.3
Annual financial planning process and CIP process. (I)	C60	DFR	3.1, 3.3
Financial control and financial reporting processes. **(I)**	C61	DFR	3.1, 3.3
Regular financial reviews at Executive Management Team (EMT) including monthly focus when non-executive directors are also invited. (I)	C62	DFR	3.1, 3.3
Service line reporting / service line management approach. (I)	C63	DFR	3.1, 3.3
Weekly Operational Management Group (OMG) chaired by Director of Operations providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks. (I)	C64	DO	3.1, 3.3
Quality Impact Assessment (QIA) process in place. (I)	C69	DNQ	3.2, 3.3
Participation in benchmarking exercises and use of that data to shape CIP. Opportunities (I)	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. Review of NHSI checklist to further strengthen CIP delivery process. (Note, review has been completed and recommendations form part of the financial sustainability plans)			*Dec 2018 Complete*

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
Monthly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to Trust Board	A21	DFR	1.2, 3.1, 3.2, 3.3

development activity				
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	DO	1.2, 3.1, 3.3
Attendance of NHS Improvement 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
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	DO	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. Ongoing review of potential upsides and mitigations. (*Note, expected completion date changed from Quarter 3 to Mar 2019 as remains behind plan requirement, but has improved since previous quarter)*	Mar 2019
Balanced financial plan for 2018/19 not yet in place. Financial sustainability plan being developed. *(Note, expected completion date changed from Quarter 3 to Mar 2019 as work on the financial sustainability plan has commenced with an initial paper taken to December Trust Board. Further work scheduled for quarter 4)*	March 2019

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. (I)	C71	DHR	3.4
Director portfolios clearly identify director level leadership for strategic priorities. (I)	C72	CEO	3.4
Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (I)	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. (I)	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. **(I)**	C75	DFR	3.4
Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2018/19 priorities. (I)	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. (P, N) (I)	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.(P) (I)	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. (P) (I)	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. (P) (I)	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.(P) (I)	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	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**
	quarterly exception reports. Draft plan submitted March 2018. Final plan due 30 April 2018. (P, N) (I)			
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. (P) (I)	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. (P) (I)	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. (P) (I)	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.(P) (I)	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 29 January 2019
Agenda item 6.2

<table>
<tr><td>Title:</td><td>Corporate/Organisational Risk Register Quarter 3 2018/19</td></tr>
<tr><td>Paper prepared by:</td><td>Director of Finance and Resources</td></tr>
<tr><td>Purpose:</td><td>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.</td></tr>
<tr><td>Mission / values:</td><td>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.</td></tr>
<tr><td>Any background papers / previously considered by:</td><td>Previous quarterly reports to Trust Board.
Standing agenda item at each sub-committee meeting.
Triangulation of risk performance and governance report to Audit Committee and EMT in January 2019</td></tr>
<tr><td>Executive summary:</td><td>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 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.
<table>
<tr><th colspan="3">Our six strategic priorities</th></tr>
<tr><th>Improving health</th><th>Improving care</th><th>Improving resources</th></tr>
<tr><td>Working in partnership</td><td>Safety first, quality counts and supporting our staff</td><td>Ready for tomorrow: Operational excellence</td></tr>
</table>
The risk register is reviewed at each sub-committee meeting and any recommendations made to the Executive Management Team (EMT) to consider as part of the cyclic review. EMT re-assess risks 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 ORR contains the following 15+ risks:
<table>
<tr><th></th><th>Risk ID</th><th>Description</th></tr>
<tr><td></td><td>1080</td><td>Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.</td></tr>
<tr><td></td><td>1368</td><td>Risk that given demand and capacity issues across West Yorkshire and nationally children and younger people requiring a CAMHs bed are temporarily located in a bed designated for adults.</td></tr>
</table>
</td></tr>
</table>

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

Risks 15+

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	Actions updated	Reviewed by lead Director and EMT. Actions updated including additional actions.
	1368	Risk that given demand and capacity issues across West Yorkshire and nationally children and younger people requiring a CAMHs bed are temporarily located in a bed designated for adults.	Controls and actions updated	Reviewed by lead Director and EMT. Controls and actions updated including additional actions.

Risks below 15 (outside risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	905	Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications	Actions updated	Reviewed by lead Director and EMT. Additional action included.
	1078	Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment.	Controls and actions updated	Reviewed by lead Director and EMT. Controls and actions updated including additional actions.
	1369	Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing.	Risk level increased, actions and controls updated	Reviewed by lead Director and EMT. Risk consequence reduced to '4 major' and likelihood increased to '3 possible' – current risk level is now 12 and 'amber / high'. Actions and controls updated including additional control.
	1370	Risk that the cessation of the current waste management contract and transition to new arrangements results in the Trust being unable to dispose safely of its clinical waste.	Controls and actions updated	Reviewed by lead Director and EMT. Controls and actions updated including additional actions.
	522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	Actions updated	Reviewed by lead Director and EMT. Additional action included.
	852	Risk of information governance breach leading to inappropriate	Actions updated	Reviewed by lead Director and EMT. Actions updated

		circulation and / or use of personal data leading to reputational and public confidence risk.		including additional action.
	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.	Actions updated	Reviewed by lead Director and EMT. Actions updated including additional action.
	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.	Actions updated	Reviewed by lead Director and EMT. Actions updated.
	1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	Description and actions updated	Reviewed by lead Director and EMT. Risk description and actions updated including additional action.
	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.	Actions updated	Reviewed by lead Director and EMT. Actions updated.
	1158	Risk of over reliance on agency staff which could impact on quality and finances.	Actions updated	Reviewed by lead Director and EMT. Actions updated.
	1213	Risk that sub-optimal transition from RiO to SystmOne will result in significant loss or ineffective use of data resulting in the inability capture information, share information and produce reports.	Controls and actions updated	Reviewed by lead Director and EMT. Controls and actions updated including additional control.
	1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	Actions updated.	Reviewed by lead Director and EMT. Actions updated.
	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.	Actions updated	Reviewed by lead Director and EMT. Actions updated including additional action.
	1319	Risk that quality of care will be compromised if people continue to be sent	Actions updated	Reviewed by lead Director and EMT. Actions updated

		out of area.		including additional action.
	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	Actions updated	Reviewed by lead Director and EMT. Actions updated.

Risks below 15 (managed within risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	Actions updated	Reviewed by lead Director and EMT. Actions updated

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.

In addition, as part of EMT's cyclic review of the ORR the risks identified in Quarter 2 have been considered for inclusion:

- Inpatient safety, ligatures, and other actions following CQC report - Ligature risks are on the BDU risk registers and ligature reported to Clinical Governance & Clinical Safety Committee. A risk has been drafted which covers inpatient ligature risks, learning from deaths and complaints, and clinical risk assessments. This will be considered in more depth during the fourth quarter for inclusion in the risk register

As part of the Quarter 3 review, EMT reviewed the triangulation of risk performance and governance report (Audit Committee 9 January 2019) and considered red RAG rated areas in the Integrated Performance Report (IPR) which are not on the organisational level risk register:

- Complaints closed within 40 days below Trust's target of 80%, noting the regulatory requirement is within 6 months and work taking place - EMT agreed that actions will to be included as part of a risk in relation to learning.
- Mental health safety thermometer medicine omissions above the Trust target of 17.7% - EMT did not recommend for inclusion on the organisational level risk register.
- % clients in employment below national target of 10% EMT did not recommend for inclusion on the organisational level risk register.

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.

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.

	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**
Working in partnership	Safety first, quality counts and supporting our staff	Getting ready for tomorrow: 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
DO = Director of Operations
DPD = Director of Provider Development

AC = Audit Committee
CG&CSC = Clinical Governance & Clinical Safety Committee
MHA = Mental Health Act Committee
WRC = Workforce & Remuneration Committee
E&IF = Equality & Inclusion Forum

Actions in green are ongoing by their nature.

Trust Board (business and risk) - 29 January 2019

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. *(continued over)*	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 – NHS Digital re-considering its approach time scales are awaited. (DFR). (30 April 2019) ➢ 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 likely to be during Q4 18/19. (DFR). (31 March 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. *(continued over)*	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 – January 2019

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.					➢ Findings 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) ➢ Trust participating in "next generation firewall" pilot. (DFR) (October 2018 - January 2019) ➢ Cyber exercise scheduled for January 2019 (DFR) (31 January 2019)						Internal assurance report for the Trust controls and mechanisms in relation to the WannaCry Ransomware cyber-attack produced and all actions complete.	
1368	Risk that given demand and capacity issues across West Yorkshire and nationally children and younger people requiring a CAMHs bed are temporarily located in a bed designated for adults.	➢ Protocol in place for admission of children and younger people on to adult wards. ➢ The most appropriate beds identified for temporary use. ➢ CAMHS in-reach arrange to the ward to support care planning. ➢ Safeguarding policies and procedures. ➢ Safer staffing escalation processes. ➢ Bed management processes including exhausting out of area provision. ➢ Regular report to board to ensure that position does not become accepted practice. ➢ Safeguarding team scrutiny of all under 18 admissions. ➢ Letter sent to NHS England from Director of Nursing & Quality and Medical Director expressing concerns.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of new CAMHs inpatient facility in Leeds for West Yorkshire. (DO) (2020) ➢ Meeting led by NHSE took place with a follow up agreed for March 2019 (DO) ➢ Consider how the planned investment outlined in the long term plan can support improvements to services (MB/CH) (by June 2019)	DO	Ongoing risk given external influence outside our control	EMT (monthly) CG&CS (regular) Trust Board (each meeting through integrated performance report)	4 Yellow /Moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 The Trust ensures children and young people are only admitted to an adult bed as least worst option and ensure full safeguarding is in place when the need arises. This is in line with our "safety first" approach.	Every three months prior to business and risk Trust Board – January 2019

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. ➢ Weekly risk scan by Director of Nursing and Medical Director. ➢ BDU / commissioner forums – monitoring of performance. ➢ Monthly review through performance monitoring governance structure via Delivery EMT of key indicators and regular review at OMG 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. ➢ Regular ongoing review of contracts with local authorities.	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) ➢ 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. (DO) ➢ Continues to be monitored through BDU / commissioner forums. Given ongoing financial austerity review of planned activity is reflected in annual plan submission. (DPD / DD / DO) ➢ 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. (DO / DD) ➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation plans / CEO leads the West Yorkshire STP. (CEO / DHR) ➢ Engagement in each place with local authority partners through meetings and joint working. (DO)	DS	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	6 Yellow /Moder ate (4-6)	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 – January 2019
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 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Review of establishments considered by OMG and recommendations made to EMT. EMT supported recommendations and asked for them to be included in workforce plans. (DNQ) ➢ There are action plans are in place and monitored from Board to ward level. (DPD / DO) ➢ Safer staffing group meets on a monthly basis. (DNQ) ➢ Inpatients across the Trust have a separate workforce planning meeting in February 2019 (DNQ)	DO / DNQ	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 – January 2019
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.	4 Major	3 Possib le	12 Amber / High risk (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Work has taken place with commissioners and for Calderdale and a solution is funded to clear all waits. Barnsley is setting up a review across the South STP for February 2019 (DO) ➢ SWYPFT will participate in a Calderdale Summit in January 2019 (originally planned for November 2018) to engage key stakeholders in considering a strategic response to finding a solution to assessments for ASD / ADHD in children and young people. (DO) (February 2019) ➢ An investment plan is being agreed with Kirklees CCG to support further reduction in waits alongside the new pathways. (DO) (March 2019). ➢ A commitment has been made to an improvement plan by key agencies, SWYPFT, Mid Yorkshire Hospitals NHS Trust, Wakefield CCG and Wakefield	DO	Review every three months	Performanc e reporting to EMT - monthly Assurance report to Clinical Governanc e Committee Individual district performanc e reports	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 An additional £150k was made available by Kirklees CCG to support reduction of the ASC waiting list.	Every three months prior to business and risk Trust Board – January 2019

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
		➢ 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. ➢ Jointly agreed neuro-developmental pathway implemented in Kirklees.					Council. (DO) (Plan was completed in November 2018 with final review dates in March 2019) ➢ FPOC has demonstrated a positive impact in Kirklees and has been implemented in all areas. This is still being embedded. (DO) ➢ Recruitment to vacant positions is underway to increase capacity. This includes the consideration of new roles to improve opportunities to recruit. (DO) ➢ Calderdale CCG has led on development of a new diagnostic assessment pathway and is currently considering options for investment in a waiting list initiative. (DO) (Date to be confirmed by CCG).			reviewed by BDU			The strengthened pathway ensured waiting times were reduced to less than 12 months by September 2018.	
1132	Risks to the confidence in services 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. ➢ Additional investment in Barnsley secured for a waiting list initiative and to manage future demand. ➢ Arrangements agreed in Calderdale to flex capacity across the IAPT pathway	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. (DPD / DO / DFR) (September 2019) ➢ The impact of reviewed pathways is to be monitored in the BDU management meetings. (DPD / DO) ➢ Maintaining communication with commissioners to push for waiting list initiatives where demand has exceeded an optimal service supply. (DPD / DO) ➢ The risks at BDU level will be monitored in BDU meetings. (DPD / DO) ➢ Work ongoing with the commissioners to agree additional capacity in specific services. (DPD / DO)	DPD / DO	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 – January 2019
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 and Operational Fire/Unwanted Fire Activation ffor review/action by EFM Senior Managers. ➢ Quarterly review undertaken by Estates TAG. ➢ Weekly risk scan are completed by the Trust's 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 ➢ Trust smoking policies ➢ Compliance with the following regulations: 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;	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Smoking group established to review the smoking policy. (DO) ➢ Agreed trial period for vaping. (DO) ➢ New inpatient builds and major developments fitted with sprinklers. (DHR) ➢ Review use of sprinklers across all Trust buildings as part of the capital programme. (DHR)	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	Every three months prior to business and risk Trust Board – January 2019

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 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; 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.											injury to service users and damage to Trust property and buildings.	
1362	Risk the Trust is unable to fully implement the falsified medicines directive by February 2019 following the change in legislation which would lead to non-compliance with the law, litigation and the risk that our service users are not protected from falsified medicines.	➢ National guidance. ➢ Project plan. ➢ Contracts from supply chains to secondary care. ➢ Services mapped to consider areas affected and possible ways to manage changes in supply chain required.	4 Major	3 Possible	12 Amber / high risk (8 - 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Implementation of business case and associated actions. (MD) (February 2019) ➢ Trust level discussions with contracted pharmacy providers around continuing supplying until changes can be made. (MD) (February 2019) ➢ Attending regional meetings attended regarding options available to the Trust and share knowledge with other providers. (MD)	MD	February 2019	EMT (monthly)	4 Yellow /Moder ate (1-6)	CG&C S	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – January 2019
1369	Risk that a “no-deal” Brexit has implications for the Trust including product availability, medicines availability and staffing.	➢ Review regular updates from regulators. ➢ National guidance. ➢ Workforce plans. ➢ National work to ensure medicine supplies remain available. ➢ Formation of an internal group focussed on mitigating potential issues arising from Brexit.	4 Major	3 Possible	12 Amber / high risk (8 - 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Receive national guidance and instruction and feedback. (MD) ➢ Drugs & Therapeutics Committee to identify unlicensed medicines not covered by the national centralised stockpile. (MD) ➢ Formation of an internal group focussed on mitigating potential issues arising from Brexit	MD	March 2019	EMT (monthly) CG&CS (regular)	4 Yellow /Moder ate (1-6)	CG&C S	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – January 2019

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
1370	Risk that the cessation of the current waste management contract and transition to new arrangements results in the Trust being unable to dispose safely of its clinical waste.	➢Business continuity plan strengthened. ➢Safe local storage facilities for short periods of time (24 - 6 months). ➢Part of NHS England and NHS Improvement emergency planning arrangements. ➢New provider appointed, contractual arrangements agreed.	3 Moderate	3 Possible	9 Amber / high risk (8 - 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Teething problems with the start of the new contract meaning that the Trust has refused waste collections where we no confident it complies with legal requirements. Escalation of compliance issues to NHSi and MITIE. Trust to formally write to LTHT, NHSI and MITIE detailing concerns (DHR) (December 2018) ➢ Potential of an alternative provider is being explored (DHR) (January 2019)	DHR	March 2019	EMT (monthly) CG&CS (regular) Trust Board (each meeting through integrated performance report)	4 Yellow /Moderate (1-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – January 2019
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) ➢19/20 planning guidance includes independent assessment of CCG mental health investment (DFR) (April 2019)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moderate (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 – January 2019
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 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢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) ➢Commitment to support comprehensive attendance at the ICIG meeting (DO)	DFR	ICO external monitoring of progress by external evidence / desk based reviews	Progress monitored through EMT and weekly risk scans	4 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – January 2019
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current	➢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	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-	➢ Increased robustness of CIP and expenditure management. (DFR) ➢ Increased focus on raising of invoices to ensure timely payment. (DFR) ➢ Increased focus on robust financial management via	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF,	Every three months prior to business

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
	operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support.	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.				ate (1 – 6)	training. (DFR) ➢ Collaborative working within West Yorkshire STP. (DFR / CEO / DPD) ➢ Trust bidding to improve 2018/19 outturn position in order to generate additional provider sustainability funding (PSF) (DFR) (April 2019)				ate (4-6)		SO3	and risk Trust Board – January 2019
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 ➢ Approved commercial strategy	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development and implementation of longer term financial sustainability plan. (DFR) (February 2019) ➢ Formulation and delivery of proactive contract risk management plans for specific services. (DPD / DO) (To be in place for 2019/20 Contract round discussions (to start in January 2019)) ➢ Develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care. (DPD / DO) (To be in place for 2019/20 Contract round discussions (to start in January 2019)) ➢ 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. (DPD / DO). ➢ Scenario planning in operational plan and strategy regarding place based developments, where this could result in step-changes in income in either direction. (DS / DPD / DO). (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 – January 2019
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	➢ 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 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of longer term financial sustainability plan. (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 services. (DS) ➢ 2019/20 financial settlement and contract negotiation process	DFR	Annual review	EMT (monthly) Trust Board (quarterly)	4 Yellow /Moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 3	Every three months prior to business and risk Trust Board – January 2019

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
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. ➢ Workforce plans linked to annual business plans	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Proposal for On Boarding System to include recruitment Microsite (DHR) (March 2018) ➢ Marketing of the Trust as an employer of choice. (DHR) (March 2019 ➢ 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 – January 2019
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. ➢ Workforce planning includes age profile	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Refresh of workforce plans. (DHR) (March 2019)	DHR	Ongoing	EMT and Trust Board reporting through IPR (monthly) RTSC exception reports	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – January 2019
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)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – January 2019

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
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 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Establishment of staff disability network and LGBT network. (DHR) ➢ Links with Universities on widening access. (DHR / DNQ)	DHR	Ongoing	EMT (quarterly) E&I Forum (quarterly)	6 Yellow / moder ate (4-6)	WRC 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 – January 2019
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 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Recruitment to Consultant Roles (DHR / MD). ➢ Development of new roles e.g. Advanced Clinical Nurse Practitioners to reduce the need for medical locum. (DNQ)	DHR	Decemb er 2018	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – January 2019
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 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Track movement in performance. (DO)	DO	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 – January 2019
1213	Risk that sub-optimal transition from RiO to SystmOne will result in significant loss or ineffective use of data resulting in the inability capture information, share information and produce reports.	➢ Established Programme Steering Group including nonexecutive Directors, Nursing and Clinical Leads. ➢ Monthly Reporting into EMT and the Board via the IPR reviewed by Transformation Board ➢ Risks reported through Clinical Safety and Clinical Governance Committee and Audit Committee ➢ Weekly meeting with supplier (TPP) and quarterly attendance at Programme Steering Group ➢ Periodic gateway reviews and internal audits in place.	4 Major	3 Possib le	12 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Regular reports to EMT and Trust Board (DS) (Ongoing) ➢ Risk management oversight through Audit Committee (DS) (Jan 2019) ➢ Learning from other mental health SystmOne implementations (DS) (Ongoing) ➢ Report to CG&CS Committee re. quality aspects (DS) Ongoing monitoring of resources (DS) ➢ Learning from other MH Systm One implementations (DS) ➢ Develop cut over and go live plans (DS) (Dec 2018) ➢ Target of staff trained and competency level attained set as 85% (DS) (30 Jan 2019) ➢ Configuration sign off (DS) (Jan 2019)	DS	April 2019	Monthly reports to Transforma tion Board, EMT, Trust Board, and quarterly reports to CG&CS Committee and Audit Committee	6 Yellow / moder ate (4-6)	AC	Risk appetite: Strategic risk 8 – 12 Links to BAF, SO3	Every three months prior to business and risk Trust Board – January 2019

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
		➢ Established a credible implementation plan which is accepted and supported by the organisation. ➢ Maintain plans for resources, communication and engagement. ➢ Further identified investment in IT infrastructure complete					➢ Data migrated (DS) (Jan 2019) ➢ Gateway review and internal audit (DS) (Jan 2019) ➢ Completion of reports validated (DS) (Mar 2019) ➢ Continue clinical/non clinical engagement via change network (including change reference groups and design reference group). (DS) ➢ Maintain relationship with the supplier (TPP) and ensure agreed plans in place to support cut over and go live. (DS)							
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. ➢ Commercial strategy	3 Moderate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	➢ Progress report on draft plan taken to the December Board. Further detailed discussion scheduled for January (DFR) ➢ 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 / DPD / DO) ➢ 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 / moderate (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 – January 2019
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 ➢ Actions identified in internal audit report implemented	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	➢ 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) ➢ Progress updates at EMT and Audit Committee. (DFR / DNQ) ➢ Centralisation of Subject Access Requests staffing and consistent process. (December 2018) (DFR/DO) ➢ Internal audit of compliance to be factored in to the 2019/20 internal audit plans	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 – January 2019
1319	Risk that 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.	3 Moderate	4 Likely	12 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (1 – 6)	➢ Development of pathway for supporting people with Emotionally Unstable Personality Disorder. (DO) (Pathway ready September 2018, implemented by December 2018) ➢ Implementation of actions agreed in the joint action plan. (DO) (December 2018) ➢ Negotiation with commissioners to develop a risk share agreement. (DO) (to be in place by January 2019) ➢ Development of local plans of change activity to reduce admissions and plans to reduce length of stay. (DO) Development of local plans of change activity to	DO	January 2019	OMG	4 Yellow /Moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – January 2019

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
							reduce PICU bed usage. (DO) ➢ Working with STP partners to review bed management across West Yorkshire. (DO) ➢ Engagement of SSG to provide independent assessment of plans and improvement opportunities (DO) (March 2019)							
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 – Cauti-ous / moder-ate (1 – 6)	➢ Completion of actions identified on joint action plan. (DO) (review date moved to March 2019 in line with work with SSG) ➢ Review financial risk share with commissioners. (DFR) (March 2019)	DO / 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 – January 2019

Organisational level risks within the risk appetite

Risk ID	Description of risk	Risk level (current / pre-mitigation)	Risk appetite	Risk level (target)
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
812	Risk the creation of local place based solutions which change clinical pathways and financial flows could impact adversely on the quality and sustainability of other services.	Amber / High risk (8 - 12)	Open / High (8 - 12)	Amber / High risk (8 - 12)
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 risk (8 - 12)	Open / High (8 - 12)	Yellow / Moderate (4-6)
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)
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)	Minimal / low – cautious Moderate (1-6)	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)
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.	Amber / High risk (8 - 12)	Open / high (8 - 12)	Amber / High risk (8 - 12)
1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	Amber / High risk (8 - 12)	Open / high (8 - 12)	Amber / High risk (8 - 12)

Risk profile (risks outside the risk appetite) **– Trust Board 29 January 2019**

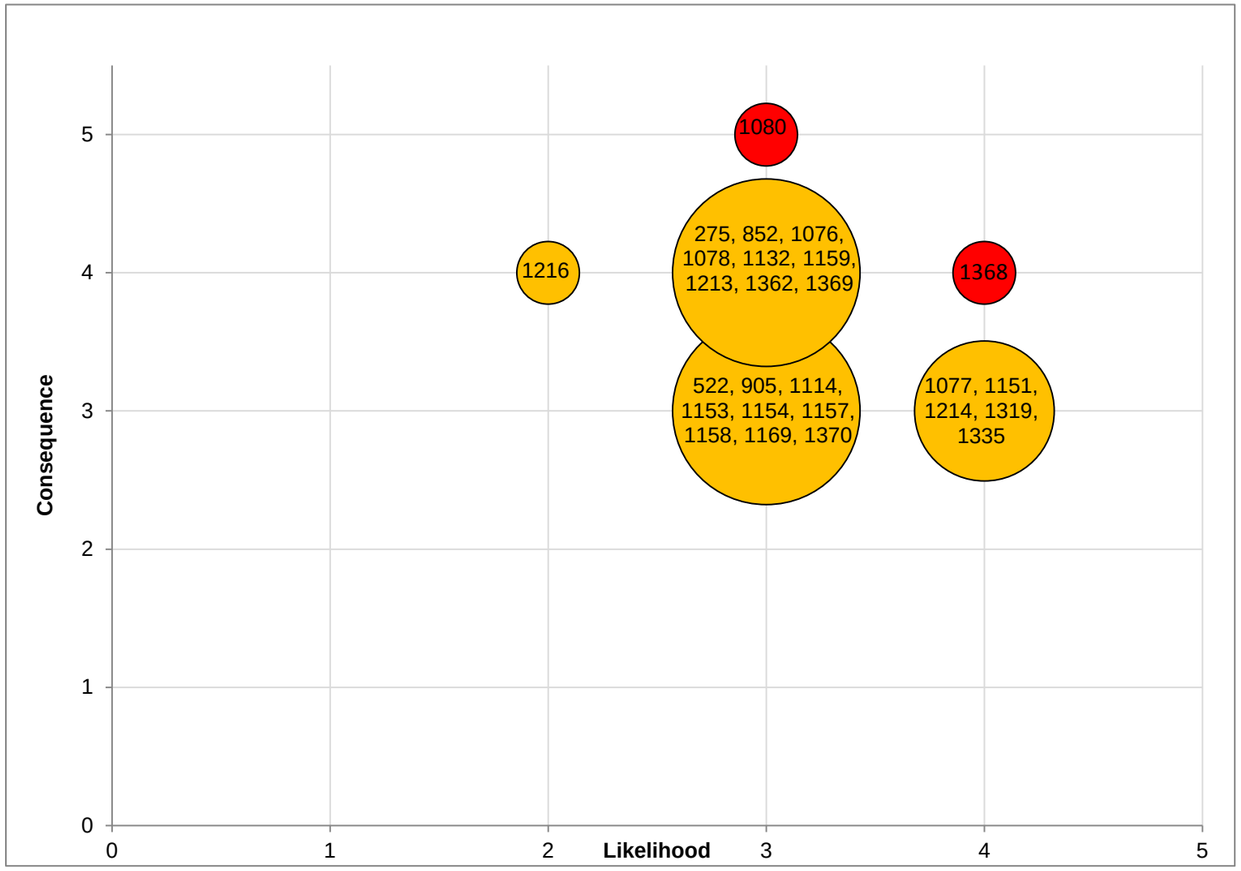
South West Yorkshire Partnership NHS Foundation Trust

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 a decentralised model for health records results in inconsistent application of standards and / or loss of health records. (1004)	= 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 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) = Risk that sub-optimal transition from RiO to SystmOne will result in significant loss or ineffective use of data resulting in the inability capture information, share information and produce reports. (1213) = Risk the Trust is unable to fully implement the falsified medicines directive by February 2019 following the change in legislation (1362) > Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing. (1369)	= Risk that given demand and capacity issues across West Yorkshire and nationally children and younger people requiring a CAMHs bed are temporarily located in a bed designated for adults. (1368)	
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 meet cost saving requirements and ensure income received is sufficient to pay for the services provided. (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 cessation of the current waste management contract and transition to new arrangements results in the Trust being unable to dispose safely of its clinical waste. (1370)	= 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) = Quality of care will be compromised if people continue to be sent out of area. (1319) = 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), (852), (905), (1076), (1077), (1078), (1080), (1114), (1132), (1151), (1153), (1154), (1157), (1158), (1159), (1169), (1213), (1214), (1216), (1319), (1335), (1362), (1368), (1369), 1370)		
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		

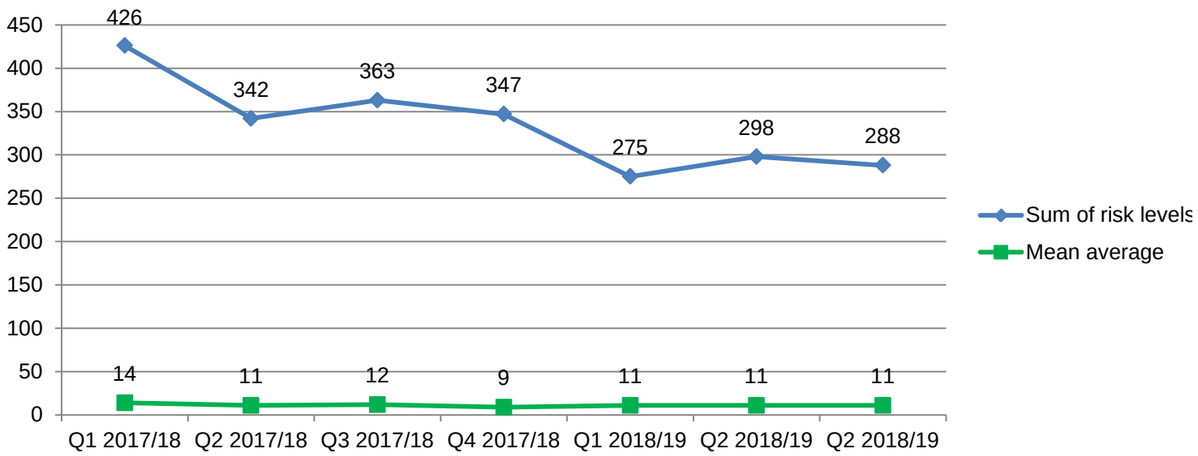
With **all of us** in mind.

Risk profile (risks outside risk appetite) **– Trust Board 29 January 2019**



Score	ID	Description
12	275	Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding.
9	522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.
12	852	Risk of information governance breach leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.
9	905	Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications.
12	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.
12	1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.
12	1078	Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment.
15	1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.
9	1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.
12	1132	Risks to the Trust's reputation caused by long waiting lists delaying treatment and recovery.
12	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.
9	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.
9	1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.
9	1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2 and WRES.
9	1158	Risk of over reliance on agency staff which could impact on quality and finances.
12	1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.
9	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.
12	1213	Risk that sub-optimal transition from RiO to SystmOne will result in significant loss or ineffective use of data resulting in the inability capture information, share information and produce reports.
12	1214	Risk that local tendering of services will increase, impacting on Trust financial viability
8	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.
12	1319	Quality of care will be compromised if people continue to be sent out of area.
12	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.
12	1362	Risk the Trust is unable to fully implement the falsified medicines directive by February 2019 following the change in legislation.
16	1368	Risk that given demand and capacity issues across West Yorkshire and nationally children and younger people requiring a CAMHs bed are temporarily located in a bed designated for adults.
12	1369	Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing.
9	1370	Risk that the cessation of the current waste management contract and transition to new arrangements results in the Trust being unable to dispose safely of its clinical waste.

Average risk level (outside risk appetite)						
2017/18				2018/19		
Q1 (31 risks)	**Q2** (31 risks)	**Q3** (33 risks)	**Q4** (35 risks)	**Q1** (23 risks)	**Q2** (27 risks)	**Q3** (26 risks)
14	**11**	**12**	**9**	**11**	**11**	**11**



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 6.3

Title:	**Contingency planning for "no deal" Brexit**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper updates the Board on the progress to date in respect of planning for the possibility that the United Kingdom (UK) leaves the EU with a no deal in place.
Mission/values:	This workstream is in place to ensure that the Trust can continue to provide services and keep service users and staff during a period of uncertainty.
Any background papers/ previously considered by:	A Brexit coordination group has been established as part of the Trust's emergency planning and preparedness arrangements. The Executive Management Team (EMT) have received this update and the Operational Management Group (OMG) are including the potential impact of a no deal Brexit in their work streams.
Executive summary:	The NHS has been asked to ensure that arrangements are in place should there be no deal when the UK is due to leave the European Union on the 29 March 2019. Whilst a no deal is not government policy, there is a duty on the Trust and NHS as a whole to plan for all scenarios. A no deal exit will have consequences in a number of key areas and the Trust along with the NHS as a whole are looking at what can be done to mitigate against any issues. The Department of Health issued new EU Exit Operational Readiness Guidance on the 21 December 2018 on actions the NHS should take to prepare for a "no deal" Brexit scenario. The Government given the current circumstances have issued this guidance to "ramp up no deal preparations" given there is less than 3 months before the planned exit. The Trust's plans for a no deal scenario have been following national guidance with each department putting appropriate arrangements in place. The EMT agreed that a Brexit Coordination Group to be established to oversee the plans for each of the work streams below. ➢ Pharmacy ➢ General Procurement ➢ Workforce ➢ Food supplies ➢ Energy ➢ Critical infrastructure continuity in Estates ➢ Information Technology ➢ General emergency planning issues arising from the centre

	A key element of the national guidance is to avoid unnecessary stockpiling at a local level and for the storage of, for example, drugs to be undertaken nationally and/or regionally. A regional group is due to be established to coordinate regional plans. The attached report identifies the work undertaken to date to respond to the potential of a no deal Brexit. **Risk Appetite** This plan is in line with the Trust's risk appetite for both clinical services and emergency planning.
Recommendation:	**Trust Board is asked to NOTE the content of the report.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019

Contingency Planning for “no deal” Brexit

Introduction

This paper is intended to update the Board on the preparations being made should there be “no deal” when the United Kingdom is due to leave the European Union on the 29th March 2019. A no deal exit will have consequences in a number of key areas and the Trust along with the NHS as a whole needs to examine what it can do to mitigate any issues. The Department of Health issued new EU Exit Operational Readiness Guidance on the 21st December 2018 on actions the NHS should take to prepare for a “no deal” Brexit scenario. The Government given the current circumstances have issued this guidance to “ramp up no deal preparations” given there are now 3 months before the planned exit. The guidance recognises that a no deal exit is not the Government’s policy but there is a duty to plan for all scenarios.

The Trust’s plans for a no deal scenario have been following the comprehensive national guidance with each department putting appropriate arrangements in place. The Executive Management Team (EMT) agreed that a Brexit Coordination Group be established to oversee the plans for each of the work streams. This group is under the emergency planning workstream led by the Director of Human Resources, Organisational Development and Estates. NHSI/NHS England have emphasised the importance of following national guidance as Trusts working independently could cause problems in itself. The Trust has liaised with other Trusts who are also following the guidance from the centre. The next step is the local emergency planning group is bringing all Trusts together to check plans and share best practice as well as giving further guidance if any is available. This meeting is on the 15th of February.

In many cases the Trust is in nationwide NHS contracts and is being kept up to date through Government communication, some of this communication is instructing the Trust what it can and cannot do.

A key element of the national guidance is to avoid unnecessary stockpiling at a local level and for the storage of, for example, drugs to be undertaken nationally and/or regionally.

Process

To date planning for a no deal Brexit has involved key departments monitoring the situation and receiving communication from suppliers as part of general preparedness. As the situation has become less certain the EMT agreed to bring key work streams leads into a regular meeting to coordinate the situation as it develops. The first meeting of this group was on the 17th of December 2018 with regular future meetings scheduled on a fortnightly basis. In between these meetings the owners of the key actions are continuing to work on contingency planning.

The key areas considered along with representatives to date are:

- Pharmacy
- General procurement
- Workforce
- Food supplies
- Energy
- Critical infrastructure continuity in estates
- Information technology
- General Emergency Planning issues arising from the centre

This group will provide regular updates to the wider organisation on a regular basis as the situation on Brexit develops. This will be done through the Operational Management Group (OMG)

Brexit Coordination Group

Whilst this group is relatively new, plans within the individual areas have been developing for some time. The initial meeting was used to allow the functional leads to update on progress to date and to identify key areas of on-going work.

Pharmacy

Purchase of most of the pharmaceutical supplies used by the Trust is through a centralised contract. The current instruction from NHS England is that no stockpiling of these goods should take place at a local level but a further update is planned in January 2019. There are six drugs which the Trust does not buy through this contract that come from Europe and pharmacy are looking at maximising stocks of these. The pharmacy team are also speaking to other NHS trusts about stock levels.

Procurement

The bulk of the Trust's purchasing is through the NHS supply chain and there is central planning going on regarding these contracts assurance is given from the NHS supplies organisation that they have tested suppliers plans and they are regarded as suitable. In addition the procurement team manage a number of local contracts and they are having ongoing discussions with suppliers to ensure continuity of supplies.

Workforce

The current expectation nationally is "that there will not be a significant degree of health and care staff leaving around exit day."

A pilot settlement scheme has been introduced for EU citizens and opened in December 2018. Communication about the scheme has been included in the Trust's weekly staff briefing, Headlines, and further communications are planned. The EMT

has agreed to pay the £65 registration fee in order to show support to our current staff who are EU citizens. However, the government have now scrapped the registration fee.

Health and care professionals, whose qualifications have been recognised and who are registered in the UK before 11pm on the 29th March 2019, will continue to be registered. Also health and care professionals, who apply to have their qualifications recognised in the UK before 11pm on the 29th March 2019, will have their application considered under current arrangements. After this there will be new arrangements not currently agreed.

There is an ongoing workgroup which is looking at eligibility to work and how registration will work after Brexit. The issue of the points-based eligibility and the £30k salary threshold is a concern which is emerging.

Food Supplies

Much of the food purchased is through supply chain and is covered by the procurement workstream. The main concern is the continuing availability of fresh and perishable foods, particularly dairy. Work is continuing with suppliers on how supplies can be maintained as stockpiling of these goods is not practical.

Energy

The Trust purchases most of its energy through a central contract and advice has been sought from them. They are not anticipating any supply issues but costs will rise post-April as we transition to new contracts. This has been confirmed by Crown Commercial Services who act as the Trust's energy broker.

Estates Infrastructure

No issues around supplies are anticipated as the quick turnover items used by the department such as light bulbs are generally from outside the EU and the use of new technology has increased life. As a precaution all generators will have fuel supplies replenished to maximum and additional fuel is being purchased.

Information Technology

At present no issues have been identified.

Recommendation

The Trust Board is recommended to note the contents of this update.

Alan Davis
Director of Human Resources, Organisational Development and Estates

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 7.1

Title:	**NHS Long Term Plan**
Paper prepared by:	Director of Finance and Resources
Purpose:	To advise the Trust Board of the key points identified in the NHS long term plan and to consider a process for the Trust Board to assess in more detail.
Mission/values:	All Trust values
Any background papers/ previously considered by:	Regular strategy updates provided to the Trust Board.
Executive summary:	➢ The NHS long term plan was published in January 2019. The plan is split into seven sections covering: • A new service model for the 21st century • More NHS action on prevention and health inequalities • Further progress on care quality and outcomes • NHS staff will get the backing they need • Digitally-enabled care will go mainstream across the NHS • Taxpayers' investment will be used to maximum effect • Next steps The full report is available at: https://www.longtermplan.nhs.uk/ ➢ Highlights of the plan include: • Greater integration of care, re-focus of efforts to boost out of hospital care • Local NHS organisations to increasingly focus on population health • Increase in use of technology to support patient care and staff efficiency • Grow and retain the workforce • Increasing role of Integrated Care Systems • NHS to become financially sustainable and return to balance • Increased investment in mental health and community health services • Increased focus on prevention • Increased focus on quality of care and outcomes including mental health, learning disability and autism ➢ Some elements of the long term plan will need to be included in the Trust operating plan and both need to align
Recommendation:	**Trust Board is asked to:** ➢ **REVIEW and COMMENT on this report; and** ➢ **AGREE to discuss in further depth at a Trust Board strategy**

	meeting which will enable the Board to agree a series of next steps to articulate and define what the long term plan means to the Trust and services it provides.
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019

NHS Long Term Plan

Introduction

In January 2019 the long term plan for the NHS was published. The purpose of this paper is to provide highlights of what is included in that plan and enable Board members to consider the potential impact on the Trust and the services it provides. The plan is extensive and wide-ranging and further detail behind it and emerging themes will develop in the coming months. As such this report focuses on key highlights as opposed to a full dissection of the plan. The link to the full plan has been provided to all Board members should they wish to review the full document. How the Trust uses this plan and considers implications in greater depth requires more focused time and as such would be a suitable topic for a board strategy meeting.

The plan document is split into seven sections, which are:

1. A new service model for the 21st century
2. More NHS action on prevention and health inequalities
3. Further progress on care quality and outcomes
4. NHS staff will get the backing they need
5. Digitally-enabled care will go mainstream across the NHS
6. Taxpayers' investment will be used to maximum effect
7. Next steps

This report follows the same split with key highlights identified in each section. Much of the wording in this report is taken directly from the plan so as to avoid any misinterpretation or ambiguity

A new service model for the 21st century

This section clearly states there is an intention to boost out of hospital care. It notes there are currently circa 400 million face-to-face appointments each year. Over the next 5 years every patient will have the right to online "digital" GP consultations and re-designed hospital support will enable avoidance of up to one third of outpatient appointments. There is stated intent to create genuinely integrated teams of GPs, community health and social care staff with new standards established to provide fast support to people in their own homes as an alternative to hospitalisation. There will also be an increase in social prescribing, personal health budgets and support for people to manage their own health in partnership with patients' groups and the voluntary sector. £4.5bn of investment is being ring-fenced to support these reforms by 2023/24.

This chapter in the plan outlines five major and practical changes to the NHS service model over the next five years:

- Boost out of hospital care and dissolve the historic divide between primary and community health services
- Redesign and reduce pressure on emergency hospital services
- People will get more control over their own health and more personalised care when they need it
- Digitally enabled primary and outpatient care will go mainstream across the NHS
- Local NHS organisations to increasingly focus on population health and local partnerships with local authority funded services through new Integrated Care Systems (ICSs) everywhere

One point particularly worth noting is the intent to deliver more joined-up and co-ordinated care. The aim being to break down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long term conditions.

Following the publication of the five year forward view (FYFV) in 2014 a number of vanguards were established nationally. From these vanguards a number of successes have been identified which can be shared and used nationally. These are included in the plan.

As already identified investment in this sector will increase by £4.5bn in real terms over the next five years. Key highlights are now provided in bullet point format:

- All parts of the country are expected to improve the responsiveness of community health crisis response services to deliver the services within two hours of referral in line with NICE guidelines where clinically judged to be appropriate. More NHS community and intermediate health care packages will be delivered to support timely crisis care.
- Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and Allied Health Professionals (AHP) such as physiotherapists and podiatrists/chiropodists joined by social care and the voluntary sector. The result will be the creation of fully integrated community-based health care
- There will be upgraded NHS support to all care home residents who would benefit by 2023/24
- There will be further improvements in care for people with dementia and delirium whether they are at hospital or at home
- The urgent treatment centre model will be fully implemented by autumn 2020 such that all localities have a consistent offer for out-of-hospital urgent care
- The NHS and social care will continue to improve performance at getting people home without unnecessary delay when they are ready to leave hospital
- As part of the wider move to “shared responsibility for health” the NHS will ramp up support for people to manage their own health. Initially this will cover diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support and online therapies for common mental health problems
- The NHS personalised care model will be rolled out across the country
- Through social prescribing the range of support available to people will widen, diversify and become accessible across the country.
- Digital technology will provide convenient ways for patients to access advice and care. Focus will be placed on the use of the NHS app. Patients will be able to

access virtual services alongside face-to-face services via a computer or smart phone. The development of apps and online resources will also be encouraged to support good mental health and enable recovery
- The plan highlights that advances in technology means an outpatient appointment is often no longer the fastest or most accurate way of providing specialist advice or diagnosis or ongoing patient care.

Role of Integrated Care Systems (ICS)

Within this chapter there is also increased clarity of direction in relation to ICSs. As above the key highlights are identified in bullet point format.

- ICSs will have a key role in working with local authorities at place level and through ICSs commissioners will make shared decisions with providers on how to use resources, design services and improve population health.
- Every ICS will need stream-lined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner and more strategic that support providers to partner with local government and other community organisations on population health, service re-design and long term plan implementation
- Every ICS will have a partnership board drawn from and representing commissioners, trusts, primary care networks, and assuming they wish to participate, local authorities, voluntary and community sectors and other partners.
- Each ICS will have a non-executive chair, sufficient clinical and management capacity (drawn from constituent organisations to enable them to implement and agreed system-wide changes) and full engagement with primary care
- Greater emphasis by the CQC on partnership working and system-wide quality
- All providers within an ICS will be required to contribute to ICS goals and performance. Potentially this will be backed up by a new licence condition
- Clinical leadership aligned around ICSs to create clear accountability to the ICS
- Each ICS is required to implement integral services that prevent avoidable hospitalisation and tackle the wider determinants of mental and physical ill-health.
- ICSs will agree system-wide objectives with the relevant NHSE/NHSI regional director and be responsible for their performance against these objectives

To support the above:

- NHSI will take a more proactive role in supporting collaborative approaches between trusts. Trusts wishing to explore formal mergers will be supported.
- A new Integrated Care Provider contract will be made available for use from 2019 to support reforms in funding flows and contracts
- A new ICS accountability and performance framework will consolidate the current amalgam of local accountability arrangements and provide a consistent and comparable set of performance measures
- Local approaches to blending health and social care budgets where councils and CCGs agree will be supported.

More NHS action on prevention and health inequalities

This section sets out new funded action the NHS will take to strengthen its contribution to prevention and health inequalities. It is emphasised this is designed to complement the role of individuals, communities, government and business, not act as a substitute for it. Five year funding allocations to local areas will be based on more accurate assessment of health inequalities and unmet need. Included for specific action there are requirements to cut smoking in pregnancy and by people with long term mental health problems, ensure people with learning disability and/or autism get better support, provide outreach services to people experiencing homelessness, help people with severe mental illness find and keep a job and improve the uptake of screening and early cancer diagnosis for people who currently miss out.

The plan notes the key three drivers that continue to result in increased demand for NHS services as being a) a growing and ageing population, b) visibility and concern about unmet health need (e.g. young people's mental health services) and c) expanding frontiers of medical science and innovation (e.g. new cell and gene therapies). These drivers can be modified by ensuring people get the right care at the right time in the optimal care setting and improving upstream prevention.

Some key points to note in bullet point format include the following:

- There is intent to cut business mileage and fleet air pollutant emissions by 20% by 2023/24
- Tackle inequalities. Examples quoted include the facts that on average adults with a learning disability die 16 years earlier than the general population and people with severe mental health illnesses tend to die 15-20 years earlier than those without.
- For five year CCG allocations a more accurate assessment of the need for community health and mental health services will be introduced from 2019/20.
- By 2023/24 it is intended for people with severe mental health problems the number receiving physical health checks will increase by 110,000.
- 50% of people sleeping rough have mental health needs. Up to £30m investment will be made on meeting the needs of rough sleepers
- Increased focus on physical health needs of people with a learning disability and/or autism
- Increased support to young carers
- Continue to commission, partner with and champion local charities, social enterprises and community interest companies providing services and support to vulnerable and at-risk groups
- Improving access to mental health support for people in work

Further progress on care quality and outcomes

This section provides information in respect of priorities relating to improving care quality and outcomes for many of the services the Trust provides as well as many others. This paper particularly focuses on those services the Trust provides.

Maternity and neonatal services

- Increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis to benefit an additional 24,000 women by 2023/24
- Expanding services to evidence-based psychological therapies within specialist perinatal mental health services
- Offering fathers/partners of women accessing perinatal mental health services evidence-based assessment for their mental health and signposting to support

Children and young people's mental health services

There was previously a commitment within the FYFV to expand mental health services for children and young people. Access is rising and there are further commitments in the long term plan which are outlined below:

- Funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending
- By 2023/24 at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services.
- Further investment in children and young people's eating disorder service resulting in 80% receiving treatment within one week in urgent cases and four weeks for non-urgent cases
- Improving crisis services through single point of access (NHS 111) to enable 24/7 access
- Mental health support for children and young people to be embedded in schools and colleges. New mental health support teams will work in schools and colleges
- A new approach to services for people aged 18-25 to support the transition to adulthood. The new model will deliver an integrated approach across health, social care, education and the voluntary sector.

Learning disability and autism

There is a clear focus on improving services and outcomes for those people with learning disability and autism. These are summarised below:

- Action to tackle the causes of morbidity and preventable deaths. This will include an improvement in uptake of the existing annual health check in primary care for people aged over 14 years with a learning disability such that at least 75% of those eligible have a health check each year. A specific health check for those with autism will be piloted.
- ICSs are expected to ensure all local healthcare providers make reasonable adjustments to support people with a learning disability or autism. Over the next five years national learning disability standards will be implemented. By 2023/24 a digital flag in the patient record will ensure staff know a patient has a learning disability or autism

- Autism diagnosis will be included alongside work with children and young people's mental health services to test and implement the most effective ways to reduce waiting times for specialist services
- Where possible people with a learning disability, autism or both will be enabled to have a personal health budget
- By March 2023/24 inpatient provision will have reduced to less than half of 2015 levels (on a like for like basis)
- Increased investment in intensive, crisis and forensic community support will enable more personalised care in the community closer to home. There will be seven day access to specialist multi-disciplinary service and crisis care
- By 2023/24 all care commissioned by the NHS will need to meet the Learning Disability Improvement Standards.

Community health services

There are a number of community health services the Trust provides in Barnsley which are highlighted in the plan and key points are noted below:

- Diabetes – patients with type 1 diabetes to benefit from flash glucose monitors from April 2019. Continued investment in supporting delivery across primary care to enable more people to achieve the recommended diabetes treatment targets.
- Respiratory – expansion in pulmonary rehab services. Use of a population management approach in primary care. Improved use of medication.
- Ensure patients have direct access to MSK first contract practitioners
- Improvements to post-hospital stroke rehabilitation models by 2020

Adult mental health services

There is significant focus on improvement to and investment in adult mental health services. The commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years is re-iterated. Practically this means real term growth of at least £2.3bn a year by 2023/24. This is the "floor" level of uplift set nationally which could be increased further by local investment decisions. In terms of specific service improvements and commitments the following bullet points provide a summary:

- IAPT services will continue to be expanded for adults and older adults
- Clear standards for patients requiring access to community mental health treatment will be established and rolled out over the next decade.
- A new community based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma informed care, medicines management and support for self-harm and co-existing substance use. Local areas will be supported to redesign and reorganise core community health teams to move towards a new place-based multi-disciplinary service across health and social care aligned with primary care network
- Services will be expanded for people experiencing a mental health crisis. A 24/7 community-based mental health response for adults and older adults will be available

by 20/21. Intensive home treatment will be offered as an alternative to acute inpatient admission.

- Alternative forms of provision for those in crisis will be offered such as sanctuaries, safe havens and crisis cafes
- Specific waiting time targets for emergency mental health services will take effect from 2020.
- Ambulance staff will be trained and equipped to respond effectively to people in a crisis
- Length of stay for inpatient acute care to be reduced to national average of 32 days.
- Plan to end acute out of area placements by 2021
- Continued focus on suicide prevention

NHS staff will get the backing they need

An entire section of the plan is dedicated to workforce. It recognises the current pressures and strain on the workforce and sets out the need to employ more staff, working in rewarding jobs and a more supportive culture. Similarly it recognises that NHS roles and careers need to be shaped to reflect future needs and priorities set out in the long term plan. As with previous sections bullet points summarising key points in this section of the plan are identified below:

- A workforce implementation plan will be published later in 2019 with a national workforce group established
- Actions will be agreed to improve the supply of nurses over the course of the plan centred on increasing the number of undergraduate nursing degrees, reducing attrition from training and improving retention. An extra 5,000 undergraduate places will be funded from 2019/20 (25% increase)
- Focus on how best to use the apprenticeship levy and growth of nursing and wider apprenticeships in clinical and non-clinical roles
- Grow medical school places from 6,000 to 7,500 per annum. This may grow further depending on the outcome of the spending review. Increase the number of doctors working in general practice and accelerate the shift from a dominance of highly specialised roles to a better balance with more generalist ones.
- Workforce implementation plan to set out new national arrangements to support NHS organisations in recruiting overseas
- Improve career development and career progression opportunities
- Expand multi-professional credentialing to enable clinicians to develop new capabilities formally recognised in specific areas of competence
- Promote flexibility, wellbeing and career development and redouble efforts to address discrimination, violence, bullying and harassment
- Use technology to free up staff time
- Support all trusts to adopt electronic rosters or e-job plans by 2021
- New compact with senior leaders to provide better support and “air cover” when taking difficult decisions
- Aim to double the number of NHS volunteers over the next three years

Digitally enabled care will go mainstream across the NHS

Within the plan the aim to improve the use of technology to make improvements in care and staff efficiency is recognised and very evident. Section 5 of the plan focuses entirely on digitally-enabled care. It recognises the progress made in development of apps, electronic prescription service and the global digital exemplar programme, whilst at the same time recognising further developments are necessary.

Ten practical priorities are identified which will drive digital transformation

1. Create straightforward digital access to NHS services and help patients and their carers manage their health.
2. Ensure clinicians can access and interact with patient records and care plans wherever they are
3. Use decision support and artificial intelligence to help clinicians in applying best practice and eliminate unwarranted variation and support patients in managing their health and condition
4. Use predictive techniques to support local health systems to plan care for populations
5. Use intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the admin burden
6. Protect patients' privacy and give them control over their own medical record
7. Link clinical, genomic and other data to support the development of new treatments
8. Ensure NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education
9. Mandate and rigorously enforce technology standards to ensure data is interoperable and accessible
10. Encourage a world leading health IT industry in England with a supportive environment for software developers and innovators

What this means in practice is best summarised below:

- Focus will be placed on empowering people with the ability to access, manage and contribute to digital tools, information and services
- NHS apps library, NHS app and login will enable easy access to personalised content and digital tools and services. The NHS app will be continually developed to create a consistent way for people to access the NHS digitally
- Digital access to the diabetes prevention programme to be offered from 2019
- By 2020 every patient with a long-term condition will have access to their health record through the summary care record accessed via the NHS app
- Ensure NHS staff have the technology and digital tools they need to efficiently deliver safe and effective patient care.
- Over the next three years all staff working in the community to have access to mobile digital services including patient's care record and plan to help them perform their role
- Informatics leadership representation on the board of every NHS organisation
- Increasing digital options for people requiring NHS advice or care
- All providers expected to advance to a core level of digitisation by 2024

- A new wave of global digital exemplars will be identified enabling more trusts to use world-class digital technology and information
- Creating the right environment to achieve these digital advances by creating a secure and capable digitally literate workforce

A range of milestones from 2019 to 2024 have been identified determining the progress expected to be made.

Taxpayers' investment will be used to maximum effect

This section of the report focuses on the financial architecture and productivity. It re-emphasises the commitment to grow revenue investment by an average of 3.4% a year in real terms over the next five years. This funding will need to deal with current pressures, unavoidable demographic change and other costs as well as new priorities. A key priority in the plan is to put the NHS back on a sustainable financial path. In practice this means:

- The NHS (including providers) will return to financial balance
- Cash releasing productivity growth of 1.1% per annum is required to be delivered and re-invested in frontline care
- Growth in demand will be reduced through better integration and prevention
- Reduced variation across the health system
- Making better use of capital investment and existing assets to drive transformation

The above are in effect five tests which need to be met. The key points are identified below.

<u>Test 1 - Returning to financial balance</u>

- 2019/20 will be a transitional year with one-year re-based control totals. The re-basing will take into account such factors as price relativities, market forces factor and national variations to tariff. ICSs will have greater flexibility to agree financially neutral changes to control totals within systems
- The provider sector to return to balance in 2020/21 and all NHS organisations by 2023/24
- Changes to payment arrangements and allocations will take better account of local cost of delivering services by phasing in an updated market forces factor
- The payment system will move towards population-based funding
- CQUIN framework will be reformed to become simpler, more impactful and easier to implement
- There will be an accelerated turnaround process in the worst 30 financially performing trusts
- Further financial reforms will be introduced to support ICSs deliver integrated care
- A new financial recovery fund will be created to support trusts and systems which are in deficit, but commit to control totals and deliver efficiency improvements

<u>Test 2 – Cash-releasing productivity growth of 1.1%</u>

Ten priority areas have been identified to deliver efficiency improvement, which will be re-invested in more and better patient care. These include the following:

- Improve availability and deployment of the clinical workforce to ensure right clinicians are available to patients at all times
- Deliver procurement savings by aggregation of volumes and standardising specifications
- Improve efficiency in community health, mental health and primary care, which currently represent £27bn a year
- Deliver value from medicines expenditure. All providers expected to implement electronic prescribing systems
- Further efficiencies in admin costs across providers and commissioners, nationally and locally
- Improve the way land, buildings and equipment are used. All providers targeted to reduce non-clinical space by a further 5%. Reduce carbon footprint by a third from 2007 levels
- Ensure least effective interventions are not routinely performed
- Improvements to patient safety to reduce patient harm and the substantial costs associated with it

Test 5 – Make better use of capital investment and existing assets

A number of reforms to the capital regime are being considered to ensure capital funding is prioritised and allocated efficiently, supports the transformation of services and increased productivity and allows for effective planning and control

The other two tests are reducing growth in demand for care through better integration and prevention, and reducing unwarranted variation in performance.

Next Steps

A range of next steps are identified within the plan. Many of these are already covered in the plan as summarised above. The key role of the ICSs is again identified. The importance of system working and it is clearly stated that "this will mean that neither trusts nor CCGs will pursue actions which, whilst potentially improving their institutional financial position, would result in a worse position for the system overall.

In addition it is worth noting that legislative changes are being considered particularly to enable NHS organisations to work better together. These may include:

- Removing impediments to place based NHS commissioning
- Support the more effective running of ICSs by letting trusts and CCGs exercise functions and make decisions jointly
- Support the creation of NHS integrated care trusts
- Remove the counter-productive effect that general competition rules and powers can have on the integration of NHS care
- Free up NHS commissioners to decide the circumstances in which they should use procurement subject to a "best value" test to secure the best outcomes for patients and the taxpayer.

- Make it easier for NHS England and NHS Improvement to work more closely together

Conclusion and Recommendations

As identified in the introduction this paper focuses on providing key points in the NHS long-term plans for board member awareness. Items covered in the plan are many and varied and will be subject of much more focused thought and consideration. The plan is for a ten year period with a number of the items identified in the plan to take effect from 2019 onwards. Importantly there are clear actions identified for many of the services we provide, with associated accompanying financial investment. Where appropriate these will be recognised in and aligned with our operating plan submission for 2019/20.

Of particular note for Board members are the increased focus on service integration, a growing role for ICSs, recognition of the need to increase workforce numbers and develop the workforce, accelerate the effective use of technology and ensure continued focus of value for money and elimination of waste. Service improvements in many of the services we provide or have a role in must also be emphasised and in conjunction with our partners we need to determine how these can best be achieved.

In the coming weeks and months the plan needs to be considered in more depth by Trust Board members. Some elements will need to be incorporated in the 2019/20 operating plan, which the Board is fully engaged in the production of. Other areas of the plan require further consideration and discussion in terms of the role the Trust has to play and how the plan is implemented within our services and places.

It is recommended the Trust Board review and comment on this report and agree to discuss in further depth at a Board strategy meeting which will enable us to agree a series of next steps to articulate and define what the long term plan means to the Trust and services it provides.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019

Agenda item 7.2

Title:	**South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates Director of Strategy
Purpose:	The purpose of this paper is to update the Trust Board on the developments within the South Yorkshire and Bassetlaw Integrated Care System (ICS), and Barnsley integrated care developments.
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 SYBICS.
Any background papers/ previously considered by:	The Trust Board have received regular updates on the progress and developments in the SYBICS (formerly Sustainability and Transformation Partnership), including Barnsley Integrated Care Developments.
Executive summary:	**1. Integrated Care System (ICS) Collaborative Partnership Board** The Shadow ICS Partnership Board last met on the 9 November 2018 and feedback from that meeting was shared with the Trust Board in December 2018. There was no meeting in December and January's was cancelled so there is no further update. However, the ICS performance dashboard for December 2018 has been published. Within the context of the pressures on the system, the ICS is overall doing well against the NHS Constitution commitments. For example, within the North and across the first wave ICSs, SYB collective A&E performance at 91.3% of people being either admitted, transferred or discharged within 4 hours (target 95%) is one of the best in the country although still below the national standard. The ICS has recognised that this is an important area where further improvement in performance is needed. Diagnostics waiting times (within 6 weeks) and also 2 week waits from GP referral are meeting the targets. However, 31 day and 62 day cancer standards on waiting targets require significant improvements. An action plan to deliver an improved position by the end of March 2019 is being agreed so that we can continue with a strong performance from Quarter One in 2019. The 3 mental health targets (Early Intervention in Psychosis; 50% starting treatment in 2 weeks; IAPT access and recovery) all continue to exceed the target levels. All other national performance targets are reported as achieved.

	2. SYB ICS Mental Health Programme Developments The ICS Mental Health Executive steering group has a number of programmes of work that have been prioritised, below is an update on some of these programmes, **Adult ASC/ADHD** A workshop is planned to focus on adult ASC/ADHD in February. Clinicians from the Trust will be attending and participating. Links have been established with the West Yorkshire and Harrogate Health and Care Partnership. **Individual Placement and Support (IPS)** Provision of IPS services is variable across the ICS and an expression of interest bid was submitted as part of the wave 2 funding. A total of £934,394 has been requested for transformation funding. Funding has been requested over two years; £497,781 in year one and £436,613 in year two. The model will be to provide a standardised service across the ICS for people with serious mental health and enduring mental health issues. The expression of interest has been accepted, and the bid is currently set to proceed, with a probable lead provider model. Currently there is an IPS service that operates across each place in the SYB ICS except Barnsley and Bassetlaw, the additional funding will support the expansion of existing services and see the development of new services in Bassetlaw and Barnsley. The Trust are working in partnership with all other providers on preparation and submission of a place based service model. Consideration is being given by commissioners to the requirements around any procurement process. The new model will commence on the 1st April 2019 with phased implementation and growth of service **Suicide Prevention** - SYB has received £555,622 targeted funding from NHS England for 2018/19 with a focus on men, support to primary care, self-harm including pathways for people in acute and mental health crisis and bereavement support. Diane Lee Head of Public Health, Barnsley Council is the chair of the SYB ICS Suicide prevention steering group that has been overseeing the development of proposals to reduce suicides across the ICS. The SYB ICS Mental Health and Learning Disability Executive Steering Group (MHLDESG) agreed proposals presented which combined will contribute towards a 10% reduction in the suicide rate. This included the development of a real time surveillance system and bereavement support. There has been some subsequent re-evaluation of the value and evidence base for real time surveillance and associated investment as a priority; this is to be discussed further in the steering group **Children and Young People -** SYB has been successful in securing transformation money as part of the green paper Trailblazer funding for Sheffield and Barnsley. **Funding to support Winter pressures -** additional funding to support winter pressures was secured by Barnsley, Rotherham and Sheffield. Two proposals for Barnsley were successful. Improved access to mental health assessment and intervention throughout the 24 hour period by increasing Single Point of Access assessment team capacity - £27,779 and increasing capacity of Mental Health Liaison £14,586.

	3. Barnsley Integrated Care Update The Barnsley Clinical Commissioning Group (CCG) continues to work 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. Partners across Barnsley continue to work together to develop integrated models of care including neighbourhood model, early help and support for people with Cardio Vascular Disease and developing an integrated model of care for stroke and frailty. **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 SYBICS and Barnsley integrated care developments.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 7.3

Title:	**West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships update**
Paper prepared by:	Director of Strategy
Purpose:	The purpose of this paper is to provide the Trust Board 1. With an update on the development of the West Yorkshire and Harrogate Health and Care Partnership and 2. Local Integrated Care Partnership developments.
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 October Trust Board.
Executive summary:	The Trust Strategy refresh outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP). The place-based plans are being mobilised through strengthening existing partnerships and developing collaborative arrangements to commission, deliver and transform services. Progress and key developments that are summarised in the paper include: • **West Yorkshire and Harrogate Health and Care Partnership** • **Kirklees**. • **Calderdale** • **Wakefield** **Risk Appetite** The development of strategic partnerships and the development and delivery of place-based plans is in line with the Trust's risk appetite supporting the development of integrated, joined up care and services that are sustainable. 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 and NOTE the updates on the development of Integrated Care Partnerships and collaborations including:** ➢ **West Yorkshire and Harrogate Health and Care Partnership** ➢ **Wakefield** ➢ **Calderdale** ➢ **Kirklees**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019

West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - update

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). The paper will also include a brief update on key developments in local places that the Trust provides services that are aligned to the ambitions of the WY&H HCP and the Trust's strategic ambitions.

2. Background

Led by the Trust's Chief Executive Rob Webster, West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

The West Yorkshire and Harrogate Health and Care Partnership emphasises the importance of place-based plans where the majority of the work happens in each of the six places (Bradford, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These build on existing partnerships, relationships and health and wellbeing strategies.

Collaboration is emphasised at WY&H level when it is better to provide services over a larger footprint; there is benefit in doing the work once and where 'wicked' problems can be solved collaboratively

In May 2018 NHS England and NHS Improvement announced that WY&H HCP would be one of four health and care systems to join the Integrated Care System (ICS) Development Programme. This demonstrated national recognition for the way WY&H partnership works and for the progress made. It means the partnership is at the leading edge of health and care systems, gaining more influence and more control over the way services are delivered and supported for the 2.6 million people living in our area. The 'Our Next Steps to Better Health and Care for Everyone' document describes and sets out how the partnership will continue to improve health and care for the 2.6 million people living across the area.

3. Update – Progress

3.1 Partnership Memorandum of Understanding

All partner organisations have now formally approved the Partnership's Memorandum of Understanding. The final version is available for viewing on the partnership website https://www.wyhpartnership.co.uk/application/files/7915/4452/6426/West_Yorkshire_and_Harrogate_MoU_December_2018.pdf

3.2 Partnership Board – Vice Chair

The new Partnership Board will bring NHS, councils and communities closer together. Councillor Tim Swift, Leader of Calderdale Council and Chair of Calderdale Health and Wellbeing Board, will be Chair of the Partnership Board for the first two years. It can now be confirmed that Angela Schofield, Chair of Harrogate District NHS Foundation Trust, will be the Vice Chair for the Partnership Board. Angela is an experienced chair, non-executive director and senior NHS manager and will bring a wealth of knowledge and experience to the Partnership Board role. The first meeting in public will take place in June 2019.

3.3 System Oversight and Assurance Group (SOAG)

The primary objectives of this group include oversight of progress for all the West Yorkshire and Harrogate priority programmes and system performance. SOAG will take full responsibility for system performance from the point at which the partnership moves to full integrated care system status, expected to be from April 2019. The group has met several times and key points from the November meeting include the following:

- **The WY&H Partnership has continued to receive positive coverage** on a number of key developments and good feedback from national bodies on the progress that is being made.
- **The ICS capital allocations** has now been released and the partnership has been successful in three out of 12 prioritised bids; namely CHFT reconfiguration, pathology services and mental health rehabilitation and recovery repatriation as discussed at the last Trust Board.
- **Additional funding allocations** were noted for population health management and winter pressures. It was agreed that a protocol was required for communication with stakeholders when in-year funding becomes available.
- **Update from the ICS programmes** was received at the meeting including:
    - ***Mental Health***
        - Positive progress was noted with the new care models for CAHMS and Adult Eating Disorders, the Trust is partner in both these programmes. WY&H had also been identified to take part in the National Dementia Pilot.
        - Work is progressing to establish a single Transforming Care Partnership for West Yorkshire, rather than the existing three footprints to support further progress.

- ***Primary and Community Care***
    - Programme leaders continued to meet with local areas as part of the development of primary care networks to build a clearer picture of the level of development of networks and support requirements. (*The Trust is working together with partners in each of the local places that it provides services to ensure that services are better integrated and joined up through the primary care networks that are developing)*
- ***Prevention at Scale***
    - The partnership is on track to achieve planned reductions in smoking and alcohol related hospital admissions, and an increased uptake in diabetes prevention programme. Further work to better understand the reductions in alcohol specific admissions is underway.
- ***Harnessing the Power of Communities***
    - £1m has been allocated to places to support VCS initiatives with a particular focus on loneliness. Rob Webster and Robin Tuddenham will meet the programme SRO and lead to discuss how to enhance connections with local government and other partners.

- **Review of System Performance and Delivery**
    - Members noted the current financial position in respect of WY&H NHS organisations including the significant risks for some acute providers.
    - The group discussed emerging financial risks, and noted that the partnership may need to provide mediation in one or two places which could not yet agree an aligned position. It was agreed that some work should be undertaken to consider how the interventions available to SOAG, and opportunities to provide support, could be deployed in relation to particularly challenged organisations.
- **Performance Dashboard**
    - The dashboard continues to be developed. In the interim it was agreed that there needed to be a focused approach to highlight significant risks that weren't necessarily captured on the dashboard but which might require intensive support. Once the Dashboard is developed it will be shared at SOAG and also available for discussion and use through Boards and Governing Bodies.
- **Planning for 2019/20**
    - Proposals had been developed for a more integrated place-based approach to planning. This new approach will allow closer working between places and WY&H programmes to ensure the impact of transformation is visible in local plans (where this was known). This was further discussed in more detail at the System Leadership Executive Group In January 2019 as summarised below.

3.4 NHS Long Term Plan and what this means for the West Yorkshire and Harrogate Health and Care Partnership

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for people out of every pound of taxpayers' investment. The Plan published on Monday 7 January has been drawn up by frontline health and care staff, patient groups and other experts. The plan builds on the work that is already happening across the partnership and emphasises the important role that Integrated Care Systems will play in developing Implementation plans that address the ambitions set out in the plan.

The Plan will enable the WY&H HCP to continue to improve care for people over the next ten years; including making sure everyone gets the best start in life; reducing stillbirths and mother and child deaths during birth by 50%; taking further action on childhood obesity. The increased funding for children and young people's mental health; bringing down waiting times for autism assessments is a much welcomed development and will support the work that has already been happening in each place and across the partnership to improve care and support for young people. It also includes the importance of delivering world-class care for major health problems; preventing 100,000 heart attacks, strokes and dementia cases; investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital and delivering community-based physical and mental health care for 370,000 people with severe mental illness a year by 2023/24.

Supporting people to age well and increasing funding for primary and community care by at least £4.5bn; coordinating care better and helping more people to live independently at home for longer are also highlighted in the Plan alongside improving the recognition of carers and support they receive and making further progress on care for people with dementia.

The Plan also sets out how we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by doing things differently and giving people more control over their own health and care whilst preventing illness and tackling health inequalities.

The plan also recognises the importance of the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. Digital technology is also high on the agenda.

Professor Chris Ham and Dr Nicola Walsh from the King's Fund joined the partnership executive meeting in January 2019 and also the wider leadership team meeting. This is part of the ongoing support from the King's Fund as part of the Partnership development. Chris and Nicola have significant experience in helping leadership teams develop and it was useful in the context of the Long Term Plan. The Partnership Group spent time reflecting on the recently published NHS Long Term Plan to start a conversation about what the Plan means for the partnership and how the partnership will collectively develop the forthcoming five year strategy building on the significant work that is already being progressed.

3.5 Operational Planning 19/20 and five year strategic plan approach

Members of the System Leadership Executive (SLE) Group discussed the proposed approach for **operational planning for 19/20** that will support the development of more integrated, place-based plans. It was agreed that the planning process will be used as an opportunity to reinforce the progress that has been made by the partnership to move towards more integrated working, both within each place and across WY&H as a whole.

Within the partnership 'place' as the primary unit of planning will be adopted. This will ensure that providers, commissioners, and local authority partners have a shared narrative about the transformation of local services and are working to a common set of assumptions about service changes, the levels of activity required, and a place level financial plan, built from an open book approach to organisational planning. The sustainability and service quality of individual providers will also be an important consideration. A focus on place will require an

understanding and management of the consequences for providers, tailoring the balance of investment to ensure the appropriate outcome.

A single executive planning lead has been identified for each place to co-ordinate an integrated approach. The named leads include, Anthony Kealy (NHS England); Julie Lawreniuk (Embed Health Consortium); Vicky Dutchburn (Greater Huddersfield CCG); Debbie Graham (Calderdale CCG); Pat Keane (Wakefield CCG); Tim Ryley (Leeds CCG). These leads are convening colleagues in CCGs, Trusts and Councils to develop whole place plans. A set of guiding principles to shape and inform the plans are set out and each plan should be clear how progress will be made on the following ambitions:

- Implementation and development of primary care networks, adopting a population health management approach, and personalised care as the basis for supporting people in each of the 50-or-so neighbourhoods, covering populations of 30-50,000 people;
- Full adoption of the evidence-based interventions prioritised by the Partnership with the Yorkshire and Humber Academic Health Sciences Network;
- Prevention of strokes by detecting and treating 89% of people with Atrial Fibrillation;
- Development of aligned incentive contracts as a framework for effective financial management in each place;
- Development of networked approaches to managing capacity for challenged specialties across WY&H;
- Introduction of standardised policies for elective care;
- Closer integration of health and social care in each place;
- Full involvement of the voluntary and community sector in local place partnerships;
- Full implementation of new care models for CAMHS and eating disorders;
- Elimination of adult placements out-of-WY&H for non-specialist mental health services;
- Taking on responsibility for MH specialised commissioning budgets.

Each STP/ICS footprint will produce a five-year strategy in response to the long term plan for publication in summer 2019. The five-year planning horizon provides an opportunity to think more creatively about the future shape of services in WY&H. The plan will build on the work of the partnership over the last few years and re-affirm and build on the philosophy and framework set out in the WY&H 'next steps' and associated documents – emphasising the importance of place, system collaboration and the principle of subsidiarity. It will also set out the partnerships ambitions for improving outcomes, with a continued focus on health and wellbeing and tackling inequalities; and responding to new priorities that emerge from the long term plan.

Staff and public engagement throughout the first half of 2019 to support the development of the 5 Year strategy will be carried out. Councils and VCS partners will have an important role in this process, as will our Trust members and governors. The timescale for the production of the strategy coincides with the first meeting in public of the new Partnership Board (4 June 2019). The intention is to use this meeting to consider the plan, which will help set the tone for

the work of the Board. An editorial group to oversee the development of the plan will be established.

3.6 Apprenticeship Levy

The use of the apprenticeship levy is variable across the WY&H HCP. The System Leadership Executive Group discussed maximising the benefit to WY&H in respect of levy utilisation by the partnership. There are opportunities to do this within organisations but also as a system.

3.7 The Truth Project's "I will be heard" campaign

The project has been created for victims and survivors of child sexual exploitation (CSE) to share their experiences in a confidential and supportive environment. The project offers the opportunity for victims and survivors of CSE to share their experience and be respectfully heard and acknowledged. They will make recommendations about support needs, as well as challenging assumptions of child sexual abuse. So far, nearly 2,000 victims and survivors have shared their experience with The Truth Project either through a private face-to-face session, by telephone or in writing.

Over the past year, the project team have been raising awareness of the opportunity for victims and survivors of CSE across England and Wales to tell their stories. The 'I will be heard' campaign has been promoted through local and national links. Now The Truth Project is advancing ambitious plans to reach a wider audience through television advertising, which commenced 14 January 2019. Partners are already engaged in supporting victims and survivors through the local safeguarding arrangements and through services that are available. The WY&H HCP agreed to support the campaign and the partnership CEO lead Rob Webster has written to the project to communicate the partnerships support. The Trusts communication team has also supported the campaign.

3.8 NHS Improvement, NHS England and NHS Digital two day visit to WY&H HCP

A group of senior leaders from NHS Digital, NHS Improvement and NHS England took part in a two day visit to the WY&H HCP. During the visit they met with senior leaders from the partnership to discuss the progress W&H is making as an ICS, and the role of digital in supporting the partnership vision and ambitions. They also visited services that have developed digitally enhanced care and services.

3.9 WY&HMHSC Committees in Common

The committee continues to meet and and drive forward the agreed transformation areas across the system in line with the national improvements set out in the Mental Health Five Year Forward View.

3.10 Mental Health Learning Disabilities and Autism programme update

Progress is being made against all programmes as reported through the Trust Integrated Performance Report and through the Committee in Common for Mental Health Providers. There are two Business cases that the Trust has an important role in and where there is potential risk for the Trust.

- Forensics New Models of Care: This project is using activity assumptions to plan for the future low and medium secure in-patient requirements across West Yorkshire ICS and the model of Community Service support, all within the existing NHSE spend.

Clinical workshops are taking place over the next month to focus on the longer term service vision and strategy, and will include discussions on: unified access and bed management arrangements; interface management, particularly focused on prisons, PICU and other non-Forensic mental health; community model and challenges to discharge; pathway development focusing on personality disorder and women's services; Forensic Outreach Liaison Service. A draft business case should be completed by March 2019 (subject to receipt of all relevant financial information from NHSE). This timetable has moved back a couple of months following discussions with NHSE about the need to ensure the business case includes more detail on the service vision and longer term model.

- An option appraisal for the future service model of Assessment and Treatment Unit (ATU) provision for people with learning disabilities across the West Yorkshire ICS is in development; this is scheduled to be completed in March 2019. There has been significant engagement with service users and carers to co-produce the business case. The West Yorkshire ATU steering group engaged 'Inclusion North' to make use of their 'service-user network' and their 'expert hub' (which included people who had lived experience of being admitted to an ATU) with a request that they discuss and provide feedback on the question 'What does a good ATU look like?' and 'What do we need to get right in our design of a future ATU model?'. In addition existing service-user feedback received from the 3 existing ATU's, which included relevant information from each ATU's latest CQC report, feedback from friends and family tests and any other satisfaction questionnaires completed by services has also informed the business case. Further engagement events with service users and carers are planned. A workshop with staff and commissioners/local authority stakeholders has also been held.

4. Local Integrated Care Partnerships- key developments

A number of the places that the Trust provides services are part of the WY&H HCP. These include Kirklees, Calderdale and Wakefield. Barnsley is part of the South Yorkshire & Bassetlaw Integrated Care System (ICS) that the Trust is a partner within. Notable developments include the following:

4.1 Calderdale

Calderdale partners are working together to deliver integrated, joined up care. Calderdale Cares is being progressed and Primary Care Networks are in the process of being established across the localities in Calderdale. North Halifax Primary Care Home and Central Halifax prototypes for Calderdale Cares continue to develop with three other localities now moving forward as primary care networks. The Sports England Bid secured to support physical activity and well-being in Calderdale continues to progress and Design Thinkers continue with the formal training and developing insights to better understand the challenges to increasing activity with a wide range of residents across Calderdale. Partners are working together to improve care and services for people living with ADHD/ASD in Calderdale and a whole system partnership event was held to commence a conversation that will shape improvements. Partners continue to work together to develop proposals to strengthen the role of arts and creativity in improving well-being as part of the Calderdale Cares development plans.

4.2 The Wakefield Integrated Care Partnership

The Wakefield partnership has continued to progress the integration agenda through the New Models of Care Board (NMoC) that is underpinned by an Alliance agreement. Priorities for 18/19 include mental health, Primary Care Home, frailty and older people, end of life care and cancer. There is a full day development session for the NMoC Board on 23 January 2019. The agenda for this session will focus on the future integration arrangements for Wakefield, and the 2019/20 Priorities in that context.

The Wakefield Mental Health Provider Alliance has continued to make progress on developing its governance framework (including the establishment of the Mental Health Stakeholder Group) and developing service pathways to improve service user outcomes and experience. The Alliance is overseeing the review and development of service pathways for service users with personality disorder/chaotic lifestyle, support for those living with dementia and their families, and implementing the action plan from the young people's mental health summits. Recent focus for the Alliance has been discussion and prioritisation of proposals for spending additional winter pressures allocations. These proposals are now being mobilised. The majority of the January Alliance meeting addressed the scope of service priorities for 2019/20, and how these should be prioritised. A key milestone for the Board is to review and agree the Alliance Agreement in February/March for it to be in place for April 2019.

4.3 Kirklees

System leaders have continued to meet and the Trust is a key partner in shaping the developments of integrated care across Kirklees. The Kirklees Health and Wellbeing Plan was discussed and supported at the Trust Board in October 2018. A summary plan on a page drawing out the key objectives and actions from the Health and Wellbeing Plan has been developed and is attached for Trust Board members to review. The Trust is leading the development of proposals to strengthen mental health and well-being through a partnership approach across Kirklees. The draft proposals include sharing the learning from the work that the Trust has led in developing an Alliance approach in Wakefield. The proposals were shared with the Kirklees Provider Board and received positively, feedback from the members of the Board will shape a further iteration of the presentation that will be further shared with the Kirklees Executive Partnership Group. As the proposals for an Alliance are developed and co-produced with partners in Kirklees, the governance arrangements will also be clarified and due diligence will be carried out as part of moving the proposals forward.

5. Recommendations

Trust Board is asked to receive and note the update on the development of Integrated Care Systems and collaborations:

- West Yorkshire and Harrogate Health and Care Partnership and
- Calderdale
- Wakefield
- Kirklees

Kirklees Health and Wellbeing Plan 2018-2023

Ambitions for our people, our places and our partnerships

DRAFT

Shared Vision for Kirklees:*

"A district combining great quality of life and a strong and sustainable economy leading to thriving communities, growing businesses, high prosperity and low inequality and where people enjoy better health throughout their lives."

Shared Outcomes:*

- Children have the **best start** in life
- People in Kirklees are as **well** as possible for as long as possible
- People in Kirklees **live independently** and have control over their lives
- People in Kirklees live in **safe, cohesive communities** and are protected from harm
- People in Kirklees have aspiration and **achieve their ambitions** through education, training, employment and lifelong learning
- Kirklees has **sustainable economic growth** and provides good employment for and with communities and businesses
- People in Kirklees experience a high quality, **clean, and green environment**

Key Health & Wellbeing Plan Major Initiatives 2019:

- Develop active communities exemplar project in majority of Primary Care Network areas
- Co-produce a new Children's Plan
- Develop a partnership wide Loneliness Vision and Action Plan
- Development plan for Primary Care Networks
- Kirklees wide integrated Frailty Model (including Intermediate Care, Care Home Support and End of Life)
- Develop a Kirklees Mental Health Provider Alliance
- Organisational Development Plan focussing on integration and innovation
- Integrated workforce strategy for community based services
- tbc – co-production
- Kirklees wide estates plan focussed on community based services, including the use of existing major sites (inc PRCHC)
- Development plan for a Kirklees Digital Care Record, making best use of the LHCRE programme support

** shared with Kirklees Economic Strategy*

We're Kirklees

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 8.1

Title:	**Integrated Performance Report (IPR) Month 9 2018-19**
Paper prepared by:	Director of Finance & Resources Director of Nursing & Quality
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for December 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 are positive overall, however some very significant local pressures remain. ➢ Under 18 admissions to acute wards have reduced for the month, work continues to ensure this is eliminated. ➢ Complaints turnaround remains a challenge, additional support is in place and backlog continues to reduce. ➢ Prone restraint position is positive for December. ➢ Staff supervision reporting has reduced and will be addressed during the final quarter. **NHS Improvement Indicators** ➢ The majority of national metrics continue to be achieved. ➢ The Trust did breach the maximum 6 week wait for diagnostics target of 99% in December leading to the third quarter performance of 98.6%. ➢ 2 days occupied by 1 child and young person in adult wards, which is an improvement compared to November. ➢ Inappropriate out of area bed admissions of 267 which is also an improved performance, although it remains well above target. **Locality** ➢ Musculoskeletal (MSK) referrals well above expected levels. ➢ The Trust was successful in recent tender exercise to provide liaison and diversion services across South Yorkshire. ➢ Calderdale local authority is continuing funding for a crisis café until March 2019. ➢ Adult occupancy on Calderdale & Kirklees wards remains high. ➢ Open dialogue approach to develop psychological resilience and resource of people in the community being initiated and funded in

	Barnsley. ➢ Ongoing discussions with NHS England regarding bed numbers and configuration in forensic services. ➢ Vacancies in learning disability and Child & Adolescent Mental Health Services (CAMHS) are being pro-actively addressed. ➢ Nil usage of out of area bed placements in Wakefield. **Priority Programmes** ➢ Work continues to implement criteria led discharge. SSG review of bed management processes has reached mid-point and due to complete end of January. ➢ Good progress on majority of milestones relating to the Clinical Records System (CRS) SystmOne implementation for mental health, but training is behind expectations. ➢ An additional 1,500 training places are being provided for staff in readiness for the SystmOne go-live. ➢ An updated business case for older peoples' services has been shared with commissioners and further conversations planned regarding how to take the model forward. ➢ Close work with Barnsley hospital on the stroke services review. **Finance** ➢ Pre provider Sustainability Funding (PSF) surplus of £158k in December taking the cumulative position to £795k deficit. ➢ Additional non-recurrent income from Barnsley Clinical Commissioning Group (CCG) was the driving factor behind this improved performance. ➢ The cumulative position does include a number one-off benefits including asset disposal gains of over £0.6m. ➢ Expenditure on out of area beds reduced in-month to £268k meaning cumulative spend is now £3.1m, already £1.4m adverse to full year plan. ➢ Cumulative net savings on pay amount to £1.2m through the level of vacancies. ➢ Agency staffing costs of £530k in month were broadly the same as previous month and cumulatively these costs are now 13% above the agency cap. ➢ CIP delivery of £6.8m is marginally below plan. ➢ The cash balance remains in relative health at £26.2m. ➢ In line with the Trust risk appetite statement which aims for financial risk of 4-6. Any implications on clinical risk must also be taken into account. **Workforce** ➢ Sickness absence improved to 5.7% in December and cumulatively has increased to 5.0%. Based on past trends this

	was anticipated with a reduction in the final quarter. Wellbeing groups are being established in all the BDUs and wellbeing champions being identified. ➢ The Trust achieved the national flu vaccination target of 75% with 76% of frontline staff being vaccinated. This was a CQUIN target. ➢ Staff turnover has reduced slightly in all areas except Wakefield and overall is slightly lower than the previous month. Work continues on the retention plan to reduce turnover particularly in clinical roles. ➢ The majority of training targets continue to be achieved although Information Governance has fallen below the 95% target, which needs to be addressed before the end of March.
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**
Private session:	Not applicable.

NHS
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Integrated Performance Report
Strategic Overview

December 2018

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for December 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 Trust's updated 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	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-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**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Year End Forecast**
Total number of children & young people in adult inpatient wards [5]	0	2	1	3	1	0	3	3	1	2	2	3	1	1
% service users followed up within 7 days of discharge	95%	97.2%	98.0%	95.8%	94.3%	99.2%	100%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	4
% clients in settled accommodation	*60%*	80.1%	79.7%	79.1%	78.9%	78.5%	79.1%	78.7%	78.8%	79.0%	78.5%	78.2%	77.9%	4
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]	95%		87.8%			86.7%			84.6%			84.2%		95%
Out of area beds [2]	Q1 940, Q2 846, Q3 752, Q4 658	268	613	730	531	282	368	437	589	384	165	389	267	1
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA Community	Community 75% Inpatient 90%					79.8%	81.1%	82.0%	82.8%	84.1%	84.5%	84.5%	83.8%	4
Inpatient [9]						89.1%	90.6%	93.3%	91.2%	90.1%	91.0%	92.5%	95.3%	4
Smoking Cessation - 4 week quit rate [8]	tbc					63%			65%			Due April 19		N/A
Improve the quality and experience of care	**Target**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Year End Forecast**
Friends and Family Test - Mental Health	85%	85%	85%	87%	86%	75%	82%	88%	91%	88%	89%	86%	90%	85%
Friends and Family Test - Community	98%	97%	97%	99%	97%	100%	98%	99%	97%	98%	100%	97%	99%	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	33	37	20	25	21	19	34	24	20	33	45	27	
Safer staff fill rates	90%	117.1%	117.5%	115.7%	118%	120%	118%	118%	117%	116%	116%	119%	118%	100%
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	7	10	4	8	11	14	16	14	15	14	20	11	
% people dying in a place of their choosing	80%	94.3%	84.4%	86.8%	82.8%	88.5%	92.9%	85.7%	90.0%	89.2%	90.9%	83.3%	87.9%	N/A
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic [7]	trend monitor		9.0%			15.1%			14.1%			13.0%		N/A
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [3]	trend monitor				39.1%	39.8%	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	
Improve the use of resources	**Target**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Year End Forecast**
Projected CQUIN Shortfall	£4.2m	£136k	£136k	£203k	-	£160k	£252k	£379k	£379k	£261k	£204k	£204k	£204k	£204k
Surplus/(Deficit)	In line with Plan	£635k	£1186K	£1139K	(£292k)	(£204k)	(£464k)	(£125k)	(£139k)	£424k	(£73k)	(£80k)	£158k	(£2026k)
Agency spend	In line with Plan	£465k	£563K	£555K	£444k	£538k	£484k	£526k	£575k	£522k	£537k	£536k	£530k	£6.5m
CIP delivery	£1074k	£6157k	£6816k	£7475k	£619k	£1308k	£1981k	£2737k	£3615k	£4452k	£5234k	£6015k	£6779k	£9.7m
Sickness absence	4.5%	5.2%	5.3%	5.3%	4.4%	4.4%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	4.9%
Aggression Management training	>=80%	77.9%	78.2%	79.3%	79.3%	81.7%	81.6%	82.9%	83.0%	82.2%	81.3%	81.4%	82.5%	80%
Moving and Handling training	>=80%	84.1%	85.4%	85.5%	85.2%	85.9%	85.6%	85.7%	86.1%	87.2%	87.3%	88.6%	89.0%	80%
Staff Turnover [6]	10%	12.4%	12.5%	12.6%	9.7%	8.5%	11.6%	12.4%	13.0%	12.8%	12.5%	12.3%	12.0%	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. Q2 data is currently with services to validate and will be included in next months report.
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. Data refreshed back to April 18 each month.
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 for all Trust smoking cessation services. National benchmark for 17/18 was 51%. Q1 data will be available in September18.
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.

Quality
• Safer staffing fill rates are positive overall, however some very significant local pressures remain.
• Under 18 admissions to acute wards have reduced for the month, work continues to ensure this is eliminated
• Complaints turnaround remains a challenge, additional support is in place and backlog continues to reduce.
• Prone restraint position is positive for December
• Staff supervision reporting has reduced and will be addressed during the final quarter

NHSI Indicators
• The majority of national metrics continue to be achieved
• The Trust did breach the maximum 6 week wait for diagnostics target of 99% in December leading to the third quarter performance of 98.6%
• 2 days occupied by 1 child and young person in adult wards, which is an improvement compared to November
• Inappropriate out of area bed admissions of 267 which is also an improved performance, although it remains well above target.

Locality
• MSK referrals well above expected levels
• The Trust was successful in recent tender exercise to provide liaison and diversion services across South Yorkshire
• Calderdale local authority is continuing funding for a crisis café until March 2019
• Adult occupancy on Calderdale & Kirklees wards remains high
• Open dialogue approach to develop psychological resilience and resource of people in the community being initiated and funded in Barnsley
• Ongoing discussions with NHS England regarding bed numbers and configuration in forensic services
• Vacancies in learning disability and CAMHs services are being pro-actively addressed
• Nil usage of out of area bed placements in Wakefield

Priority Programmes
• Work continues to implement criteria led discharge. SSG review of bed management processes has reached mid-point and due to complete end of January
• Good progress on majority of milestones relating to SystmOne implementation for mental health, but training is behind expectations
• An additional 1,500 training places are being provided for staff in readiness for the SystmOne go-live
• An updated business case for older peoples' services has been shared with commissioners and further conversations planned regarding how to take the model forward
• Close work with Barnsley hospital on the stroke services review

Finance
• Pre provider Sustainability Funding (PSF) surplus of £158k in December taking the cumulative position to £795k deficit.
• Additional non-recurrent income from Barnsley CCG was the driving factor behind this improved performance
• The cumulative position does include a number one-off benefits including asset disposal gains of over £0.6m
• Expenditure on out of area beds reduced in-month to £268k meaning cumulative spend is now £3.1m, already £1.4m adverse to full year plan.
• Cumulative net savings on pay amount to £1.2m through the level of vacancies
• Agency staffing costs of £530k in month were broadly the same as previous month and cumulatively these costs are now x% above the agency cap.
• CIP delivery of £6.8m is marginally below plan
• The cash balance remains in relative health at £26.2m

Workforce
• Sickness absence improved to 5.7% in December and cumulatively has increased to 5.0%. Based on past trends this was anticipated with a reduction in the final quarter. Wellbeing groups are being established in all the BDUs and wellbeing champions being identified.
• The Trust achieved the national flu vaccination target of 75% with 76% of frontline staff being vaccinated. This was a CQUIN target.
• Staff turnover has reduced slightly in all areas except Wakefield and overall is slightly lower than the previous month. Work continues on the retention plan to reduce turnover particularly in clinical roles.

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 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Year End Forecast Position *
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	Reporting commenced April 18				39.1%	39.8%	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	N/A
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%	12.7% 8/63	12% 6/50	9.3% 4/43	29% 2/7	20% 2/10	21% 6/28	21% 2/7	43% 3/7	57% 8/14	50% 7/14	13% 2/16	40/% 4/10	20% 2/10	1
	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	19.8% 43/217	18.2% 38/208	7.7% 13/168	16% 10/64	5% 3/57	10% 5/50	12% 11/88	15% 9/60	19% 13/68	19% 10/53	12%	21% 16/76	11% 4/35	4
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	84%	84%	86%	86%	86%	75%	82%	88%	91%	88%	89%	86%	90%	4
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	98%	98%	98%	97%	100%	98%	99%	97%	98%	100%	97%	99%	4
Quality	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	74%	75%	N/A	76%	N/A		75%	N/A	N/A	71%	N/A	N/A	N/A	N/A
	Staff FFT survey - % staff recommending the Trust as a place to work	Improving Health	Caring	AD	N/A	60%	64%	N/A	67%	N/A		70%	N/A	N/A	58%	N/A	N/A	N/A	N/A
	Number of compliments received	Improving Health	Caring	TB	N/A	81	113	148	64	26	109	44	27	45	48	63	26	60	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	N/A	337				*21*	*22*	*28*	*35*	*24*	*15*	*34*	43		N/A
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	N/A	26				0	1	*1*	*1*	*2*	*2*	*2*	1	Due Feb 19	N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	1		2	1	0	1	0	0	0	0	0	0		
	% Service users on CPA given or offered a copy of their care plan	Improving Care	Caring	CH	80%	85.2%	85.6%	85.0%	84.9%	86.3%	85.8%	86.2%	88.7%	86.3%	86.4%	86.6%	86.5%	87.5%	4
	Un-outcomed appointments [6]	Improving Health	Effective	CH	TBC	4.3%	3.3%	2.5%	2.5%	5.4%	4.3%	4.1%	3.3%	3.2%	3.0%	3.0%	2.9%	2.8%	N/A
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=8	33	22	24	21	8	11	14	16	14	15	14	20	11	
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	7.5% 3.5% from Sept 17	1.6%	2.3%	2.7%	3.7%	2.7%	2.1%	2.6%	2.4%	2.4%	1.5%	1.6%	1.9%	1.7%	4
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	TBC	Reporting commenced April 18				82.9%	85.0%	87.5%	78.5%	84.9%	91.0%	86.5%	84.3%	83.2%	N/A
	Number of records with up to date risk assessment - Community [11]									75.7%	78.4%	78.3%	74.6%	77.5%	78.4%	81.7%	86.2%	93.8%	N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	2849	3065	2962	3441	1074	1090	1039	1168	1014	862	1084	1108	970	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	13	15	25	22	15	23	31	23	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	3	8	9	7	2	1	1	4	0	3	5	4	1	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	12	17	24	11	0	7	3	5	2	2	5	10	3	N/A
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	*17.7%*	18.2%	24.3%	16.5%	20.5%	19.9%	20.6%	18.4%	23.2%	22.4%	22.1%	17.8%	22.0%	29.8%	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	109%	111.1%	114%	116.8%	118%	120%	118%	118%	117%	116%	116%	119%	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%	96.4%	92.5%	93.7%	98.3%	99.1%	96.6%	4
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	N/A	82	92	71	98	30	29	29	26	21	30	34	29	30	N/A
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	0	2	1	2	2	0	0	1	0	1	0	0	0	0	3
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	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	CH	80%	74.7%	79.5%	77.0%	75.7%	80.0%	61.3%	75.0%	76.3%	72.7%	72.7%	88.6%	81.3%	90.9%	4
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	139	139	150	181	40	40	44	43	37	52	40	41	50	N/A
	Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	345	424	442	589	173	211	143	192	151	134	190	201	136	N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	1	0	0	0	0	0	0	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	0	0	4
Quality	No of staff receiving supervision within policy guidance [7]	Improving Care	Well Led	CH	80%	59.3%	61.0%	64.7%	86.5%	81.3%			79.6%			74.9%			4

Quality Headlines

** 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 and categorisation of incidents has been updated in the year to reflect the requirements of the General Data Protection Requirements (GDPR)
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 Trust's contracts have not been varied to reflect this, however the Trust now monitors performance against 3.5%.
11. Number of records with up to date risk assessment - data now available for April 18 onwards. Criteria used is - Inpatients, we are counting how many Sainsbury's level 1 assessments were completed within 48 hours prior or post admission and for community services for service users on care programme approach we are counting from first contact then 7 working days from this point whether there is a Level 1 Sainsbury's risk assessment.

Quality Headlines

During 2017/18 the Trust undertook some work to develop the key quality measures and this has continued into 18/19. There are now only a small number that require additional development.

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

• Number of restraint incidents - the number of restraint incidents decreased during December. The highest proportion of incidents are in the standing position (59). The Trust continues to ensure that during training the emphasis on non-physical interventions remains paramount and when it comes to teaching and discussing prone restraint the course continues to inform staff of the risks associated with the prone position and the need to move from any prone restraint position as soon as possible. The Trust target of 80% of prone restraints being under 3 minutes is discussed at length and the importance of striving to maintain this is strongly emphasised.

• % of prone restraint with duration of 3 minutes or less - during December there were a total of 20 out of incidents recorded, this is a good improvement reporting at 90%. 2 of those incidents lasted between 4-5 minutes:

• related to Clark Ward - Barnsley. Due to level of aggression and continued attempts at self-harm; 1 related to Walton PICU – Wakefield. To administer I.M medication (This was an incident of rapid tranquilisation appropriate monitoring commenced following administration and rapid tranquilisation care plan insitu).

• NHS Safety Thermometer - Medicines Omissions – Performance has deteriorated compared to previous months and stands at 29.8% for December. 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 data collection for December was on a bank holiday (boxing day). Analysis of the data has been undertaken and does identify some hotspot areas. This is currently being investigated but one suggestion for the very high numbers is that the data collectors may have included those on leave as having had doses missed. We would not normally count this as the doses are given at home not omitted. There will have been many service users having day or part day leave on the data collection day. Guidance for the data collectors is being re-issued and information is being shared with business delivery units.

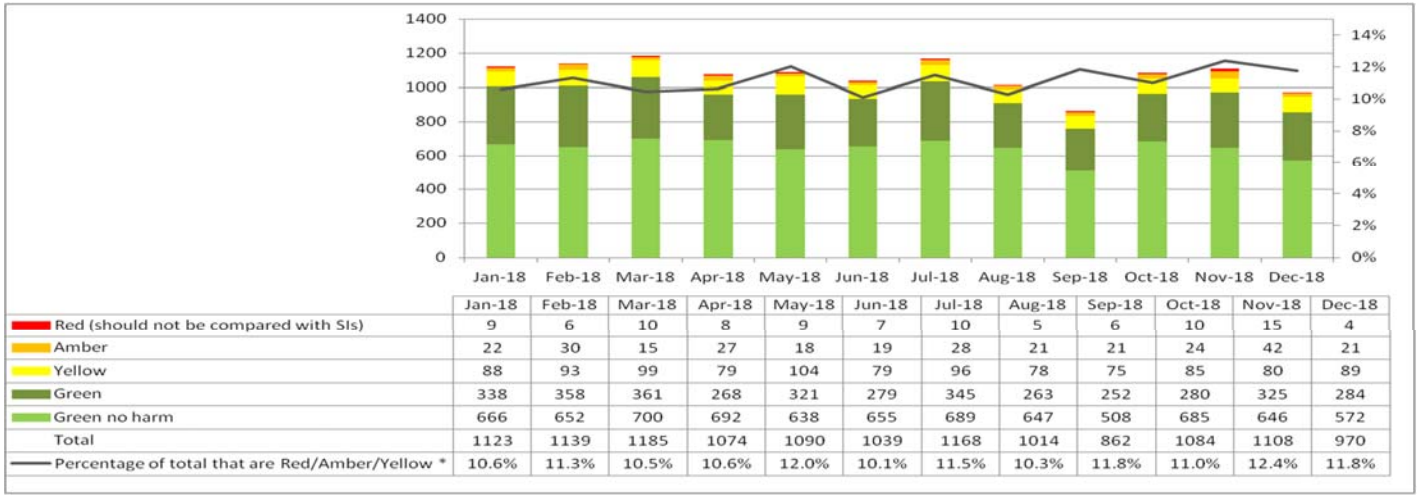
• Number of falls (inpatients) - December saw an increase in fall incidents during the month. Falls this month have occurred in all BDUs with the exception of specialist services and the greatest number of falls are attributed to Wakefield business delivery unit. In Wakefield, the higher number of falls continue to be attributed to the number of service users with physical frailties across the two older people's wards.

• % people dying in a place of their choosing - the Trust has been monitoring data for this indicator since April 2018 and has shown an improving trend which in some part is due to work undertaken to improve the collection and recording of this data.

Safety First

Summary of Incidents during 2017/18 and 2018/19

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



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Red (should not be compared with SIs)	9	6	10	8	9	7	10	5	6	10	15	4
Amber	22	30	15	27	18	19	28	21	21	24	42	21
Yellow	88	93	99	79	104	79	96	78	75	85	80	89
Green	338	358	361	268	321	279	345	263	252	280	325	284
Green no harm	666	652	700	692	638	655	689	647	508	685	646	572
Total	1123	1139	1185	1074	1090	1039	1168	1014	862	1084	1108	970
Percentage of total that are Red/Amber/Yellow *	10.6%	11.3%	10.5%	10.6%	12.0%	10.1%	11.5%	10.3%	11.8%	11.0%	12.4%	11.8%

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

Safety First cont…

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

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2017/18	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Total
Informal patient absent without leave	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Information disclosed in error	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Lost or stolen hardware	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Lost or stolen paperwork	0	1	1	0	0	0	0	0	0	0	0	1	0	1	0	0	2
Self harm (actual harm) with suicidal intent	0	0	1	1	0	1	0	0	0	0	0	0	0	1	0	0	2
Suicide (incl apparent) - community team care - current episode	4	3	4	6	2	3	1	1	3	0	2	1	0	2	1	1	17
Suicide (incl apparent) - community team care - discharged	2	1	0	0	0	0	0	0	0	2	0	1	0	0	0	0	3
Suicide (incl apparent) - inpatient care - current episode	0	0	1	2	1	0	1	0	0	0	0	0	0	1	0	0	3
Unwell/Illness	0	1	1	0	0	0	0	0	0	0	0	1	0	0	0	1	2
Allegation of violence or aggression	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1
Physical violence (contact made) against staff by patient	1	0	1	0	0	0	0	0	0	1	0	0	0	1	0	0	2
Physical violence (contact made) against other by patient	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1
Pressure Ulcer - Category 3	1	1	0	1	1	0	0	0	0	1	1	0	0	0	0	0	3
Total	8	9	10	12	4	4	4	1	3	4	5	4	0	6	2	2	39

The below charts show historic data of serious incidents by category.

- 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, the format and content is currently being reviewed.
- No never events reported in Dec 2018
- Patient safety alerts not completed by deadline of December 2018 - None

SI by category 2017/18

	Administration/supply of medication from a clinical area	Death - confirmed as accidental	Death - confirmed related to substance misuse (drug and/or alcohol)	Fire / Fire alarm related incidents	Formal patient absent without leave	Information disclosed in error	Self harm (actual harm)	Self harm (actual harm) with suicidal intent	Suicide (incl apparent) - community team care - current episode	Suicide (incl apparent) - community team care - discharged	Suicide (incl apparent) - inpatient care - current episode	Vehicle Incident	Allegation of violence or aggression	Homicide by patient	Physical violence (contact made) against other by patient	Pressure Ulcer - Category 3	Physical/sexual violence by other
Mar 2018	0	0	0	0	0	0	0	0	1	0	1	0	1	0	1	0	0
Feb 2018	0	0	0	0	0	0	0	1	3	0	0	0	0	0	0	0	0
Jan 2018	0	0	0	0	0	0	0	0	2	0	1	0	0	0	0	1	0
Dec 2017	0	0	0	0	0	0	0	0	5	1	1	0	0	0	0	1	0
Nov 2017	1	0	0	0	1	2	0	0	5	0	1	0	0	0	0	1	0
Oct 2017	0	0	0	0	0	0	0	0	4	1	0	0	0	0	1	1	0
Sep 2017	0	1	0	0	0	1	0	0	3	1	0	0	0	0	1	0	0
Aug 2017	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0
Jul 2017	1	0	0	1	0	0	0	0	5	1	0	0	0	0	0	1	0
Jun 2017	0	0	0	1	0	0	1	0	2	0	0	1	0	1	1	1	1
May 2017	0	0	0	0	0	1	0	0	2	0	0	0	0	0	0	0	0
Apr 2017	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0

SI by Category 2018/19

	Informal patient absent without leave	Information disclosed in error	Lost or stolen hardware	Lost or stolen paperwork	Self harm (actual harm) with suicidal intent	Suicide (incl apparent) - community team care - current episode	Suicide (incl apparent) - community team care - discharged	Suicide (incl apparent) - inpatient care - current episode	Suicide (incl apparent) - inpatient care - discharged	Unwell/Illness	Physical violence (contact made) against staff by patient	Pressure Ulcer - Category 3
Jan 2019	0	0	0	0	0	1	1	0	1	0	0	0
Dec 2018	0	0	0	0	0	1	0	0	0	1	0	0
Nov 2018	0	1	0	0	0	1	0	0	0	0	0	0
Oct 2018	0	0	0	1	1	2	0	1	0	0	1	0
Sep 2018	0	0	0	0	0	0	0	0	0	0	0	0
Aug 2018	0	0	0	1	0	1	1	0	0	1	0	0
Jul 2018	1	0	1	0	0	2	0	0	0	0	0	1
Jun 2018	0	0	0	0	0	0	2	0	0	0	1	1
May 2018	0	0	0	0	0	3	0	0	0	0	0	0
Apr 2018	0	0	0	0	0	1	0	0	0	0	0	0

The purpose of the Risk Panel is to assess and make recommendation in response to clinical risks impacting on the Trust arising from serious incidents reported on Datix. The panel meets weekly to:

- Review red and amber serious incidents (Sis) reported on DATIX in previous week
- Review Serious Incidents that are potentially STEIS reportable
- Contribute to the terms of reference for Stage 1 SI reviews
- Commission reviews and/or advise on objectives for reviews of amber incidents and/or clinical reviews as required
- Escalate any risks and concerns to the Chief Executive
- Review stage 1 SI reviews and decide whether stage 2 review required
- Contribute to the terms of reference for stage 2 SI review
- Identify where themes or trends emerge following the reviewing of incidents
- Advise on remedial actions if required
- Review intelligence from within and outside the Trust.

Mortality

Training: Structured Judgement Reviewer training is planned for 31 January 2019.
Assurance: 360 Assurance internal audit report on Learning from Healthcare Deaths has been received giving Significant Assurance. Remaining actions relating to updating the policy by 31/1/19. The revised policy is at EMT 10/1/19 for approval, having been to the clinical policies group in December.
Reporting: The Trust's Learning from Healthcare Deaths information is now reported through the quarterly incident reporting process. The latest report is available on the Trust website. 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 is shared in Our Learning Journey report for 2017/18
-Structured Judgement Reviews – learning from 2017/18 and Q1-2 cases is included in the latest report.
56% of reviews completed to date rated overall care as good or excellent
SJR Themes
Risk assessment: 35% of cases reviewed were rated good or excellent
Allocation/Initial Review: 46% of cases reviewed were rated good or excellent
On-going Care: 56% of cases reviewed were rated good or excellent
Care during admissions (where applicable): 57% of cases reviewed were rated good or excellent
Follow-up management / Discharge: 56% of cases reviewed were rated good or excellent
End of life care: 100% of relevant cases in inpatient care were rated good or excellent
51% of reviews completed to date rated the quality of the patient record as good or excellent
All completed structured judgement reviews (SJRs) go back to business delivery units for consideration through governance groups. SJRs should be used to identify overall themes rather than individual action, but teams do receive the reviews back and are now reflecting on the SJR by responding using the Situation, Background, Assessment, Recommendation (SBAR) learning template. Those completed to date have included some team learning/change. Themes from all reviews (good/excellent and adequate and below) are included by phase of care in the learning from healthcare deaths reporting. This information will be reviewed by the clinical mortality review group in March for organisational learning.
The learning from healthcare deaths report includes examples of areas for improving practice identified by the reviewers, and also good practice examples.
Work to embed recording the SJR within Datix has been completed which will aid extraction of themes.

Safer Staffing

Overall Fill Rates: 118%
Registered fill rate: (day + night) 96.6%
Non Registered fill rate: (day + night) 138.9%

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

BDU Fill rates - October 18 - December 18

Overall Fill Rate	Month-Year		
Unit	Oct-18	Nov-18	Dec-18
Specialist Services	119%	129%	165%
Barnsley	122%	125%	120%
C & K	103%	108%	107%
Forensic	113%	116%	114%
Wakefield	133%	135%	130%
Overall Shift Fill Rate	**116%**	**119%**	**118%**

The figures (%) for December 2018
Registered Staff - Days 89.2% (a decrease of 4.5 on the previous month); Nights 104.0% (a decrease of 0.5% on the previous month)
Registered average fill rate - Days and nights 96.6% (a decrease of 2.5% on the previous month)

Non Registered Staff - Days 135.8% (a decrease of 0.2 on the previous month); Nights 142.0% (a decrease of 0.4% on the previous month)
Non Registered average fill rate - Days and nights 138.9% (a decrease of 0.3% on the previous month)

Overall average fill rate all staff - 117.9% (a decrease of 1.5% on the previous month)

Summary
There has again been no ward fall below a 90% overall fill rate. Of the 31 inpatient areas listed 24, an increase of one on the previous month (76.8%), achieved greater than 100%. Indeed of these 24 areas, 12 achieved greater than 120% fill rate. This was an increase of two wards.
Registered On Days (Trust Total 89.2%)
The number of wards that have failed to achieve 80%, five wards in all (16.0%), has increased on the previous month. Four wards were within the Forensic BDU (Appleton, Chippendale, Hepworth and Johnson) and Poplars ward within the Wakefield BDU. There were various factors sited including vacancies, sickness and supporting acuity across the BDU.
Registered On Nights (Trust Total 104.0%)
Johnson ward within the Forensic BDU has fallen below the 80% threshold which also occurred in the previous month however; they have had an increase of 5.6% on the previous month and fell just below the threshold. The number of wards which are achieving 100% and above fill rate on nights remained consistent on 21 wards (67.2%) from the previous month.
Average Fill Rates for all areas increased in December. Barnsley BDU decreased by 3% to 120%. Calderdale and Kirklees BDU decreased by 1% to 107%. Forensic BDU were 114% a decrease of 2%. Wakefield BDU decreased by 5% to 130%. Specialist services were 165% with an increase of 36%. Overall fill rate for the trust decreased by 1% to 118%.
Despite the achievement and above of expected fill rates, significant pressures remain on inpatient wards due various influences including demands arising from acuity of service user population, vacancies and sickness.

Information Governance

There were 11 confidentiality breaches during December involving patient healthcare record issues, Information disclosed in error, non secure disposal – hardware. There were significantly fewer breaches recorded comnpared to recent months.
There were no incidents reported to the information commissioners office.

Commissioning for Quality and Innovation (CQUIN)

CQUIN leads have been agreed for 2019/20. Services continue to work towards the requirements for 18/19. The Trust submitted its quarter 2 reports towards the end of October and full achievement has been confirmed in relation to all schemes. Work is underway for the quarter 3 submission which is due to be submitted at end of January 19.

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 the required threshold means that the Trust would need to be in the top 6 of 200+ trusts nationally. The Trust has agreed some additional local measures related to staff health and wellbeing which reduces the total amount of risk associated with this indicator.

• Cardio metabolic assessment and treatment for patients with psychoses - The early intervention in psychosis element of this indicator has been rated as amber based on the 17/18 results. A number of mitigating actions are being put into place to further reduce this risk.

• Reducing restrictive practices - the detail of this is being worked through to ensure as much mitigation is in place as possible but is currently rated as green for Q1, Amber for Q2 and Red for Q3 and Q4.

The total CQUIN value for 2018/19 is £4.4m. The Trust currently has a risk of circa £204k shortfall for 2018/19. CQUIN leads are working to mitigate this risk as far as possible.

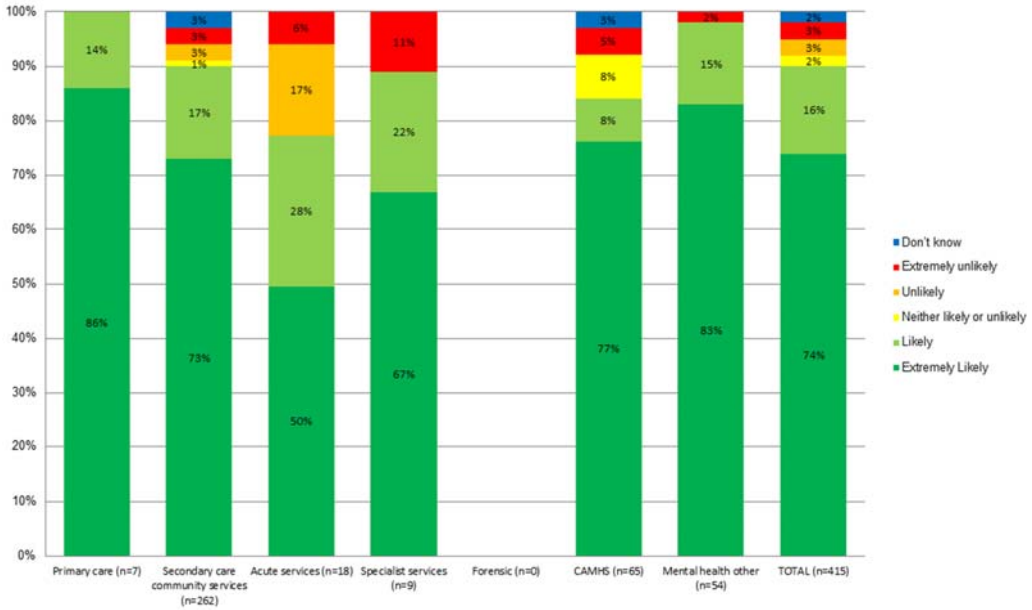
• Flu vaccinations - the Trust has now exceeded the 75% threshold and therefore achieved all income associated with this indicator. Final overall % performance for vaccination uptake is awaited.

Patient Experience

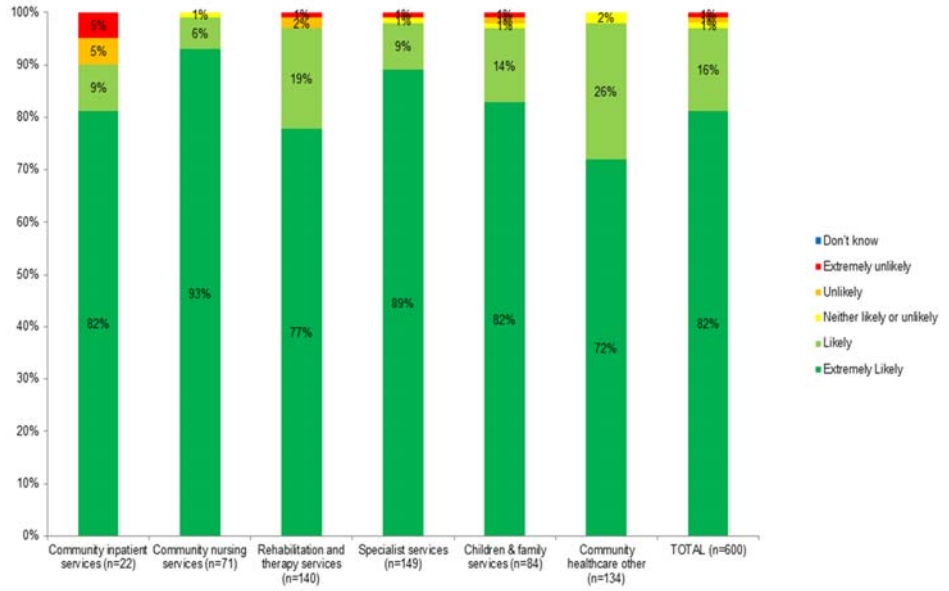
Friends and family test shows

- Community Services – 99% would recommend community services.
- Mental Health Services – 90% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 50% in acute services and 86% in primary care
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



Friends and family test feedback is viewed by business delivery units either via the live dashboard or in bespoke reports. Data is used to inform trends and to focus on areas of good practice and areas for improvement. The Trust asks 2 open ended questions:

What was good about your experience?
What would have made your experience better?

Free text responses are used to demonstrate specific positives and improvements that could be made.

Headines for the month of December:

- 94% of respondents would recommend Trust services
- December saw a significant increase in the number of responses (92%) (Nov 528 responses – Dec 1015 responses). This is due to the Barnsley Community electronic responses being uploaded in December.
- 41% (169/410) of community mental health responses were received via text message. A plan has been proposed to operational management group to enable all services to collect friends and family test via text message in line with the SystmOne 'go live'
- There has been a 248% (Dec 2017 291 responses – Dec 18 1015 responses) increase on the previous year's returns
- Patient experience surveys have been developed for the acute inpatient (working age adult) wards and are being deployed throughout January.
- Other areas under development include patient experience surveys for all other inpatient areas and posters with QR codes in child and adolescent mental halth services waiting areas linked to patient experience surveys. The quality improvement and assurance team are exploring the potential further usage of tablets including, staffing systems, audits and self-help app usage.

Care Quality Commission (CQC)

CQC Re inspection MUST/SHOULD do action plan – progress report December 2018
Following the March 2018 core service visits, the CQC issued the Trust with 18 MUST do and 47 SHOULD do actions. These included one MUST do and six SHOULD do Trust wide actions.

Monitoring of actions against our CQC action plan by the CQC

- We have developed a governance structure around the progress and management of the action plan.
- We provide EMT with a regular update of progress against the action plan, including any areas of concern which may delay or impact on timescales being met.
- We submit our monthly action plan progress updates to CQC.
- These are also discussed within our regular engagement meetings when we meet directly with CQC and update them on our progress and improvements and about any areas where improvements are still needed.
- We provide updates when we meet with our CQC Relationship Manager (Catherine Beynon-Pindar) on a regular basis.

	Progress at 31.12.18	
	MUST (n =18)	SHOULD (n=47)
Blue	2	24
Green	11	16
Green / Amber	3	7
Amber / Red	2	0
Red	0	0
Total	18	47

	Nov-18	
	MUST (n =18)	SHOULD (n=47)
Blue	2	16
Green	13	26
Green / Amber	3	4
Amber / Red	0	0
Red	0	0
Unrated	0	1
Total	18	47

The RAG ratings on the action plan will be agreed within the monthly Clinical Governance Group meetings.

Blue – Action completed.
Green – On-target to deliver actions within agreed timeframes.
Amber Green – Off trajectory but ability/confident can deliver actions within agreed time frames.
Amber Red – Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
Red – Actions/targets will not be delivered

These ratings are provisional until validation at the clinical governance group on 23.1.19.

- Progress continues to be made across all areas of the action plan, with 72% of MUST DO actions, and 85% of SHOULD DO either being completed or making good progress.
- The number of green/ amber and red /amber ratings has risen, due to the risk of timescales not been met. Where this is the case, clinical services have proved assurance that the task will be complete but not necessarily within the timescale identified. Challenges to getting actions completed are discussed in the clinical governance group and actions escalated to OMG when necessary.

There are 10 actions that have been rated as green/amber in December:

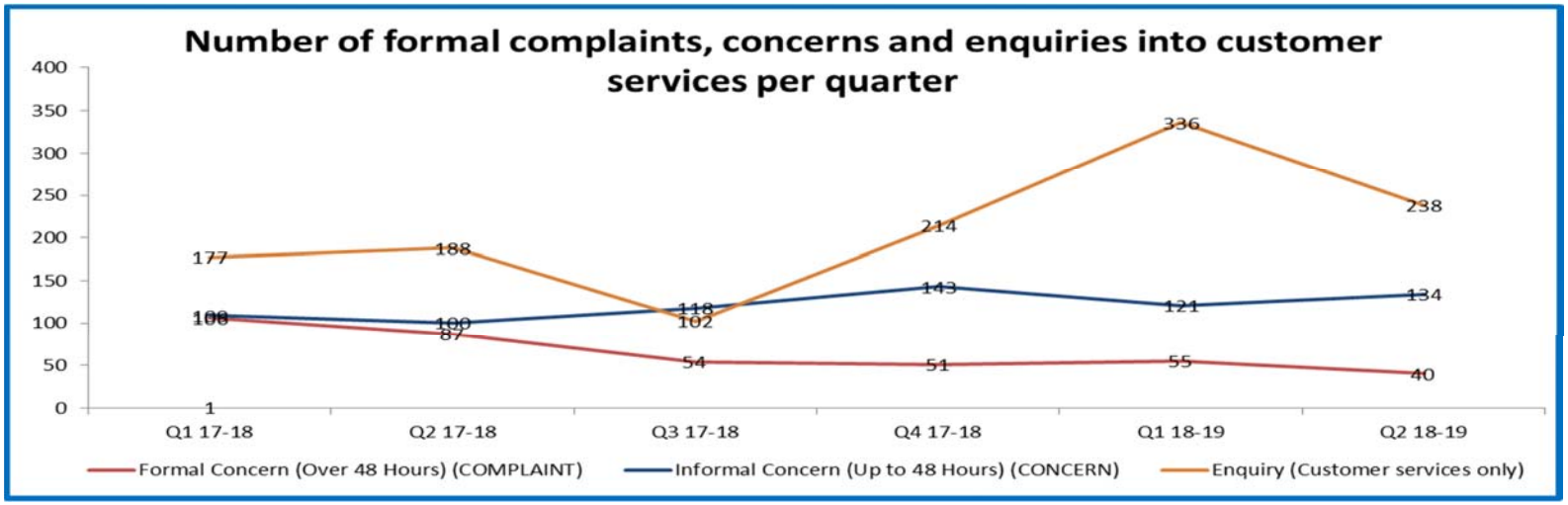
- Forensic core service: 3 green amber actions related to 'should do actions' medical equipment, replacement of door handles and access between Ryburn and Newhaven in an emergency (interim plan is in place to mitigate risk on both these actions).
- CAMHS core service: 2 green amber actions related to 'must do actions' environmental audits, out of hours on call and 3 should do actions, lone worker devices, referral to treatment times (plan is being actioned but with delay) and governance processes
- Acute: 1 'must do' complete S17 leave forms / carers & patients understand their responsibilities, 1 should do reporting of cancelled section 17 leave

There are 2 actions that have been rated as amber /red in December. These are both in the 'Acute & PICU ' core pathway.

Must do actions:
- Safe management of medicines – there continues to be medicines omissions that are unrecorded.
- Clinic room temperatures - clinical room temperatures: systems have been put in place but are not fully embedded across the acute pathway.

Next steps
1. The Clinical Governance Group continues to have oversight of the action plan and will escalate concerns accordingly.
2. OMG have requested a shared drive so BDUs can access an updated version of the action plan
3. Quality improvement work to be identified to address areas where teams are struggling to address actions

Customer Services



Overall the number of formal complaints received into the Trust, since April 2018 continues to decline. This can be explained by an actual reduction in people making complaints and the Trusts approach to complaint management, i.e. when people contact customer services we are proactive in seeking an early resolution to the issues raised within 48 hours. In line with this, the number of concerns has increased as expected.
At the start of July 2018 there were 118 complaints open which were over the 40 day timeframe. To date there are 12 complaints open over the 40 day timeframe and 5 of these complaints are from before the new sign off process was implemented in July.
The number of general enquiries into customer services has increased overall, however we saw a decline in this quarter.
Information Commissioner's Office (ICO): The Trust currently has one complaint with the ICO regarding the lack of information provided to the requester in response to a freedom of information request.
One decision notice received stated that the Trust correctly applied section 40(2) to the information it withheld and does not require the Trust to take any steps to ensure compliance with the legislation.
Care Quality Commission (CQC): During Quarter 2 the Trust received 3 requests for information from the CQC. All requests have been responded to and information shared.

Safeguarding

The specialist adviser:
• Supported a practitioner through supervision and revision of documentation for a serious case review for the MAPPA process.
• Jointly pulled together with the legal team and administration staff a mental capacity act (MCA) audit for Calderdale. The audit was disseminated to front line practitioners for completion. The findings were positive as practitioners had received training and were undertaking capacity assessments.
• Specialist advisor and the associate director of nursing attended a challenge event in Kirklees to discuss and highlight positive partner engagement.
• Attended a meeting with the recovery college to discuss process and possible safeguarding considerations for development and delivery of a course to discuss transsexual issues.

Safeguarding children:
• Safeguarding nurse advisor has worked alongside adult acute service and Locala regarding information sharing for mental health in-patient's with parenting responsibilities
• Parental mental health training has been delivered by the safeguarding children's nurse advisor as part of the multi-agency training offer in Barnsley, Kirklees and Wakefield.
• Extra level 3 safeguarding children mandatory training has been provided and well attended to target hotspots.
• Named nurse safeguarding children attended the NHS England regional prevent forum.
• Safeguarding children nurse advisor is completing the chronology for a child safeguarding practice review.
• SWYPFT and Calderdale hospitals NHS foundation trust (CHFT) liaison meeting is now attended by the named midwife and perinatal mental health lead from midwifery.

Exception: As a result of a large scale Child Sexual Exploitation Court hearing in 2018, in relation to Kirklees, which resulted in a significant number of convictions, SWYPFT need to consider how the organisations works collaboratively with partners within the Local Authority and other services to ensure there is a range of timely and appropriate responses to the victims of this crime which may require an approach which takes us outside of normal process. It is reported that all the victims of 'Operation Tendersea' who were between the ages of 11 and 17 when these crimes were committed, are now above the age of 18. Whilst this could create additional pressure for services, the risk of not responding in a timely manner could lead to a failure of services to appropriately support victims and potential reputational damage. To note, not all victims and their families will require or want to access to SWYPFT services. Further convictions are likely to occur over the next two years.
https://www.bbc.co.uk/news/uk-england-leeds-45618067

Infection Prevention Control (IPC)

• Progress on the Infection Prevention and Control Annual programme 2018-19, has been good, all objectives in Q3 have been completed. Progress in Q3 is good and there are no areas at risk of non-completion.
• Surveillance: there has been no MRSA Bacteraemia, Clostridium difficile, or any other alert organisms. Barnsley BDU has a locally agreed C difficile Toxin Positive target of 5.
• No outbreaks within are wards areas, but to note Norovirus and respiratory viruses are circulation in the communities, this is a national picture.
• No outbreaks, few wards have had IPC restriction in place but when monitored and investigate no outbreak confirmed.
• Wakefield - 6, Barnsley (mental health and community) - 0, Forensics - 2, Calderdale/Kirklees – 4, Specialist Services - 0 and Corporate Support Services - 1.
• Incident breakdown – 4 sharp related incidents, 2 sharp related not needle stick, 2 disposal of sharp, 2 outbreak restrictions in place (not outbreak), 2 exposure to infection and 1 contact with urine.
• Severity rating – 11 incidents were risk rated green and 1 yellow.
• 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.
• There is still reduced capacity within the team, (there is 1 IPC nurse vacancy). The team have review current process and put contingency plans in place. This has reduced the offer from the service.

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	Q4 17/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Q1 18/19	Q2 18/19	Q3 18/19	Year End Forecast Position *	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	97.4%	97.1%	97.3%	97.2%	97.1%	96.2%	97.2%	98.0%	99.0%	99.3%	97.1%	97.2%	98.6%	4	
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97.9%	100%	100%	98.6%	4	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	99.6%	*95.5%*	98.3%	98.8%	98.9%	97.5%	97.0%	99.0%	98.8%	97.6%	97.6%	97.9%	98.9%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	96.7%	94.3%	99.2%	100%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	97.7%	97.1%	97.1%	4	
Data Quality Maturity Index [4]	Improving Health	Responsive	CH	95%	98.3%	98.3%	98.2%	98.2%	98.2%	98.2%	98.2%	98.3%	98.2%	Due Feb 19	98.2%	96.8%	Due Feb 19	4	
Out of area bed days [5]	Improving Care	Responsive	CH	Q1 840, Q2 846, Q3 752	1608	531	282	368	437	589	384	165	389	267	1181	1410	821	1	
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	CH	50%	54.0%	52.9%	57.2%	53.2%	54.0%	52.1%	47.1%	*49.5%*	50.10%	Due Feb 19	54.4%	*50.6%*	Due Feb 19	3	
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	CH	75%	90.6%	91.6%	88.0%	93.9%	93.9%	94.8%	*94.0%*	*94.7%*	*96.8%*	Due Feb 19	91.3%	*94.2%*	Due Feb 19	4	
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	CH	95%	100%	100%	98.7%	100%	99.7%	99.5%	*99.6%*	*99.8%*	*99.5%*	Due Feb 19	99.4%	*99.6%*	Due Feb 19	4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	53%	89.8%	93.5%	81.0%	70.0%	92.0%	91.4%	90.3%	94.2%	94.7%	88.6%	81.7%	90.3%	92.6%	4	
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	79.1%	78.9%	78.5%	79.1%	78.7%	78.8%	79.0%	78.5%	78.2%	*77.9%*	79.1%	78.8%	*78.2%*	4	
% clients in employment [6]	Improving Health	Responsive	CH	*10%*	9.1%	9.0%	8.7%	8.6%	8.5%	9.5%	8.9%	8.6%	9.0%	*9.4%*	8.6%	8.8%	*9.0%*	1	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Improving Care	Responsive	CH			Due June 19												2	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q4 17/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Q1 18/19	Q2 18/19	Q3 18/19	Year End Forecast Position *	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	96	2	0	14	22	1	22	8	29	2	16	45	39	2	
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	4	1	0	3	3	1	2	2	3	1	4	6	6	2	
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	180	212			192			184			212	192	184	N/A	
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	CH	*Trend Monitor*	9.0%	15.1%			14.1%			13.0%			15.1%	14.1%	13.0%	N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q4 17/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Q1 18/19	Q2 18/19	Q3 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	CH	90%	98.1%	97.4%	97.7%	97.5%	98.8%	98.5%	99.1%	98.9%	97.0%	*98.8%*	97.8%	98.8%	*97.9%*	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	CH	99%	99.8%	99.8%	99.9%	99.9%	99.9%	100.0%	99.9%	100.0%	99.9%	*99.9%*	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	CH	90%	90.6%	90.7%	90.5%	90.8%	90.5%	95.5%	95.1%	91.0%	90.9%	*90.5%*	90.8%	91.1%	*90.8%*	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
- The proportion of people completing treatment who move to recovery within Improving Access to Psychological Therapies (IAPT) is just above threshold for November. Decembers final data is not yet available but will be reported in next month's report.
- During December 2018, the number of service users aged under 18 years placed in an adult inpatient ward dropped to 1 - there were no new admissions during the month, this was a service user that was admitted during November and discharged early December. 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. 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. The target was not met in quarter one or two and although the quarter 3 has seen an overall reduction in the number of bed days this is still above trajectory and therefore not achieved. Focus remains on reducing the levels of bed days out of area.
- % clients in employment- the Trust is involved in a West Yorkshire and Harrogate Health & Care Partnership wave 1 three-year funding initiative, led by Bradford District Care, to promote, establish and implement an Individual Placement Support (IPS) scheme. IPS is evidence based vocational scheme to support people with mental health problems to gain and keep paid employment. Work is currently ongoing in Calderdale to expand the opportunities we can offer people under this scheme.

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

Barnsley BDU:

Community

Key Issues

• Musculoskeletal – increased numbers of referrals above those expected in specification continues. Approx. 200 additional per month.
• Dietetics - a number of unnecessary referrals for face to face contact within dietetics. Working with Barnsley hospital on a solution.
• Occupational Therapy (OT) – Significant workload and resource pressures in this service.

Strengths

• Barnsley flu vaccination achieved target
• Green for mandatory training (Equality and Diversity; Data Security Awareness; Fire; Hand Hygiene; mental capacity act/deprivation of liberty; Moving and Handling; Safeguarding Levels 1,2 & 3)
• Joint working with BHNFT via multi-disciplinary meetings, intermediate care at risk of re-admission pathway and In-reach nurse.
• Ongoing development in line with cardio vascular disease and frailty workstreams
• Musculoskeletal – despite increased numbers maintaining triage of referrals within 2 days (114%)
• Professional lead for occupational therapy (OT) determining issues and assisting forming resolutions for OT staff.
• All Yorkshire smoke free (YSF) and Live Well Wakefield (LWW) services are performing well.
• YSF Wakefield have successfully established an in-house stop smoking service at Mid York's Hospital
• Health and Wellbeing (HWB) - All staff have completed mental health first aid training
• Friends and family test for LWW is outstanding
• YSF Facebook page is the 3rd most viewed Smoke Free site in the country
• Health and wellbeing - Very low staff turnover rates despite the uncertainty re tenders
• Children's - all services are performing well
• Children's - Friends and family test are very good with some services areas being outstanding
• Child health information system and vaccination and immunisation contract rolled over for 2019/20

Challenges

• End of Life/Palliative Care service review to commence in New Year.
• Barnsley integrated community equipment store (BICES) - due to sickness – contingencies in place – high priority being maintained may be some delay in low priority deliveries, made services aware.
• YSF Barnsley is out for tender this year (runs until 30.09.19). Calderdale contract has been extended until 31.03.20 but as yet Commissioner has not shared their future intentions. Doncaster has a reduced budget year on year for the life of the contract which is challenging. Sheffield have challenging targets which are payment by result.
• HWB - Referrals from our internal SWYPFT teams are very low which is frustrating as our offer fits in to our Trust wide aims and objectives
• Children's CCG/LA Commissioned Services being reviewed in 2019.20
• Children's - Specialised nature and size of teams make them vulnerable if a member leaves or on LTS.

Areas of Focus

• Pulmonary Rehab – performance noticed received. "Joint investigation" following meeting with commissioners.
• Musculoskeletal – staff well-being; time out prepared
• OT – work with Mental Health managers to help recognise lack of OT clinical support through structures.
• Un-funded Wakefield Dietetic service being ceased
• Podiatry – demand and capacity process due for completion
• Dietetics – work with CCG reviewing diabetes offer to learning disability patients with diabetes
• Speech and language therapy professional lead and service manager retirement planning (due end Sept 2019)
• Neuro rehabilitation unit beds – ongoing marketing for out of area beds. Discussions commenced with CCG re STP focus.
• Podiatry - following enquiry by CCG preparing internal review of service / service offer
• Stroke rehabilitation unit – development of integrated stroke pathway including new early supported discharge service and workforce requirements in line with hospital services review

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

Key Issues
•The acute service line continues to experience high demand and some staffing pressures leading to ongoing bank expenditure. This is being kept to a minimum by utilisation of resources across the wards and effective skill-mixing.
• Average length of stay remains in excess of target and has been identified as part of the trust wide programme of improvement in addressing demand and capacity in acute services.
• Demand and capacity is a challenge in community services, particularly in the enhanced pathways, where adjustments are being made following the changes in the integrated service model and the return of social work resources to the council. Particular work has been needed in one team, where an action plan is in place to cope with demand and capacity and support with staff wellbeing. Partnership approaches and effective communication continues between the council and SWYFT.
• SWYFT were successful in the recent tender process and will become the new provider of Liaison and Diversion Services across South Yorkshire with effect from 1 April 2019. Work is now underway with NHS England, existing providers and external and internal stakeholders to develop and implement the new service model.

Strengths
• Management of patient flow.
• Open dialogue is an innovative approach in mental health, developed in Finland, centred on techniques and strategies that develop the psychological resilience and resources of people in the community. It has a growing evidence base of positive service user outcomes, enabling people to recover from psychotic crises by intervening quickly and effectively, and with a reduction in the use of medication. The early intervention in psychosis team have been successful in securing £43k additional funding from Barnsley CCG to enable open dialogue. UK to put on a one year foundation level course for 18 staff, which will mean Barnsley will become a designated beacon site for open dialogue in the north. Staff are being trained from different services so that the approach can be embedded across the system, creating exciting opportunities for joint working and organisational development across neighbourhoods and networks.

Challenges
• Demand and capacity in community services.
• Adult acute occupancy levels remain high.
• Action plan is in place to improve data quality and in particular performance around care programme approach (CPA) reviews and 14 day access as a key performance indicator, this continues to be impacted upon by the council staff being withdrawn from the integrated teams as above.
• Expected activity levels in the enhanced and core teams require re-defining following the disaggregation of social care resources.

Areas of Focus
• Admissions and discharges and patient flow in acute adult services.
• Continue to improve performance and concordance in service area hotspots tracked team by team by general managers.
• Demand and capacity work in the enhanced pathway.
• Reduction of agency and bank spend in acute services.

Calderdale & Kirklees BDU:

Key Issues
• Delayed transfers of care (DTOC) - performance against reduction in DTOCs continues. We have now implemented weekly, newly designed mental health MADE (multi agency discharge planning) clinical commissioning group (CCG), local authority and Trust meetings.
• Continued pressure for admissions and out of area (OOA) beds. Occupancy and acuity remains high on all adult wards and across the business delivery unit (BDU). Kirklees local authority and CCGs have allocated social care and health winter pressure money allocations to a new safe SPACE (commencing February) and discharge co-ordinators. We are focusing on, community and social care admission avoidance options, alternative crisis provision in the community and wrap around complex support packages. Plus some bespoke older adult packages.
• Calderdale local authority is funding the continuation of a local crisis café until March 2019.
• % of clients in employment is recorded as 11.68% in December which reflects an increasing and improving trend and focus within the BDU. This relates to service users aged 18 to 69 years and on the care programme approach.
• Friends and family response numbers have increased significantly since using a text approach with a 90% positive experience result.

Strengths
• High levels of clinical supervision are being recorded.
• Strong and positive performance on mandatory training continues.
• Very positive appraisal completion across all bands.
• Discharge co-ordinator capacity on all wards started in December to reinforce flow management. All 5 now in post.

Challenges
• Adult occupancy levels are high and discharge rates on some ward have reduced. The medical clinical lead is reviewing individual ward performance and giving additional support to local consultants.
• Recruitment of psychological wellbeing practitioner (PWP) workers in improving access to psychological therapies (IAPT). Appointees identified and are commencing employment

Areas of Focus
• Continue to improve performance in service area hotspots such as adult inpatients
• Recruitment to posts in community especially Kirklees IAPT PWP workers and consultants.
• Ward 18 garden area reviewed for overall safety and new anti-ligature, anti-climbing and netting work is due to commence in all Priestley unit gardens in late January.
• Adult ward nursing staff recruitment ongoing and increase in line with executive management team (EMT) agreement in order to improve safety and patient experience. Additional band 2/3s undergoing recruitment.

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

Forensic BDU:

Key Issues

• NHS England (NHSE) intend to de commission 8 Learning Disability beds. Following a meeting with NHSE a draft business case for alternative use of the beds has been shared.
• Service review/business case as lead provider continues to progress. 3 key themes of work identified. Meeting of key clinicians across West Yorkshire to explore future demand and capacity.
• Learning disability forensic outreach and liaison service (LD FOLS) continues to develop recruitment to initial service has commenced. Team Leader and key clinicians appointed on a fixed term/secondment basis.
• NHSE commissioned an independent review into Forensic child and adolescent mental health services CAMHs service in Her Majesty's prison (HMP) / Youth offending institute (YOI) Wetherby and Adel Beck following concerns regarding the delivery of HSB (Harmful Sexual Behaviour) and wider service delivery issues. Final report now received and work has commenced with LCH and HMP/YOI Wetherby to develop an action plan.
• Occupancy levels in medium secure above 95% but remain below target in Low secure.

Strengths

• Strong performance on mandatory training.
• Developing innovative and collaborative work in the delivery of this years CQUINs.
• Progress being made on care quality commission (CQC) action plans. Only action waiting to be addressed is the call system which will form part of an overall Trust response.
• Service well-being group has identified key areas of development moving forward.

Challenges

• Low secure occupancy levels well below 90%
• Recruitment of Band 5 nurses (17 vacancies across the business delivery unit).
• Reducing sickness.

Areas of Focus

• Reducing sickness.
• Development of Learning disability forensic outreach and liaison service.
• Continue to improve performance in service area hotspots.
• Working through action plans in a timely manner.
• More detailed analysis of agency spend to minimise increase.
• Leadership development within FCAMHs.

Specialist BDU:

Key challenges

• There have been three recent suicides of young people (18 years+) in Wakefield. Two of the young people had been known to child and adolescent mental health services (CAMHs). The Wakefield Safeguarding Board is now leading on a serious case review in relationto all three cases and is undertaking further review regarding the potential for 'cluster' suicides in the last 2/3 years. An internal investigation is being progressed with respect to the young people known to CAMHs which will support the review.
• The suicides come at a time of some clinical concern over growing caseload risk. A review of all aspects of the service with the commissioner of how demand is best met, the service offer and funding is now required and recommendations will be reported accordingly. This needs to take into account the safeguarding review and internal management review. Encouragingly there is considerable focus on these services in the NHS long term plan and a considerable degree of senior engagement across a Wakefield organisations on the next steps.
• An action on autism summit was held in Calderdale on 10 January 2019. Partners from across the local system - including children/young people and families – were in attendance. The purpose was to initiate a strategic review of arrangements for diagnostic assessment and support.

Strengths

• Kirklees and Calderdale learning disability (LD) service services are now live with the text reminder service for psychiatry patient appointments, with Wakefield and Barnsley part way through their implementation plan for this
• In learning disabilities services there has been improvement in all four localities on 3 month post discharge review
• Barnsley CCG has committed to investment in development of an all-age liaison model. Work is progressing with a view to May 2019 implementation.
• Kirklees application to be a CAMHs Trailblazer site was successful. This partnership-based project will see a significant strengthening of school-based support.

Areas for focus

• Proactively addressing vacancy levels in learning disability services and consultant posts in CAMHs
• Calderdale CCG has invested in an autistic spectrum condition (ASC) diagnostic waiting list initiative led by CAMHs. This will increase pathway capacity from 5-15 assessments per month for a 12 month period.
• Wakefield CCG has invested in a CAMHs waiting list initiative focused on group and brief intervention support.
• Barnsley CCG has invested £61k in a non-recurrent attention deficit hyperactivity disorder (ADHD) focused waiting list. A business case has been develop for recurrent funding to address the waiting times for ADHD diagnostic assessment and treatment.

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

Wakefield BDU:

Key Issues

• The acute service line continues to experience high demand and staffing pressures leading to ongoing bank expenditure.
• Out of area beds for Wakefield service users has been maintained as nil usage and intensive work takes place to adopt collaborative approaches to care planning, to build community resilience; and for presenting acute episodes, to explore all possible alternatives at the point of admission.
• The pressures of demand and capacity across the whole acute services system continue to have an adverse impact on the business delivery unit financially.
• Average length of stay remains in excess of target and has been identified as part of the trust wide programme of improvement in addressing demand and capacity in acute services.
• Medical recruitment remains a challenge in both acute and community service lines leading to continued expenditure on agency medical staffing.

Strengths

• Management of patient flow and for Wakefield nil out of area bed usage.
• Care programme approach review performance remains high.

Challenges

• Adult community consultant vacancies and gaps continue to be a pressure leading to financial and clinical continuity challenges.
• Adult acute occupancy and acuity levels remain high.
• Expenditure on bank and agency staffing in acute services and agency spending on medical staff in community.

Areas of Focus

• Admissions and discharge flow in acute adults with an emphasis on current approach to alternatives to admission and collaborative inter-agency planning.
• Continue to improve performance in service area hotspots through focussed action planning.
• Medical recruitment to consultant psychiatry and specialty doctor posts.
• Reduction of agency spend.

Communications, Engagement and Involvement

• Christmas Countdown on social media which generated excellent staff engagement (particularly on Facebook), plus coverage of Christmas activities
• Flu campaign continued, based on insight and in line with communication plan, utilising all existing routine channels.
• SystmOne for mental health - continued promotion of training, confirmation of new go live dates, and regular updates to super users.
• Co-production of a partnership communication strategy with Barnsley Hospital, the CCG and GP Federation to promote alliance working and partnership working successes
• Support for the changes to stroke pathway in Barnsley - regular updates to staff via newsletter
• Forensic service review – promotion of training for community staff to improve links with forensic services.
• Support for transformation programmes – community, older people's and rehab and recovery services in Kirklees
• Support to EyUP! through promoting and supporting Christmas events, and with fundraising manager recruitment, including social media advertising

This is the January 2019 priority programme update for the integrated performance report for progress on the 2018/19 Trust priorities. It therefore covers activity up to and including 31 December 2018

Note: Where a priority programme is already reported in another section of the IPR, e.g. patient safety, new business etc., then those updates are not repeated in this priority page but appear elsewhere in the report.

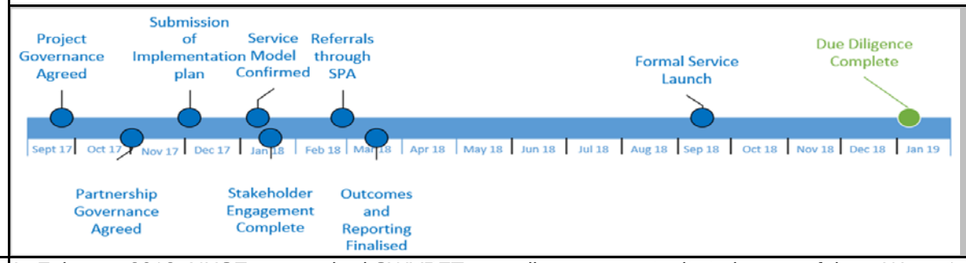
A summary of key updates for activity conducted in December includes:
Flow and out of area beds:
Bed pressures remain in the system and out of areas placements continue, although the levels fluctuate, and the risk the expenditure will exceed forecast levels still persists.
• Work continues toward implementing criteria led discharge across inpatient units. Wakefield BDU and Barnsley are now live. Calderdale/Kirklees are implementing in January 2019.
• Work continues with the external consultants to focus on the root causes of the out of area situation and establish change activity to support improvement. A mid-point review took place on the 10th January where early hypothesis were considered; the end project report is due by 31 January.

Clinical Record System:
• Trust Board have approved the cutover approach and a new go live period (Monday 25 February – Tuesday 5 March). Inpatient teams will go live on Monday 25 February, followed by the rest of the services on Tuesday 5 March
• We've been working with the supplier of SystmOne to resolve the issues that might prevent us going live. There are currently three issues being worked through and escalated to the appropriate level within the Trust and the supplier and good progress is being made.
• Our strong engagement with clinical teams continues, involving change reference group attendees in the reviewing of clinical documentation/assessments. There has also been extensive engagement with representatives from inpatients, community and specialist services in go live planning.
• 53% of staff have demonstrated competency and will have their smart cards updated, ready for go live, and schedules are in place to offer training in January and February 2019. We're encouraging staff to make use of the extra 1500 places we've made available. If staff do not complete training, their smart cards will not be updated for go live. Our aim remains to have at least 85% of staff competent by the end of January. This has been raised as a critical risk.

Older Peoples Services
• Amendments to the business case continued through December.
• A partnership board discussion was conducted and this initiated further conversations with commissioners about how best to take the model forward.
• Further meetings with commissioners have taken place though Barnsley meeting arranged.
• Task and finish activity is ongoing to ensure that we have the right physical environment for any future dementia specialist ward.

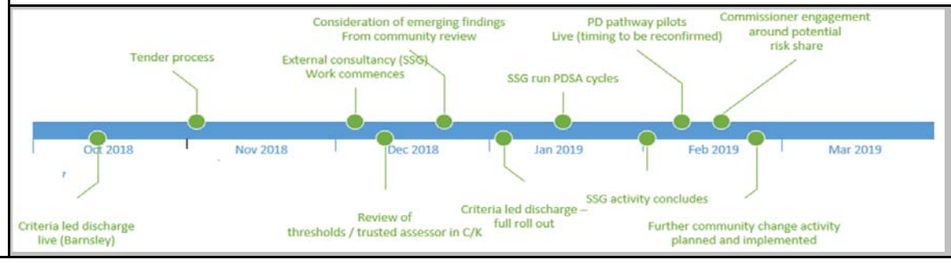
Priority	Scope	Narrative Update	Area	RAG
IMPROVING HEALTH				
Joined Up Care				
South Yorkshire Projects: Stroke Service Review	Work with our South Yorkshire partners to deliver shared objectives as described through the integrated care systems plans. This includes work on: • Stroke service review As a result of the South Yorkshire ICS work on the Hyper-Acute Stroke provision and the wider Hospital Services Review SWYPFT and Barnsley Hospital NHS Foundation Trust (BHNFT) were asked to work together by CCG on an integrated pathway for stroke patients in Barnsley. The key themes within this are: MDT (Multi Disciplinary Team) working TIA (Trans Ischaemic Attacks) pathway ESD (Early Supported Discharge) pathway Project Objectives: • Develop integrated stroke services across Barnsley to establish improved patient flow and pathways • Reduce potential duplication across the borough, in particular TIA clinics and provide a one stop shop for patients. • Establish integrated multi disciplinary team (MDT) working across both organisations to reduce the impact of pathway handovers on patient care and improve system wide patient flow. This element overlaps both 2 and 3. • Develop a stroke specific ESD service which will support improved patients flow from the new HASUs and enable patients to reach their rehabilitation potential closer to home as/when appropriate in their recovery journey	Update this month : • Task action groups (TAG) continue for both single transient ischaemic attack (TIA) pathway and Early Support Discharge (ESD) workstreams. • Quality impact assessment (QIAs) are drafted and with Barnsley Hospital NHS Foundation Trust (BHNFT) for comment • Equality impact assessment (EIAs) are also drafted and again with BHNFT for comment • Communications update was issued to staff in mid December following Steering Group held 10 December • Outline model/new developments was presented to Clinical Forum on 6 December – positive feedback was received • Senior/Executive level stocktake meeting is arranged for 21 January 2019 by CCG <u>Single TIA pathway (TIA)</u> • Timetable agreed including medical cover • Clinics at BHNFT to start week commencing 7 January 2019 • Referral forms have been updated in line with Barnsley system needs and wider Health and Working Together in South Yorkshire and Bassetlaw HASU model – these have been shared at SYB ICS Stroke Implementation Group in December. • Further work underway to finalise the review process later in the TIA pathway. Follow up clinics will take place at Cudworth, staffed by SWYPFT clinicians <u>Stroke early support discharge (ESD)</u> • Demand and capacity work continues • Meeting held with commissioners 30 November to review projected activity and help inform the likely demand on ESD • ESD draft proposal shared with TAG members and taken to Steering Group 10 December 2018 • Financial projection work underway in preparation for January discussions <u>MDT</u> • SWYPFT and BHNFT colleagues have been meeting to discuss how to improve patient flow. • SWYPFT colleagues are joining BHNFT multi disciplinary team (MDT) meeting weekly (rota basis) to discuss potential Stroke Rehabilitation Unit (SRU) patients. • Proposal for project support to develop integrated dashboard reporting system to share real time information to support MDT working and decision making	Progress Against Plan	
		Initial areas of risk include: • Finances/contracting, in particular if there are issues with the cost of the remodelled ESD pathway. • Recruitment and retention. Recruitment could be a challenge in early 2019 if additional staffing is required to establish the new pathway. Also retaining current staff in the new model. • Contracting arrangements • HASU timeline not on track • Demand for radiology / availability of diagnostic testing within required timescale • Social care not yet fully included in scope of stroke developments • Requirement for shared IT systems • Viability of six acute beds	Management of Risk	

		High level milestones: ESD pathway mapping - September 2018 - Complete TIA - move to Barnsley Hospital – 7 Jan 2019 ESD - proposals for model developed - end of November 2018 ESD - financial projections in place (Dec / Jan) ESD – senior meeting to be organised for January 2019 ESD - service model agreement - January 2019 ESD - implementation process - February to March 2019		
South Yorkshire Projects: Neurological rehabilitation	Work with our South Yorkshire partners to deliver shared objectives as described through the integrated care systems plans. This includes work on: • Neurological rehabilitation	This priority reports bi-monthly on the IPR. The next update is due in the February 2019 IPR but the last update from December 2018 included the following: • The project team is working towards a robust plan to promote and market capacity in NeuroRehabilitation unit (NRU) beds in Barnsley that will be available due to de-commissioning. Progress is in line with this plan and is nearing completion. • The project team consists of representatives of the service, supported by members of the integrated change team, business development and our communications and marketing team. • A publicity leaflet about the unit, its service offer, facilities, outcomes and costs has been professionally designed and finally signed off prior to printing which occurring currently. This leaflet, with accompanying cover letters, will be part of targeted marketing of the service to local GPs, intensive treatment units, neighbouring CCCGs etc. • Pull-up banners to promote the service at conferences and clinical events have also been designed • Updates to the information on the web about the NRU will align to information contained in the publicity leaflet.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Implementation Plan in place		
South Yorkshire Projects: Autism and ADHD	Work with our South Yorkshire partners to deliver shared objectives as described through the integrated care systems plans. This includes work on: • Autism and ADHD	• Initial discussions are still taking place on developing a plan and determining objectives and resource implications for this priority. • This plan include gaining learning lessons from the West Yorkshire and Harrogate Health and Care Partnership (WY&HHCP) priority for improving autism and Attention deficit hyperactivity disorder (ADHD) and potentially delivering them as one combined piece of work.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Implementation Plan not yet available		
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.	New business activity within this priority is covered by the monthly bids and tenders report to EMT and is therefore not updated specifically in this priority section of the IPR.	Progress Against Plan	
		New business activity within this priority is covered by the monthly bids and tenders report to EMT and is therefore not updated specifically in this priority section of the IPR.	Management of Risk	

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	Following implementation of this project, and subsequent handover to business as usual (BAU), this priority will, from January 2019, report bi-monthly. Activities completed for the reporting period of December 2018 include: • Clarity has now been obtained in regards to data submission for the national evaluation, our assistant psychologist is liaising with other regional teams and the national teams to ensure we are gathering required data across Yorkshire and Humber. • KPI feedback data remains low for feedback from young people, professionals and carers, steps have been taken to imbed this into clinicians practice to increase feedback gained. • A meeting is scheduled with performance and information (P&I) on 31 January 2019 to review key performance indicator (KPI) data collection and to ensure this is being accurately reported from the system. This will also allow for planning around the implementation of SystmOne and any impact of this. • The new band 6 mental health practitioner post is completing pre-employment checks and should be filled shortly. • Operational meetings continue to take place and will be scheduled to continue quarterly through 2019. Attendance from partners is an area to be addressed, as this is not consistent presently. • The West Yorkshire area within the FCAMHS Yorkshire and Humber region remains the busiest. Referrals slowed over the Christmas and New Year two week period, which was predicted. • A plan is being developed with regards to on-going service development for the next 12 months, this will continue to be reviewed within monthly business meetings, to ensure this is on track. • The December highlight report (reporting on November progress) was issued to NHS England (NHSE) as the final highlight report for the Yorkshire and Humber regional forensic CAMHs implementation project. NHSE has acknowledged this and is in agreement as the project moves to BAU.	Progress Against Plan	
		• There are currently no high level risks identified in this project. • Risk sharing agreements are 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.	Progress Against Plan	N/A
		Not applicable	Management of Risk	N/A
		Not applicable		

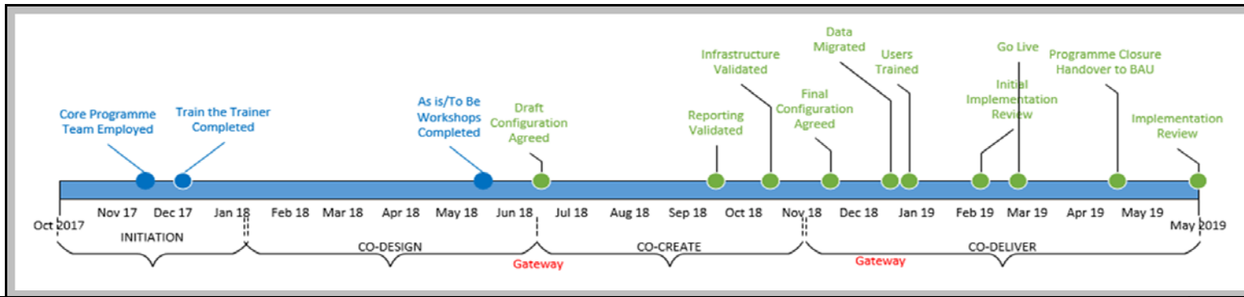
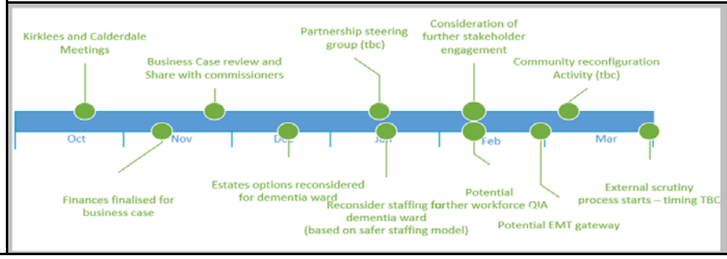
West Yorkshire Projects: Forensic Community LD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Forensic community LD	• SWYPFT submitted a proposal to NHS England (NHSE) for provision of a Community Forensic 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. • Although SWYPFT are awaiting confirmation of funding we know that Leeds CCG currently hold £470k of funding for this priority	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	• Separate workstreams under the WY&H HCP MH Programme Board have been initiated for both Adults and Children's ASC (Adults Autistic Spectrum Condition) ADHD (Attention-Deficit/Hyperactivity Disorder). • The greater focus currently is on the Children's ASC/ADHD project which has the key objective to reduce waiting times for ASC/ADHD assessment/diagnosis by focusing on sharing evidence based improvements and learning and where possible embedding consistency of approach/standardisation of practice. There will be an obvious link to the adult project which has the same key objectives as the children's. • Sean Rayner is the SRO for both projects under the WY&H HCP MH Programme Board. <u>Children's ASC ADHD:</u> • Waiting times for assessment and diagnosis for Children and Young People continue to be an issue across West Yorkshire and there is clearly enthusiasm and commitment from providers to work collectively to share the challenges faced in this priority and reduce waiting numbers in parallel to introducing new pathways for assessment and diagnosis. • Work has commenced to understand the evidence base around new initiatives for children's ASC ADHD and a report is being prepared on what would be needed to address the issues identified. <u>Adults ASC ADHD:</u> • Pertinent work currently is that waiting list challenges in Bradford are being reviewed collectively by the three providers and support to the Bradford service is on offer from both SWYPFT and LYPFT.	Progress Against Plan	
		<u>Children's ASC ADHD high level risk:</u> • Risk around transition points (different services support assessment at different ages and interdependences with adults). Workstreams to be aligned and come together in an ASC/ADHD steering group to be established. <u>Adults ASC ADHD: high level risk:</u> • There is no nationally recommended pathway or specification for adult Autism and ADHD - the remedy is to determine whether WY&H HCP set their own.	Management of Risk	
		Development of an implementation plan of key milestones is yet to be finalised		

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 the lead 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. Update on progress made in this period includes: • The project is on track against plan - hence is green RAG. • Contract with NHSE has been finalised. following discussion on finance. • Quarterly North region ODN meetings established with North East and North West regions • Contract agreement is progressing with a view that the clinical lead post will commence soon. • ODN Project Support commence in post on 10th December. • Further workstream leads have been agreed with just one existing vacancy for the Autism LD Community Infrastructure workstream which is being currently pursued. • A rehab utilisation paper is in development. • Work continues between the project team and SWYPFT IM&T to further scope the network tool 'SLACK' and agree options going forward. • Assessment of support needs across all workstreams is ongoing.	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	This priority reports bi-monthly on the IPR. The next update is due in the February 2019 IPR but the last update from December 2018 included the following: • Work continues in this priority which is focused on delivering of services for children's admissions differently 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 a pilot for two-years and SWYPFTs 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	• 'New Care Models' for Eating Disorders (ED) are being established across the country as part of NHS mental health forward view. • The West Yorkshire Eating Disorders Community Service is one of eleven national early-wave pilot sites to test new approaches. • A proposal to build upon the foundation of the established community services in Leeds (and including the service in Huddersfield) was accepted and funded by NHS England with the aim to replicate the community treatment and outreach approach that was working well in Leeds in each of the delivery areas making up the West Yorkshire & Harrogate STP. [Note: there was previously no community ED provision in Calderdale and Wakefield] • The project had central co-ordination, project management and leadership from Leeds and York Partnership NHS Foundation Trust with SWYPFT with supporting. • The financial case is based on minimising the requirement for out of area placements and avoiding extended lengths of stay with the aim of reducing the cost of out of area placements by £951k. • The existing community eating disorders services (Leeds and Kirklees) have been supplement by an additional investment of £810k to form the new community service. • The new service went live on the 1st April 2018.	Progress Against Plan	

		Any implementation risks are with Leeds and do not transfer to SWYPFT. There are however a number of concerns raised about: • Potential gaps between the new service and the previous service commissioned for Huddersfield. It's too early to be certain, but this needs monitoring in conjunction with the CCG. • One GP practice has refused to monitor the physical health of a patient that they have argued would have been hospitalised prior to the introduction of the new model. Leeds and the Greater Huddersfield CCG are responding to this and SWYPFT medical staff have provided physical health monitoring in the interim. • Communications has been a weakness and may have contributed to some misunderstandings and dissatisfaction in both primary and secondary care.	Management of Risk	
		Implementation plan is with Leeds		
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.	<u>Out of Area</u> • Bed pressures remain in the system and out of areas placements continue, though the levels fluctuate. All recent placements have been from the Calderdale/Kirklees locality, and the risk the expenditure will exceed forecast levels still persists. • Work continues toward implementing criteria led discharge across inpatient units. Wakefield BDU and Barnsley are now live. Calderdale/Kirklees are implementing in January 2019. • Work continues with SSG Health to focus on the root causes of the OOA situation and establish change activity to support improvement. A mid point review is planned for 10 January where early hypothesis will be considered; the end project report is due by 31 January. <u>PD Pathway</u> • There has been some delay in implementation of the PD pathway due to the PD lead taking a secondment. • PD lead has however continued to oversee the project whilst recruiting a senior advanced nurse practitioner (SANP) to continue leading the PD work and implement the PD pathway. • This post is shortlisted and interview is planned for 8th February	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.	• Increased internal marketing of available roles across SWYPFT. 1st stage is completed which involved publication of internal job vacancies newsletter weekly complete. Now into it's 14th edition published this week in Headlines which is seen weekly. • All new vacancies are now automatically uploaded to NHS Yorkshire Jobs Facebook page. • Development has commenced for a bespoke webpage for apprenticeships which will include 'day in the life of…' information about roles available, benefits for working with the Trust. • Development of Physio apprenticeship placement with Sheffield Hallam University commenced. Course is programmed to begin in January 2019 (potentially delayed until April). Trust is evaluating 30-month physio apprenticeship with SHU as an alternative entry into the Trust. Scope of the potential, plan to implement and potential rotation of role across Trust ongoing. Numbers at this time not yet known. • Development of TNA and nursing apprenticeships ongoing. Workforce Planning workshops now arranged for Jan/Feb 2019. Workforce workshops focusing on identification of numbers for development roles in teams for TNA's nurse associates, ACP roles, physician associates and other potential developmental roles amongst other areas of workforce risk and training needs analysis, leadership development. Workforce plans by BDU to be signed off in readiness for April 2019. • Trusts Clinical Support Workforce plan to be updated for 2019-2021. Initial 2016-18 plan now concluded. This is linked to the development of the roles above along with the continued delivery of the HCSW apprenticeship cohorts. Current cohort delivery matched to projected turnover of HCSW roles. To be published by April 2019 following BDU Workforce Plans being signed off and complete. • Collaborative workforce planning being set up across both SY&B and WY&H being led by SWYPFT workforce planning and L&D leads – large scale collaborative workforce planning in early stages aimed at improving our collective workforce needs into Universities and FE's. Goal to be lead in production of West Yorkshire Strategic Workforce Plans. Work ongoing. • Nursing professional leads and workforce/L&D leads have met to discuss timelines for dovetailing an updated Nursing Strategy and the refresh of the Trusts Clinical Support Workforce Strategy. The Clinical Workforce refresh will focus on further strengthening the apprenticeship model, developing clearer band 3 role design and expand the role/opportunity of band 4/TNA roles and development across the Trust with scoping of career progression from non-clinical roles into clinical roles (B4 to B5).	Progress Against Plan	
		Despite ongoing work around nursing strategy and recruitment/retention, we are still seeing an increase in nurse vacancies across the whole Trust. To achieve 100% nursing establishment approx. 230 additional WTE would be required over the next 12 months. Nurse vacancies are not reducing. Mitigating plans are being planned against which include greater emphasis on improving our nurse bank and increase/over recruitment into clinical support roles.	Management of Risk	
		Milestones from the implementation plan for this priority: • Initial recruitment/retention steering group set up July • Analysis and focus groups in high turnover areas – July • Wellbeing survey deep dive commences - August • West Yorkshire collaborative activity to commence - September • Professions Workforce Planning Workshop November - to be planned • Workforce planning cycle starts - January 2019 following Trust structure review • Clinical workforce support strategy refresh – Two-year plan to be developed by January 2019.		

Clinical record system	Plan and deliver a new clinical record system which supports high quality care	The update for this priority includes: • Trust Board have approved the cutover approach and a new go live period (Monday 25 February – Tuesday 5 March). Inpatient teams will go live on Monday 25 February, followed by the rest of the services on Tuesday 5 March, so we can focus on the areas most at risk. We've held workshops with service managers to co-produce the cutover approach. • We've been working with TPP (the supplier of SystmOne) to resolve the issues that we have concerns about that might prevent us going live. There are currently three issues being worked through and escalated to the appropriate level within the Trust and the supplier but good progress is being made. • Our strong engagement with clinical teams continues, involving change reference group attendees in the reviewing of clinical documentation/assessments. There has also been extensive engagement with representatives from inpatients, community and specialist services in go live planning. • With regard to training on SystmOne 53% of staff have demonstrated competency and will have their smart cards updated ready for go live and schedules are in place to offer training in January and February 2019. We're encouraging staff to make use of the extra 1500 places we've made available. If staff do not complete training, their smart cards will not be updated for go live. Our aim remains to have at least 85% of staff competent by the end of January. This has been raised as a critical risk. • We have put additional resources into 'business readiness', supporting the clinical safety design group, in the ownership of all the processes that need to be in place for go live. in preparation • The second super user pre-go live briefing session ('On Your Marks...') has taken place in four locations across the Trust. The next session ('Get Set…') will take place in January.	Progress Against Plan	
		Risks Identified, as at 31 December 2018 (with Datix risk references notated): • 1223 PROGRAMME: Inadequate clinical engagement through all the key workstreams results in a risk that the system is configured in a clinically unsafe way • 1348 PROGRAMME RISK: ROLES AND RESPONSIBILITIES Risk of role confusion after transfer to SystmOne with responsibilities being unclear between clinical and administrative staff • 1251 CUTOVER: During the transition (cutover) 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. This risk also refers to Risk: • 1345 DELAYS TO GO LIVE: a range of factors may conspire to cause potential delays to the programme, to which a suitable contingency response should be available. • 1285 DATA MIGRATION (DM): All planned DM testing activities are completed, however there are still 68/575 raised issues outstanding. These are sat with TPP and are being monitored daily by the team. Of these five are identified as go live critical these are: 1)missing current inpatients (17) 2) care planning 3) MHSDS 4) 30k missing appointments 5) care coordinator not showing across all units • 1224 TRAINING: Staff may not be competent and are therefore unable to fulfil their job role at Go live. Inadequate number of staff attending the training and demonstrating competency will result in the organisation not getting the best use out of the clinical records system • 1316 TESTING: It is not possible to replicate 600+ concurrent users prior to go-live which might result in the system not able to handle the additional load and difficulty for users getting into the system • 1350 REPORTING: Completeness of data during the cutover period - impact on report completeness. Sub risk of the cutover risk not being in plan. Details of phased business go live (2 stages) • 1277 REPORTING: Contract negotiations taking place on or near go live which may result in change requirement to reporting that cannot be met • 1305 CONFIGURATION: Insufficient time for system analysts to create required configuration from co-design outputs resulting in SystmOne is configured but not meeting requirements • 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. • 1344 RESOURCES: the team is made up from a range of temporary resources. Progress may be slower as staffs leave and replacement is recruited. Costs may go up as more skilled and experienced staff is required nearer to go live.	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>This priority reports bi-monthly on the IPR. The next update is due in the February 2019 IPR but the last update from December 2018 included the following:
• Final amendments have been made to the business case and this has been shared with commissioner at end November. A partnership board discussion is planned for mid-December and we expect the business case to trigger further conversations with commissioners about how best to take the model forward.
• Further meetings with commissioners have taken place though Barnsley meeting needs rearranging.
• Task and finish activity is ongoing to ensure that we have the right physical environment for any future dementia specialist ward.</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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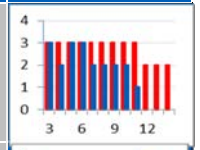
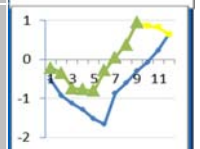
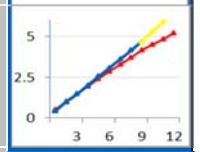
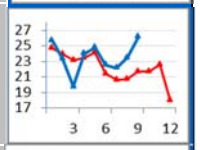
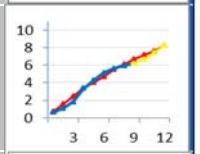
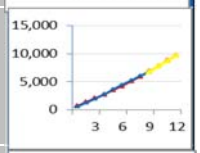
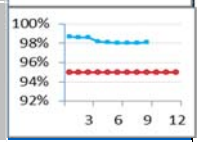
RAG Ratings	
	On Target to deliver within agreed timescales/project tolerances
	On Trajectory but concerns on ability/confident to deliver actions within agreed timescales/project tolerances
	Off Trajectory and concerns on ability/capacity to deliver actions within agreed timescales/project tolerances
	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	1	2	The capital service capacity metric has improved from 2 to 1 in month; this has improved the Trust's overall finance and use of resources risk rating from 2 to 1. This is ahead of plan. All individual ratings are currently at level 1 or 2.	
2	Normalised Surplus (inc STF)	(£0.8m)	(£2m)	December's financial performance is a surplus of £0.2m pre PSF (Provider Sustainability Fund). The cumulative deficit is £0.8m. This position is supported by a number of non-recurrent benefits such as gains on asset disposals and additional one off commissioner investment.	
3	Agency Cap	£4.2m	£6.5m	Agency expenditure was £0.5m in December. Year-to-date costs are £4.7m which is £0.5m (13%) above cap. Current year-end projection is to exceed our agency cap by £1.3m (25%).	
4	Cash	£26.2m	£22m	Cash remains ahead of plan primarily due to one off benefits such as asset sales and due to low levels of outstanding debtors.	
5	Capital	£6.2m	£8.2m	Expenditure is £0.5m (8%) behind plan for the year to date. A number of small changes have been made to the overall programme in year and these are forecast to complete in Qtr 4.	
6	Delivery of CIP	£6.8m	£9.7m	Savings of £6.8m have been identified for the year to date which is £0.1m (1.7%) behind plan. Previously identified upside opportunities are expected to close the current £0.6m gap during Qtr 4 ensuring that the CIP value is delivered in full during 2018/19.	
7	Better Payment	98%		This performance is based upon a combined NHS / Non NHS value and remains ahead of plan.	

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

Contracting - Trust Board

Contracting Issues - General

Contract negotiations 2019/20 - Preparations are underway in advance of commissioners publishing their commissioning intentions. An initial meeting with Kirklees, Calderdale and Wakefield Commissioners in December. Proposed changes to the NHS Standard Contract are being consulted on by NHS England. These are being reviewed internally to identify required actions to address and meet requirements within proposed timescales, identify risks to delivery and identify any issues to feedback through the consultation process for the 1 February deadline

CQUIN

Work ongoing to prepare submissions for Q3 submissions to commissioners

Contracting Issues - Barnsley

Work is prioritised on preparation for 2019/20 contract negotiations including determining the key priority areas for mental health investment in 2019/20 under the Five Year Forward Review. As part of joint planning with the CCG, further priority areas for future investment in Mental Health have been agreed including all age liaison psychiatry, further expansion of improving access to psychological therapies for long terms conditions and addressing attention deficit hyperactivity disorder in children and young people. These have been agreed through the CCG Governing Body as priority areas. Investment levels are yet to be determined and confirmed . Work continues with the CCG to review Children's Therapies services pressures and the review of continence services is being finalised.

Contracting Issues - Calderdale

Work is prioritised on preparation for 2019/20 contract negotiations including determining the key priority areas for mental health investment in 2019/20 including Five Year Forward Review priorities. Key work strands relate to out of area, crisis/intensive home based treatment services, early intervention in psychosis and child and adolescent mental health services.

Contracting Issues - Kirklees

Work is prioritised on preparation for 2019/20 contract negotiations including determining the key priority areas for mental health investment in 2019/20 including Five Year Forward Review priorities. Key work strands relate to out of area, crisis/intensive home based treatment services, early intervention in psychosis and expansion in core and long term conditions improvement in access to psychological therapies.

Contracting Issues - Wakefield

Work is prioritised on preparation for 2019/20 contract negotiations including determining the key priority areas for mental health investment in 2019/20 including Five Year Forward Review priorities.

Contracting Issues - Forensics

Work is prioritised on preparation for 2019/20 contract negotiations including determining the key priority areas for mental health investment in 2019/20 under the Five Year Forward Review. The key priority work stream remains the review and reconfiguration of the medium and low secure service beds as part of the work with NHS England in addressing future bed requirements as part of the wider regional and West Yorkshire integrated care system work.

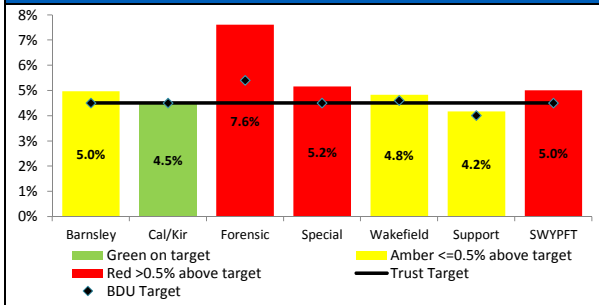
Contracting Issues - Other

Work has commenced on a waiting list initiative for the assessment and diagnosis of autistic spectrum conditions in Calderdale children's and young peoples mental health services. A similar initiative is to be supported in Kirklees under the 0-19 contract. SWYPFT has been awarded the contract for the provision of NHS England commissioned services for the provision of liaison and diversion services across South Yorkshire covering Barnsley, Rotherham, Doncaster and Sheffield. Wakefield Council have been awarded the contract for the provision of these services across West Yorkshire to which SWYPFT will be sub-contracted for the provision of mental heath input.

Workforce

Human Resources Performance Dashboard - December 2018

Sickness Absence



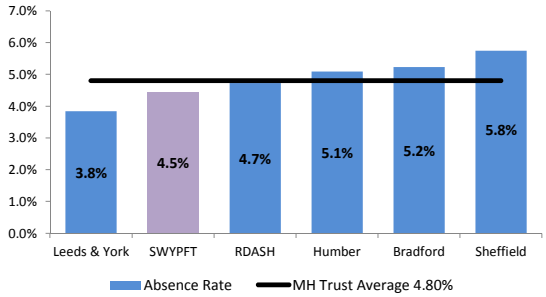
Current Absence Position and Change from Previous Month - Dec 2018

	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	6.10%	4.90%	8.20%	5.80%	5.30%	4.70%	5.70%
Change	↓	↑	↑	↓	↔	↓	↓

The Trust YTD absence levels in December 2018 (chart above) were above the target at 5.01%.

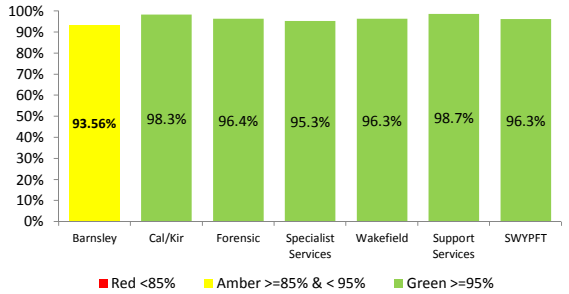
0

0



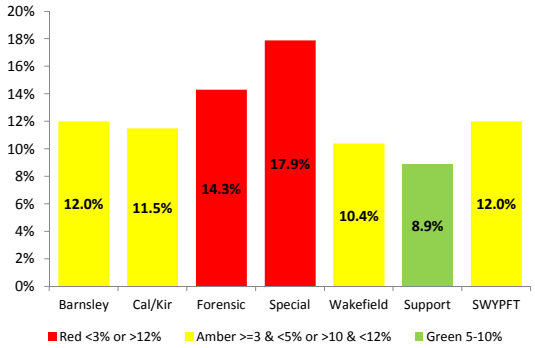
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2018 to July 2018.
During this time the Trust's absence rate was 4.46%% which is below the regional average of 4.8%.

Appraisals - All Staff

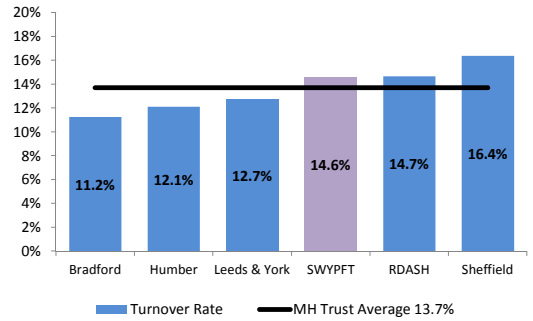


The above chart shows the appraisal rates for all staff to the end of December 2018.
The inclusion of appraisals for Band 5 and below from September has resulted in an overall percentage drop, however, all areas have improved month on month and only one BDU is now below the target of 95%.

Turnover and Stability Rate Benchmark

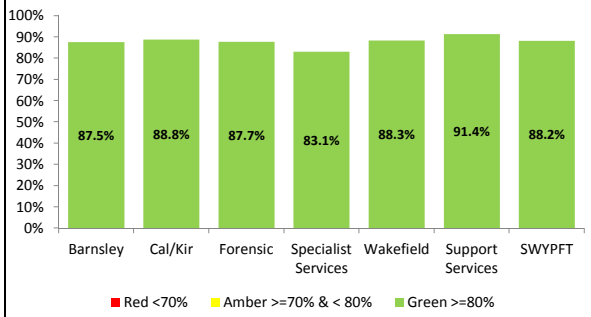


This chart shows the YTD turnover levels up to the end of December 2018.
Turnover figures may look out of line with the average across the Trust but this is because of the small amount of data; the figures will level out over the new reporting year.
*The turnover data excludes recently TUPE'd services



This chart shows turnover rates in MH Trusts in the region for the 12 months ending in July 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 December 2018. The Trust continues to achieve the 80% target across all BDUs.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	5.1%	5.2%	5.3%	5.3%	4.4%	4.4%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	5.8%	6.2%	6.0%	4.9%	4.4%	4.4%	4.4%	4.7%	4.8%	5.1%	5.7%	5.9%	5.7%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	98.1%	97.9%	97.8%	97.8%	7.3%	26.1%	72.2%	87.7%	92.8%	95.0%	95.8%	98.1%	98.2%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	95.7%	95.9%	95.9%	96.0%	0.8%	2.8%	9.4%	21.6%	48.1%	78.6%	87.2%	94.3%	95.0%
Aggression Management	Improving Care	Well Led	AD	>=80%	78.0%	77.9%	78.2%	79.3%	79.3%	81.7%	81.6%	82.9%	83.0%	82.2%	81.3%	81.4%	82.5%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	76.6%	77.0%	78.5%	81.4%	82.3%	84.0%	84.5%	84.8%	83.3%	81.6%	80.1%	80.2%	81.2%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	82.5%	83.8%	85.3%	85.1%	85.6%	85.5%	85.8%	85.9%	86.0%	85.8%	85.8%	86.1%	87.4%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	86.9%	88.3%	88.9%	88.5%	89.0%	89.8%	89.7%	89.8%	90.1%	89.8%	90.2%	90.7%	91.3%
Fire Safety	Improving Care	Well Led	AD	>=80%	82.4%	83.8%	84.6%	85.4%	85.3%	86.8%	86.6%	86.6%	87.4%	86.3%	86.8%	86.7%	88.1%
Food Safety	Improving Care	Well Led	AD	>=80%	78.6%	79.3%	77.8%	77.2%	76.2%	77.2%	77.5%	80.8%	81.9%	81.7%	81.9%	84.1%	82.2%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	83.2%	85.0%	86.5%	86.8%	87.0%	87.3%	87.3%	87.8%	88.5%	89.1%	89.3%	89.1%	89.7%
Information Governance	Improving Care	Well Led	AD	>=95%	83.8%	89.2%	95.7%	96.5%	92.4%	92.7%	92.1%	91.9%	92.2%	92.1%	92.3%	90.2%	90.8%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	81.9%	84.1%	85.4%	85.5%	85.2%	85.9%	85.6%	85.7%	86.1%	87.2%	87.3%	88.6%	89.0%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	91.1%	91.0%	91.1%	90.7%	91.1%	91.4%	91.3%	92.2%	91.7%	90.9%	91.4%	92.6%	92.3%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	86.6%	86.4%	86.0%	84.7%	85.7%	86.8%	86.5%	88.1%	87.3%	85.9%	85.8%	87.7%	86.7%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%	66.8%	87.6%			81.3%			79.6%			74.8%		
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	87.8%	89.0%	89.8%	89.9%	90.0%	91.0%	91.3%	91.7%	91.7%	91.5%	92.1%	93.0%	93.7%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	85.1%	86.7%	87.5%	87.8%	88.4%	88.6%	89.4%	90.1%	90.4%	90.0%	90.4%	89.4%	91.4%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	93.3%	93.8%	94.3%	93.4%	94.4%	95.1%	94.9%	95.8%	95.2%	94.6%	94.6%	94.1%	94.5%
Bank Cost	Improving Resources	Well Led	AD	-	£534k	£604k	£655k	£907k	£557k	£603k	£768k	£646k	£730k	£845k	£615k	£674k	£678k
Agency Cost	Improving Resources	Effective	AD	-	£430k	£465k	£563k	£555k	£444k	£538k	£484k	£526k	£566k	£522k	£537k	£536k	£530k
Overtime Costs	Improving Resources	Effective	AD	-	£8k	£11k	£13k	£6k	£8k	£13k	£5k	£11k	£5k	£8k	£4k	£5k	£7k
Additional Hours Costs	Improving Resources	Effective	AD	-	£39k	£34k	£24k	£23k	£29k	£15k	£23k	£31k	£32k	£29k	£30k	£31k	£24k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£594k	£633k	£532k	£483k	£430k	£449k	£420k	£461k	£471k	£507k	£586k	£580k	£580k
Business Miles	Improving Resources	Effective	AD	-	305k	271k	275k	230k	274k	264k	259k	291k	269k	279k	267k	299k	279k

1 - this does not include data for medical staffing.

Workforce - Performance Wall cont…

Mandatory Training Compliance at 31 December 2018

Green Compliance Status:
- Aggression Management – 82.48% 1.07% increase in compliance from last month.
- Aggression Management / Physical Interventions – Clinical Level 2 – 85.84%
- Aggression Management / De-escalation and Breakaway – Clinical Level 1 – 82.96%
- Aggression Management / Personal Safety and Breakaway – Non Clinical Level 2 – 69.55%
- Cardio Pulmonary Resuscitation – 81.22% 1% increase in compliance from last month.
- Cardiopulmonary Resuscitation – Immediate Life Support – 80.51%
- Cardiopulmonary Resuscitation – Basic Life Support – 81.34%
- Clinical Risk – 87.40% 1.25% increase in compliance from last month.
- Equality and Diversity – 90.67% no significant change in compliance from last month.
- Fire Safety – 88.15% 1.47% increase in compliance from last month.
- Fire Safety – Ward based staff – 87.12%
- Food Safety – 81.18% 1.92% decline in compliance from last month.
- Food Safety – Level 4 – 100%
- Food Safety – Level 3 – 92.31%
- Food Safety – Level 2 – 81.45%
- Food Safety – Level 1 – 85.51%
- Infection Control and Hand Hygiene – 89.73% no significant change in compliance from last month.
- Infection, Prevention and Control – 89.59%
- Hand Hygiene – 90.17%

Green Compliance Status cont...
- Mental Capacity Act – 92.31% no significant change in compliance from last month.
- Mental Capacity Act / Deprivation of Liberty Safeguards – Clinical – 89.23%
- Mental Capacity Act – Non Clinical – 100%
- Mental Health Act – 86.72% no significant change in compliance from last month.
- Mental Health Act – Registered Clinical Mental Health – Inpatient – 84.13%
- Mental Health Act – Registered Clinical Mental Health – Community – 88.91%
- Mental Health Act – Non Registered Clinical Inpatient and Community – 84.79%
- Moving and Handling – 88.97% no significant change in compliance from last month.
- Moving and Handling – Level 2 – 78.61%
- Moving and Handling – Level 1 – 90.66%
- Safeguarding Adults – 93.70% no significant change in compliance from last month..
- Safeguarding Adults Level 2 – 93.35%
- Safeguarding Adults Level 1 – 94.45%
- Safeguarding Children – 91.41% 1% increase in compliance from last month.
- Safeguarding Children – Level 3 – 90.29%
- Safeguarding Children – Level 2 – 87.41%
- Safeguarding Children – Level 1 – 94.64%

Targeted training has been delivered in areas of low compliance and this has been well received.
- Sainsbury's Tool – 94.50% no significant change in compliance from last month.

Amber Compliance Status:
- Data Security Awareness Level 1 (formally IG) – 90.79% no significant change in compliance from last month..

Red Compliance Status:

Sickness
- The overall sickness rate is 5%.
- Sickness absence improved to 5.7% in December and cumulatively has increased to 5.0%. Based on past trends this was anticipated with a reduction in the final quarter. Wellbeing groups are being established in all the BDUs and wellbeing champions being identified.
- The Trust achieved the national flu vaccination target of 75% with 76% of frontline staff being vaccinated. This was a CQUIN target.

Turnover
- Staff turnover has reduced slightly in all areas except Wakefield and overall is slightly lower than the previous month. Work continues on the retention plan to reduce turnover particularly in clinical roles.

Guardian of Safe Working Report

High Level Data

Number of doctors in training (total):	49
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. 1 out of the 7 Wakefield posts remains vacant. On the Calderdale and Kirklees Core Training Scheme there are a number of less than full time trainees and another on maternity leave; there is therefore the equivalent of 4 out of 10 posts vacant and 4 may complete their training this summer. None of the 4 CT posts in Barnsley are vacant but there is a GPVTS vacancy in this rotation, in addition to Specialty Doctor vacancies which affect 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 core trainee having to stay late to complete an MDT meeting in Barnsley. The trainee was given time of in lieu.

Fines

There have been none within this reporting period.

Rota gaps and cover arrangements

Gaps by rota October/November/December '18

Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency /	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	24 (13%)	19 (79%)	1 (4%)	4 (16%)	0
Calderdale 1st	49 (27%)	44 (90%)	2 (4%)	3 (6%)	0
Kirklees 1st	23 (25%)	23 (100%)	0	0	0
Wakefield 1st	5 (3%)	5 (100%)	0	0	0
Total 1st	101 (16%)	91 (90%)	3 (3%)	7 (7%)	0
Wakefield 2nd	3 (3%)	0	0	3 (100%)	0

Costs of Rota Cover October/November/December '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	19	£6,606	0	0	
Calderdal	44 (^)*	£14,086	2 (4)	£208	
Kirklees	23 (352)	£12,340	0	0	
Wakefiel d	5 (44.75)	£1,566	0	0	
Total	74 (^)	£34,598	2 (4)	£208	£34,807

**4 shifts in Barnsley and 2 shifts in Calderdale were covered by Specialty Doctors who were paid according to their individual terms and conditions.*

^ Data incomplete.

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. The medical bank seems to be working well so that fewer shifts have had to be offered to agency or external staff. In this quarter, there were no shifts unfilled and staff were always able 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 with, 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. The first MTI (1) and WAST (2) doctors have now joined the trust and it is hoped that with support and training they have been taking part in the on-call rotas. Unfortunately there were no new core trainees appointed to the Calderdale in Kirklees scheme to start in February and it would be extremely concerning if this is the case again for August.

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 still needs support from agency locums. It is positive that no shifts were 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. Where concerns do not relate directly to the contract, issues are raised with the relevant clinical lead.

Education and support – The guardian will continue to work closely with the associate medical director for postgraduate medical education to improve trainees experience and to support clinical supervisors. The guardian will continue to encourage trainees to use exception reporting, both at induction sessions and through the junior doctors' forum.

IT system – Initial issues with the allocate system seem to have been resolved and this is working smoothly.

Publication Summary

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

NHS Improvement

Developing a patient safety strategy for the NHS

This consultation outlines NHS-wide proposals to ensure improved patient safety. The proposals include a commitment for some of the most important types of avoidable harm to patients to be halved over the next five years in areas such as medication errors and never events, alongside developing a 'just culture' for the NHS where frontline staff are supported to speak up when errors occur. The consultation is open for responses until 15 February 2019.
Click her for link to consultation

Public Health England

Health matters: reducing health inequalities in mental illness
This guidance brings together data and evidence of what works in removing health inequalities experienced by people living with mental illness. It focuses on some of the actions that local areas can take to reduce these health inequalities, so that people with mental illness can achieve the same health outcomes and life expectancy as the rest of the population.

Click here for guidance

Department of Health and Social Care

EU exit operational readiness guidance: actions the health and care system in England should take to prepare for a 'no deal' scenario

This guidance, developed and agreed with NHS England and NHS Improvement, will support the health and care system in England to be prepared for a no-deal scenario. It summarises the areas that the Department of Health and Social Care is focusing on in its no-deal exit contingency planning and those in which local action is required. Further operational guidance will be provided to support the health and care system to prepare for the UK leaving the EU before 29 March 2019.

Click here for guidance

NHS England

The NHS long-term plan
The plan focuses on improving services outside hospitals and moving towards more joined-up, preventive and personalised care for patients and on the ambition to establish integrated care systems in every part of the country by 2021. It includes measures to: improve out-of-hospital care, supporting primary medical and community health services; ensure all children get the best start in life by continuing to improve maternity safety; support older people through more personalised care and stronger community and primary care services; make digital health services a mainstream part of the NHS. In addition, this plan includes measures to prevent 150,000 heart attacks, strokes and cases of dementia over the next 10 years and to provide better access to mental health services for adults and children.

Click here for plan

Publication Summary

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

NHS workforce statistics: September 2018
Learning disability services monthly statistics: provisional statistics (assuring transformation: November 2018, mental health statistics data set: September 2018 final)
NHS sickness absence rates: August 2018, provisional statistics
Diagnostic imaging dataset statistical release: provisional monthly statistics, August 2017 to August 2018
Seasonal flu vaccine uptake in health care workers 2017 to 2018: provisional monthly data for 1 September 2018 to 30 November 2018
Seasonal flu vaccine uptake in children of primary school age: monthly data, 2018/19

NHS Improvement provider bulletin: 19 December 2018:

- Have your say on the national patient safety strategy for the NHS
- Give your views on the draft standard ambulance vehicle specification
- Monthly finance return: technical guidance update — overseas visitors income
- Mental health trusts invited to enter garden competition
- New outpatients diagnostic dashboard
- Medical device safety officer (MDSO) and medication safety officer (MSO) conference 2019
- Updates from our partners

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

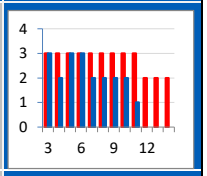
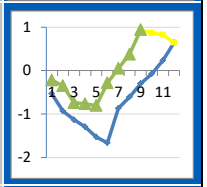
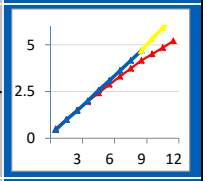
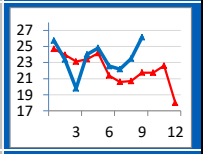
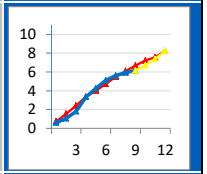
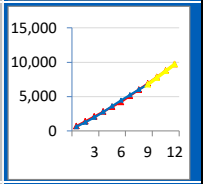
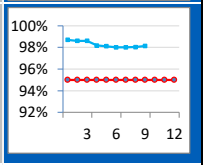
Month 9
Appendix 1
(2018 / 19)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0 Executive Summary / Key Performance Indicators

	Performance Indicator	Year To Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	1	2	The capital service capacity metric has improved from 2 to 1 in month; this has improved the Trust's overall finance and use of resources risk rating from 2 to 1. This is ahead of plan. All individual ratings are currently at level 1 or 2.	
2	Normalised Deficit (excl PSF)	(£0.8m)	(£2m)	December's financial performance is a surplus of £0.2m pre PSF (Provider Sustainability Fund). The cumulative deficit is £0.8m. This position is supported by a number of non-recurrent benefits such as gains on asset disposals and additional one off commissioner investment.	
3	Agency Cap	£4.2m	£6.5m	Agency expenditure was £0.5m in December. Year-to-date costs are £4.7m which is £0.5m (13%) above cap. Current year-end projection is to exceed our agency cap by £1.3m (25%).	
4	Cash	£26.2m	£22m	Cash remains ahead of plan primarily due to one off benefits such as asset sales and due to low levels of outstanding debtors.	
5	Capital	£6.2m	£8.2m	Expenditure is £0.5m (8%) behind plan for the year to date. A number of small changes have been made to the overall programme in year and these are forecast to complete in Qtr 4.	
6	Delivery of CIP	£6.8m	£9.7m	Savings of £6.8m have been identified for the year to date which is £0.1m (1.7%) behind plan. Previously identified upside opportunities are expected to close the current £0.6m gap during Qtr 4 ensuring that the CIP value is delivered in full during 2018/19.	
7	Better Payment	98%		This performance is based upon a combined NHS / Non NHS value and remains ahead of plan.	

Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective lev	Plan
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels	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 9	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	3.18	1	2.2	2
	20%	Liquidity (Days)	23.6	1	19.1	1
Financial Efficiency	20%	I & E Margin	0.6%	2	-0.2%	3
Financial Controls	20%	Distance from Financial Plan	0.8%	1	0.0%	1
	20%	Agency Spend	12.8%	2	0.0%	1
Weighted Average - Financial Sustainability Risk Rating				1		3

Impact

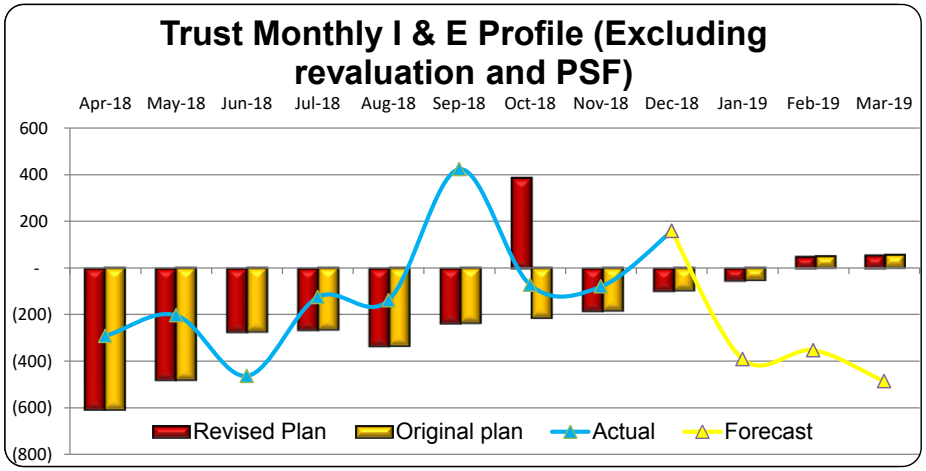
The Trust's I & E Margin (including PSF) remains a small surplus and as such the risk rating has achieved a level 2. The Capital Service Capacity metric has improved from 2 to 1 in December therefore the overall finance risk rating which is based on a weighted average has improved from 2 to 1, the highest rating available.

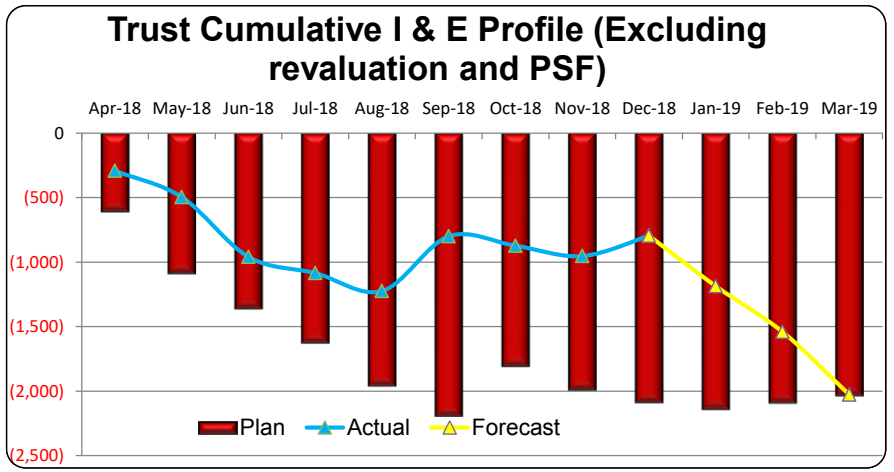
Definitions

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**
				16,780	17,169	390	Clinical Revenue	150,778	151,381	603	201,117	201,907	790
				16,780	**17,169**	**390**	**Total Clinical Revenue**	**150,778**	**151,381**	**603**	**201,117**	**201,907**	**790**
				1,201	1,280	80	Other Operating Revenue	10,039	10,483	444	13,252	13,829	577
				17,980	**18,450**	**470**	**Total Revenue**	**160,817**	**161,864**	**1,047**	**214,369**	**215,736**	**1,367**
4,094	4,018	(76)	1.9%	(14,086)	(13,861)	225	Pay Costs	(126,248)	(125,075)	1,173	(168,363)	(167,419)	944
				(3,698)	(3,771)	(72)	Non Pay Costs	(31,712)	(32,406)	(695)	(41,766)	(41,696)	70
				486	103	(383)	Provisions	1,484	1,118	(366)	2,486	(27)	(2,513)
				0	0	0	Gain / (loss) on disposal	600	654	54	600	654	54
4,094	**4,018**	**(76)**	**1.9%**	**(17,298)**	**(17,528)**	**(230)**	**Total Operating Expenses**	**(155,875)**	**(155,709)**	**167**	**(207,043)**	**(208,488)**	**(1,445)**
4,094	**4,018**	**(76)**	**1.9%**	**682**	**921**	**240**	**EBITDA**	**4,942**	**6,155**	**1,213**	**7,326**	**7,248**	**(78)**
				(472)	(490)	(17)	Depreciation	(4,260)	(4,320)	(59)	(5,671)	(5,783)	(112)
				(310)	(294)	16	PDC Paid	(2,794)	(2,742)	52	(3,726)	(3,625)	101
				4	20	17	Interest Received	34	112	78	45	134	89
4,094	**4,018**	**(76)**	**1.9%**	**(97)**	**158**	**255**	**Normalised Surplus / (Deficit) Excl PSF**	**(2,079)**	**(795)**	**1,284**	**(2,026)**	**(2,026)**	**0**
				407	407	0	PSF (Provider Sustainability Fund)	1,736	1,736	0	2,670	2,670	0
4,094	**4,018**	**(76)**	**1.9%**	**310**	**565**	**255**	**Normalised Surplus / (Deficit) Incl PSF**	**(342)**	**942**	**1,284**	**644**	**644**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,094	**4,018**	**(76)**	**1.9%**	**310**	**565**	**255**	**Surplus / (Deficit)**	**(342)**	**942**	**1,284**	**644**	**644**	**0**





Income & Expenditure Position 2018 / 2019

Supported by additional commissioner investment in mental health services in December 2018 the Trust have recorded a surplus in month. The recurrent run rate remains a concern.

Update to plan

The plan position was updated in October 2018 as agreed by Trust board to reflect the one-off £0.6m gain on the disposal of Trust properties. This is a challenging target but if achieved will enable access to an additional £1.2m Provider Sustainability Funding (PSF) monies through the 2:1 incentive scheme. The Trust has agreed a revised total of £2.0m deficit (pre PSF) for 2018/19 and a surplus of £644k including PSF.

Month 9

The December position is a pre PSF surplus of £158k and a post PSF surplus of £565k. The main driver is additional non recurrent investment of £500k received in December, without which the December position would be a deficit of £342k. This underlying position remains concerning. The normalised year-to-date position is a pre PSF deficit of £795k, which whilst favourable to plan, has only been made possible by a number of non-recurrent measures.

Non pay expenditure pressures continue to provide the greatest financial challenge with on-going out of area bed usage (and associated costs) only being partially offset by other non-pay underspends.

Income

At month 9 income is £390k higher than plan and includes additional non recurrent funding investment in realtion to improving the inferface between mental health and primary care in Barnsley. A full breakdown of income is shown on page 7.

Income risks continue to be assessed; the year to date position includes an estimate of current CQUIN risk and work continues to minimise this risk.

Pay Expenditure

In December pay underspent by £225k. This underspend position occurred due to the level of vacancies offsetting costs associated with temporary staffing to meet clinical and service requirements. These are often not within the same service line or locality and recruitment is actively being undertaken. As such this could lead to increased cost pressure in the future. The Trust continues to work on its recruitment and retention action plan. Additional analysis is included within the pay information report to highlight the different expenditure levels across the services.

December bank and agency costs are in line with year to date averages. Year to date bank costs are £1.4m (29%) higher and agency costs £0.4m (11%) higher than the comparative period in 2017/18.

Inpatient wards across the Trust continue reporting significant pressures. Across all inpatient wards (excluding Forensic BDU) the average overspend each month year to date is £182k due to high occupancy levels, high acuity levels, vacancies and sickness.

Non Pay Expenditure

Non pay is overspent by £72k in December. Out of area bed spend is £331k in-month and £3.1m cumulatively, both spend and activity are 35% lower than the November position. More details are included within the out of area focus page. Drugs costs remains a pressure, overall spend has reduced from 2017/18 however this is primarily due to decommissioning of services, a year on year comparison of current services shows a marginal increase in costs.

Provisions

The provision line shows as a pressure in December due to budgets associated with currently unidentified savings targets as discussed in this report; these will be aligned as mitigations are finalised.

Forecast

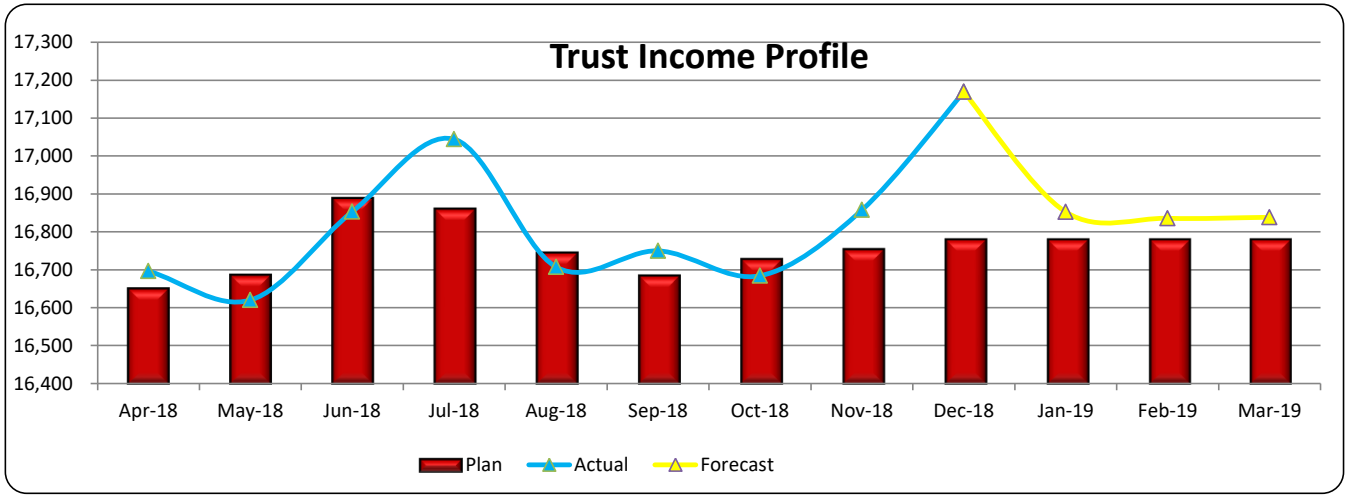
The Trust is currently forecasting to achieve a challenging revised year-end outturn of £2.0m deficit. Achievement of this position would enable access to a minimum of £2.7m PSF which will support the Trust's cash position and capital programme.

Many of the potential upsides identified to manage this position are one off / non-recurrent in nature. As such additional actions are required to ensure return to a sustainable position. A financial sustainability plan is under development.

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. This is subject to regular discussions and triangulation with commissioners to ensure that we have no differences of expectation. This is periodically formally assessed by NHS Improvement.

	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	Total 17/18 £k
CCG	12,132	12,012	12,286	12,453	11,924	11,948	11,872	12,023	12,290	12,004	11,990	11,958	**144,891**	**151,142**
Specialist Commissioner	1,946	1,946	1,946	1,946	1,872	1,931	2,035	1,946	1,946	1,946	1,946	1,946	**23,356**	**23,661**
Alliance	1,053	1,105	1,079	1,079	1,270	1,270	1,257	1,298	1,282	1,292	1,290	1,325	**14,601**	**11,478**
Local Authority	430	413	422	438	426	426	416	437	437	437	437	437	**5,157**	**4,851**
Partnerships	577	577	577	585	655	595	561	612	611	614	614	614	**7,190**	**6,838**
Other	558	567	543	543	560	579	542	542	604	559	559	559	**6,713**	**6,981**
Total	**16,696**	**16,620**	**16,853**	**17,044**	**16,707**	**16,750**	**16,684**	**16,858**	**17,169**	**16,852**	**16,836**	**16,838**	**201,907**	**204,951**
17/18	17,133	17,247	17,174	17,355	16,953	16,553	17,534	17,083	17,308	16,950	16,922	16,739	**204,951**	



Income has increased in December 2018 due to:

Additional non recurrent funding (£500k) from Barnsley CCG relating to investment in mental health and primary care engagement and improvement.

Recharges to non-local commissioners are higher than planned.

These are offset by reduced income against plan for Neuro Rehab beds; actions to increase income continue to be explored.

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 / 18 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. Additional analysis has been included to highlight the varying levels of overspend by service and is the focus of the key messages below.

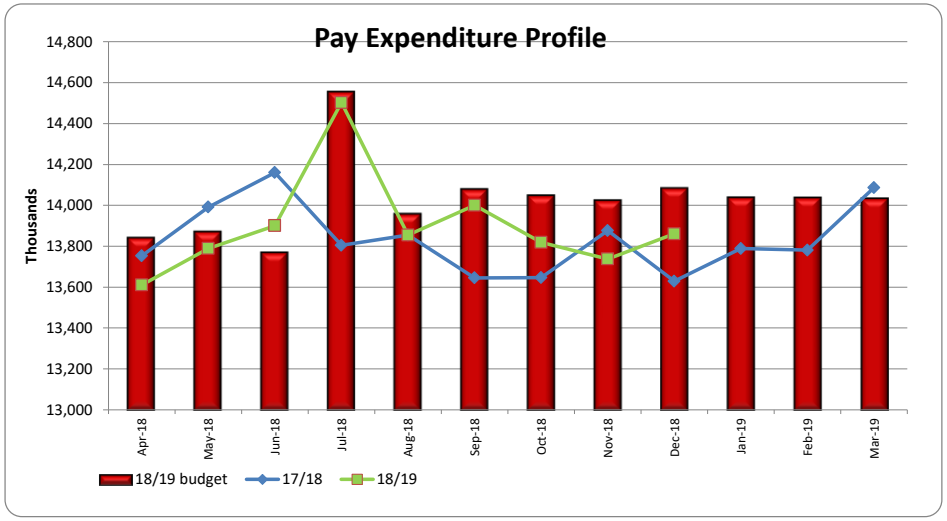
	Apr-18 £k	May-18 £k	Jun-18 £k	Jul-18 £k	Aug-18 £k	Sep-18 £k	Oct-18 £k	Nov-18 £k	Dec-18 £k	Jan-19 £k	Feb-19 £k	Mar-19 £k	Total £k
Substantive	12,595	12,598	12,578	13,290	12,529	12,600	12,647	12,498	12,605				**113,939**
Bank & Locum	571	652	839	687	749	878	635	704	726				**6,442**
Agency	444	538	484	526	575	522	537	536	530				**4,693**
Total	**13,610**	**13,789**	**13,901**	**14,503**	**13,854**	**14,000**	**13,819**	**13,738**	**13,861**	**0**	**0**	**0**	**125,074**
17/18	13,752	13,992	14,161	13,804	13,854	13,645	13,646	13,876	13,629	13,788	13,781	14,087	**166,257**
Bank as %	4.2%	4.7%	6.0%	4.7%	5.4%	6.3%	4.6%	5.1%	5.2%				5.2%
Agency as %	3.3%	3.9%	3.5%	3.6%	4.2%	3.7%	3.9%	3.9%	3.8%				3.8%

Year to Date Budget v Actuals - by staff group

	Budget £k	Substantive £k	Temp £k	Agency £k	Total £k	Variance £k
Medical	16,492	13,391	313	2,580	16,283	208
Nursing Registered	45,402	39,328	2,000	459	41,787	3,615
Nursing	13,436	12,703	3,243	1,088	17,033	(3,597)
Other	29,965	29,904	396	540	30,840	(875)
Corporate Admin	11,453	10,551	125	0	10,676	777
BDU Admin	9,446	8,063	366	26	8,455	991
Total	**126,194**	**113,939**	**6,442**	**4,693**	**125,074**	**1,120**

Year to date Budget v Actuals - by service

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
MH Community	53,795	47,496	1,100	3,025	51,621	2,174
Inpatient	32,135	27,826	4,609	1,470	33,905	(1,769)
BDU Support	5,118	4,722	106	0	4,828	290
Community	15,343	14,944	281	169	15,393	(50)
Corporate	19,803	18,952	346	29	19,327	476
Total	**126,194**	**113,939**	**6,442**	**4,693**	**125,074**	**1,120**



Key Messages

In absolute terms pay expenditure has increased from £124.4m to £125.1m for the first 9 months of the year (0.6%). However this is an increase from 81% to 83% as a proportion of Trust healthcare income due to the reduced levels of income in 2018/19.

The YTD overspend on inpatient services (excluding forensics) is £1.6m. In December this equates to an additional 102 members of staff. Of the 19 wards (excluding Forensics), 15 are reporting an overspend. The majority of wards are commissioned and staffed to operate at 85% occupancy level. Due to high demand many are operating at 100% and therefore require additional staff. Additional staffing requirements are often exacerbated by high observation levels, escorts, vacancies and sickness.

The overspend on inpatient areas is offset by underspends across all other service areas, more noticeably in mental health community (£2.1m) and corporate services (£0.5m).

Bank expenditure in December is £22k higher than the previous month. Year to date bank expenditure is £1.4m (29%) higher than the same period in 2017/18 and agency expenditure is £448k (11%) higher than the same period in 2017/18. Where contracts have been agreed with agencies to supply agency workers under the NHS capped rates e.g. nursing, the comparative hourly rates between bank and agency do not differ substantially. Where rates have not been agreed or preferred suppliers are unable to meet demand, agency rates can exceed bank by up to 30%. These rates differences are more pronounced in specific medical staffing groups such as CAMHS.

Year to date medical staffing is underspent by £208k, and is running with circa 45 WTE vacancies, half of which are covered by temporary staffing and some by additional allowances to substantive staff.

2.1 Agency Expenditure Focus

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

The forecast of £6.5m exceeds cap by £1.3m

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 have recently begun to increase again to a value in excess of £0.5m per month. The maximum agency cap established by NHSI for 2018/19 is £5.2m which is £0.6m lower than actual spend last year.

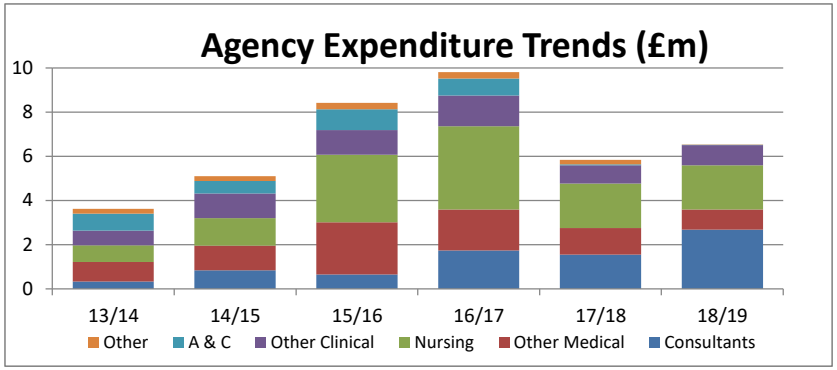
The cap has been profiled to reduce spend across the year as actions have their desired impact. The cap profile reduces from £500k per month in April 2018 to £359k per month in March 2019. Actual expenditure needs to reduce considerably to remain under this cap. The current forecast position exceeds cap by £1.3m (25%), at this level the Trust's NHSI agency metric will reduce from 2 to 3 at month 12. If all other metrics remained constant this would reduce the overall finance rating from 1 to 2.

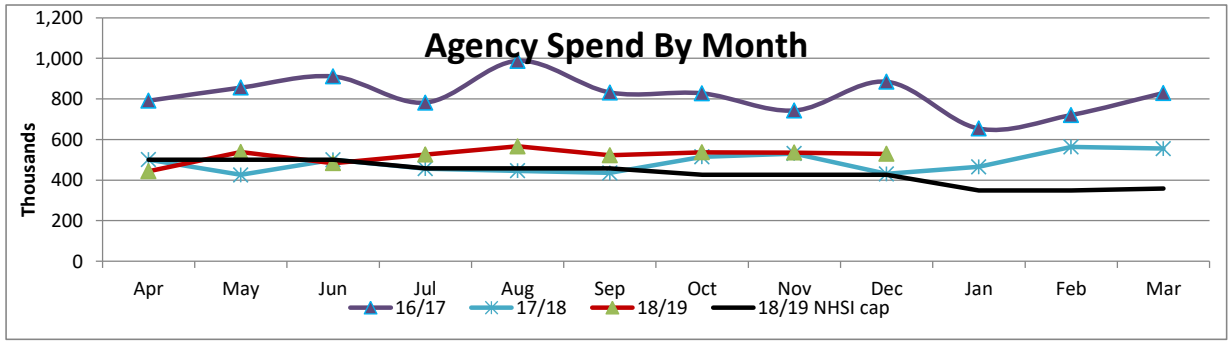
At month 9 agency spend is £530k, 24% above cap. Agency expenditure has remained at a consistent level for the last two quarters.

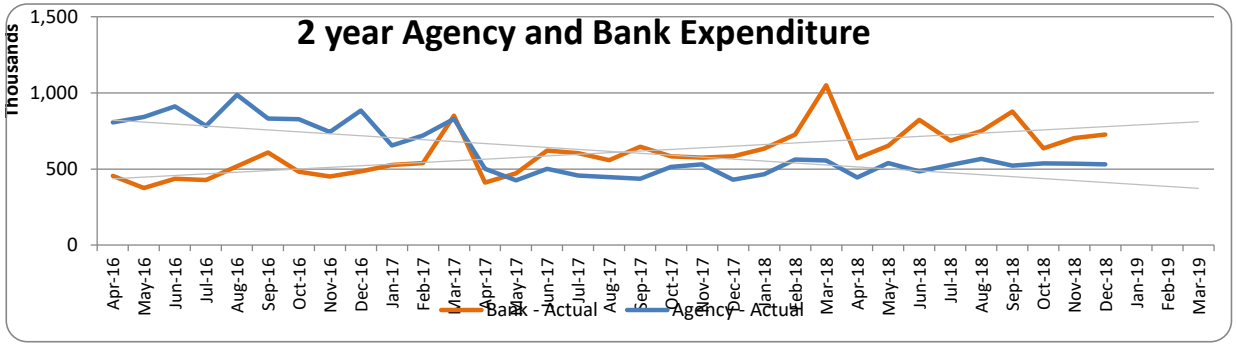
Year to date agency expenditure totals £4.7m, this is £0.5m higher than the same period in 2017/18. Agency medical staffing is £0.6m higher in 2018/19 offset by small reductions across other headings.

Agency expenditure is subject to detailed scrutiny at all levels within the Trust. Plans continue to be progressed to reduce this level of expenditure. The Trust continues to report agency usage to NHS Improvement on a weekly basis.

Bank expenditure in December is £726k, in line with year to date averages. Year to date 81% of bank expenditure is on nursing staff, 67% is across the Trust's 30 wards. Bank nursing expenditure on 4 wards, Johnson, Sandal, Nostell and Walton accounts for 28% of total year to date bank nursing expenditure.





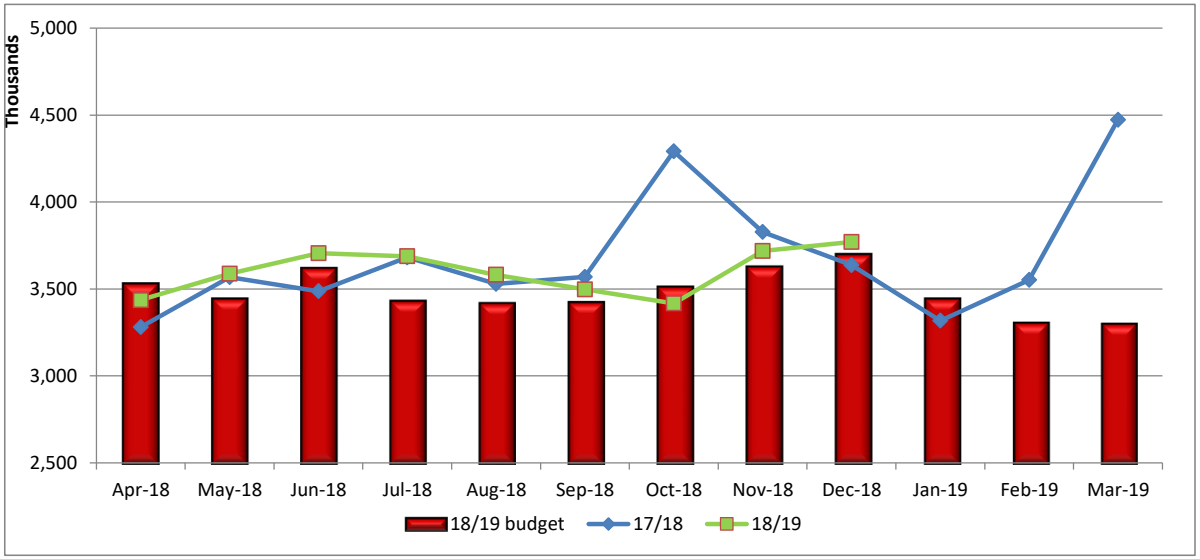


2.1 Non Pay Expenditure

Whilst pay expenditure represents over 75% of all Trust costs, non pay expenditure presents a number of key financial challenges. This analysis focuses 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	3,689	3,582	3,498	3,417	3,719	3,771				**32,406**
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	2,020	2,240	(221)
Drugs	2,173	2,593	(420)
Healthcare subcontracting	3,605	4,980	(1,376)
Hotel Services	1,388	1,383	5
Office Supplies	3,893	3,428	465
Other Costs	3,586	3,198	389
Property Costs	5,091	5,043	48
Service Level Agreements	4,656	4,588	68
Training & Education	582	450	132
Travel & Subsistence	2,831	2,496	336
Utilities	898	960	(62)
Vehicle Costs	989	1,047	(58)
Total	**31,712**	**32,406**	**(695)**
Total Excl OOA and Drugs	**25,933**	**24,833**	**1,101**



Key Messages

Healthcare subcontracting relates to the purchase of all non-Trust bed capacity and is overspending by £1.4m. As a constant and significant pressure the out of area focus provides further details on this.

Drugs expenditure is the second highest overspend category. As at December 2018 this is £420k overspent against budget. The Pharmacy department continue to review prescribing practices, standardise drugs and ensure that price changes are proactively managed.

Excluding those two key areas we continue to see good non-pay expenditure control across the majority of areas. The largest favourable variances to budget are within travel and subsistence and other costs. Other costs includes a wide variety of expenditure associated with running such a diverse Trust. This includes advertising, recruitment, membership fees, interpretation and professional fees.

2.1 Out of Area Beds 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 (£)

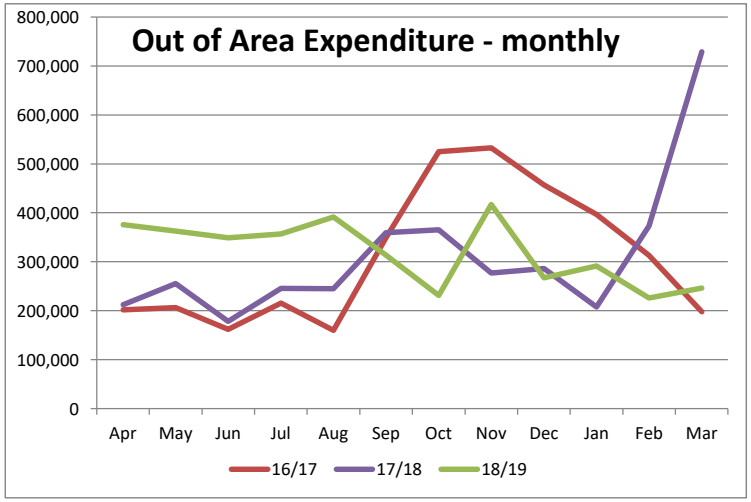
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
16/17	202	206	162	216	160	349	525	533	457	397	313	198	**3,718**
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268				**3,066**

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	607	374	412	501	680	473	245	508	331				**4,131**

Bed Day Information 2018 / 2019 (by category)

PICU	316	207	142	91	76	30	48	41	31				**982**
Acute	278	157	258	348	542	401	127	396	280				**2,787**
Gender	13	10	12	62	62	42	70	71	20				**362**
Total	607	374	412	501	680	473	245	508	331				**4,131**



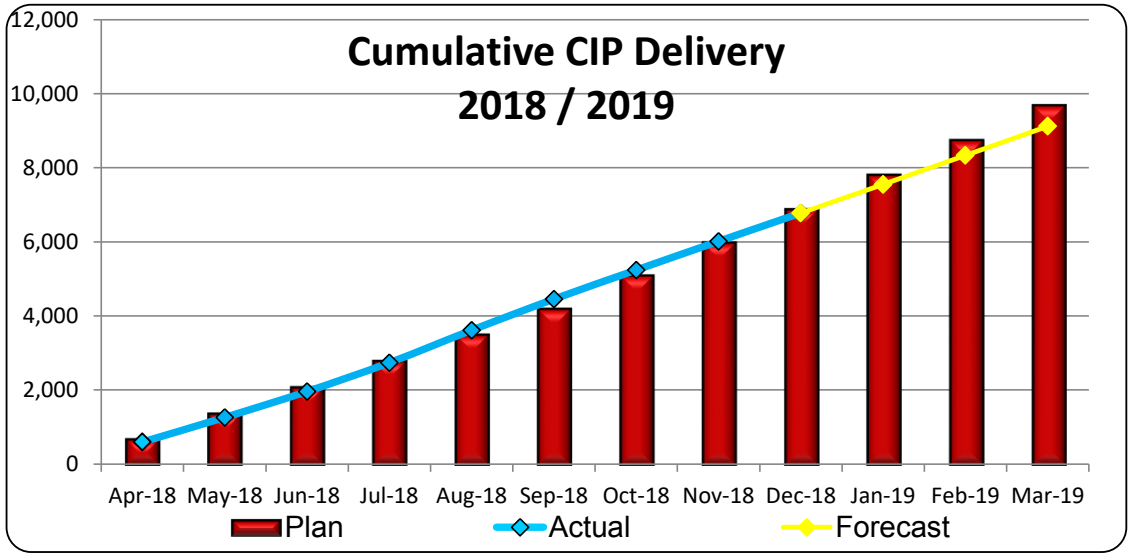
Due to the increasing levels of high demand from January to March 2018 the out of area budget has been weighted to account for higher spend at the start of the year reducing significantly across the year as actions from the project board are implemented.

In December acute activity has returned to previous levels and PICU activity remains low. The trajectory assumes a significant reduction in acute activity however this will be challenging over the winter months when activity typically increases. It is expected that criterial led discharge and appointment of discharge coordinators in Kirklees and Calderdale will support the reduction.

The out of area project board is reviewing and benchmarking community staffing models across the districts and reviewing metrics to improve information to services. External support are working with services to support the reduction in use and the Trust Board will be kept up-to-date with progress. This work is due to be completed by the end of January.

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	6,894	9,701
Delivery as originally planned	555	1,136	1,699	2,259	2,827	3,394	3,975	4,560	5,139	5,732	6,335	6,939	5,139	6,939
Mitigations - Recurrent & Non-Recurrent	39	124	260	478	788	1,061	1,264	1,455	1,640	1,820	2,001	2,181	1,640	2,181
Mitigations - Upside schemes										192	384	581	0	581
Total Delivery	**595**	**1,260**	**1,959**	**2,737**	**3,615**	**4,455**	**5,240**	**6,015**	**6,779**	**7,744**	**8,720**	**9,700**	**6,779**	**9,700**
Variance	(96)	(122)	(132)	(61)	114	251	139	17	(116)	(79)	(42)	(0)	(116)	(0)



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

There has been no movement in savings identified in month with the gap required to be closed through mitigations and upsides remaining at £581k. The key upside arising from a review of Trust asset valuations (and associated impact on PDC and depreciation charges) is planned to deliver this with final values to be confirmed in Qtr 4.

Work continues in the identification of additional saving opportunities to support delivery of the 2018/19 financial position and for the 2019/20 annual plan.

3.0 Balance Sheet 2018 / 2019

	2017 / 2018 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	123,810	125,169	125,012	1
Current Assets				
Inventories & Work in Progress	232	232	232	
NHS Trade Receivables (Debtors)	1,388	2,407	1,832	
Non NHS Trade Receivables (Debtors)	1,913	3,077	1,470	2
Other Receivables (Debtors)	1,219	1,000	2,038	3
Accrued Income	3,660	4,650	3,223	4
Cash and Cash Equivalents	26,559	21,752	26,156	5
Total Current Assets	**34,971**	**33,118**	**34,952**	
Current Liabilities				
Trade Payables (Creditors)	(4,158)	(4,970)	(3,359)	6
Capital Payables (Creditors)	(1,142)	(1,892)	(377)	6
Tax, NI, Pension Payables	(5,782)	(6,000)	(6,384)	
Accruals	(5,799)	(6,000)	(6,876)	7
Deferred Income	(670)	(670)	(935)	
Total Current Liabilities	**(17,552)**	**(19,532)**	**(17,931)**	
Net Current Assets/Liabilities	**17,419**	**13,586**	**17,021**	
Total Assets less Current Liabilities	**141,229**	**138,755**	**142,033**	
Provisions for Liabilities	(6,490)	(5,740)	(6,344)	
Total Net Assets/(Liabilities)	**134,739**	**133,015**	**135,689**	
Taxpayers' Equity				
Public Dividend Capital	44,015	44,015	44,023	
Revaluation Reserve	24,938	24,938	25,328	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	60,566	58,842	61,119	8
Total Taxpayers' Equity	**134,739**	**133,015**	**135,689**	

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 detail has been included when compared to 2017 / 18 to highlight accrued income and payables due to tax, National Insurance (NI) and pension arrangements.

1. Capital expenditure is detailed on page 14. Year to date spend remains below plan but the year end forecast remains on target.

2. Non-NHS Debtors, and debtors generally continue to be the focus for the Trusts cash management strategy. As such debtors remain significantly lower than plan.

3. Other Receivables, including prepayments, is higher than plan. The majority relates to payment timing for licences and the lease car insurance.

4. Accrued income is currently lower than plan, this is reviewed regulary to ensure invoices are raised on a timely basis.

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 16.

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

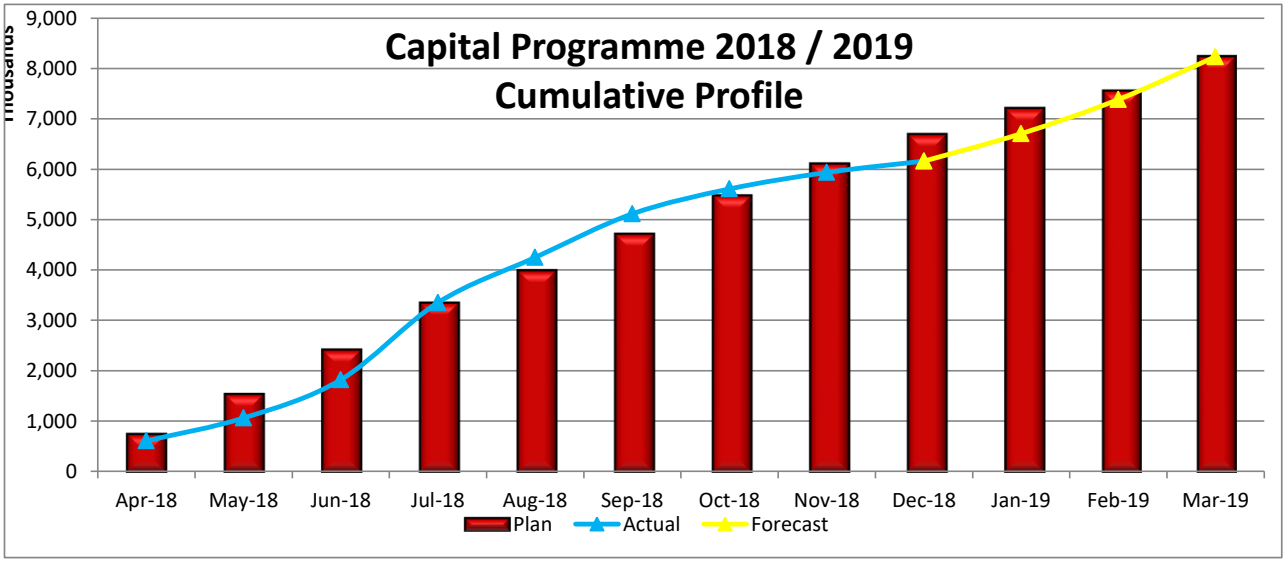
7. Accruals are higher than plan. Some invoices expected in Qtr 3 remain outstanding and are being chased.

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	1,628	955	766	(189)	1,862	234	3
Equipment Replacement	0	0	27	27	67	67	
IM&T	1,550	1,325	915	(410)	1,304	(246)	2
Major Capital Schemes							
Fieldhead Non Secure	4,229	3,587	3,896	309	4,249	20	4
Clinical Record System	828	828	615	(213)	808	(20)	4
VAT Refunds	0	0	(56)	(56)	(56)	(56)	
TOTALS	**8,235**	**6,695**	**6,162**	**(533)**	**8,235**	**(0)**	1

Remaining capital schemes are forecast to be delivered during 2018/19.



Capital Expenditure 2018 / 2019

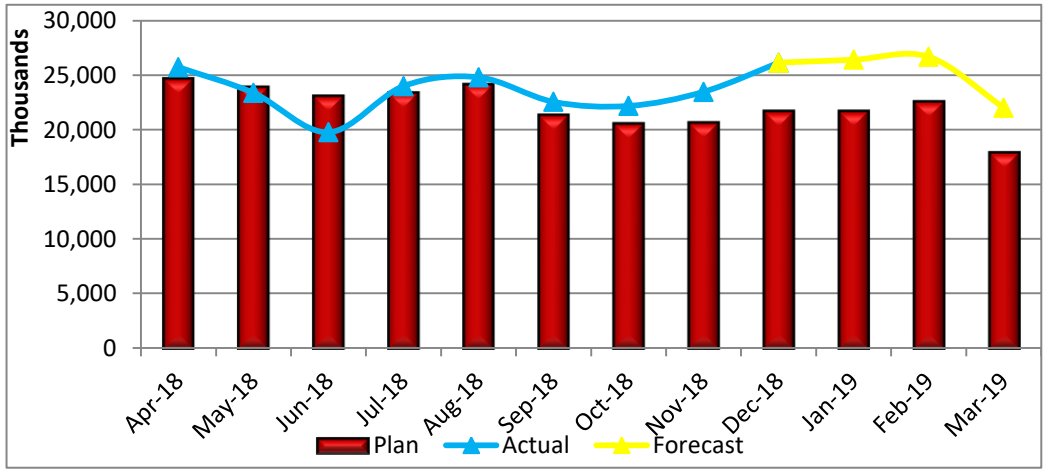
1. The originally agreed capital plan for 2018 / 19 was £8.1m and schemes are guided by the current estates and digital strategy. A further £135k has been added from national funding.

2. IM & T forecast underspends relates to schemes such as Business Intelligence which have been deferred pending completion of the Clinical Record System scheme. Other schemes have progressed as planned.

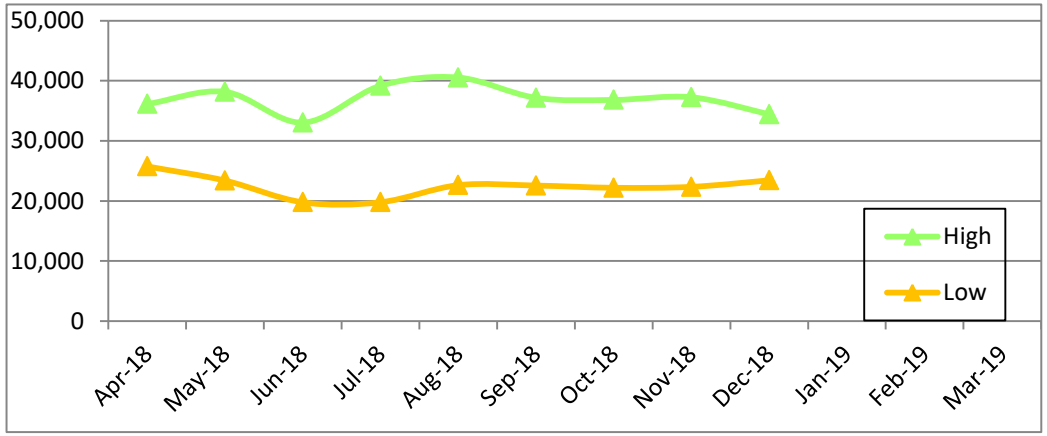
3. A number of minor capital schemes have commenced later than originally planned. These are progressing and are forecast to complete in year.

4. The major schemes continue and will be finalised in early 2019/20.

3.2 Cash Flow & Cash Flow Forecast 2018 / 2019



	Plan £k	Actual £k	Variance £k
Opening Balance	26,559	26,559	
Closing Balance	21,752	26,156	4,404



Effective cash management remains a key financial objective

Overall cash has increased by £2.6m in month to £26.2m and a detailed reconciliation of working capital compared to plan is presented on page 16.

The key components have been unplanned one off benefits such as asset sales and low debtor levels.

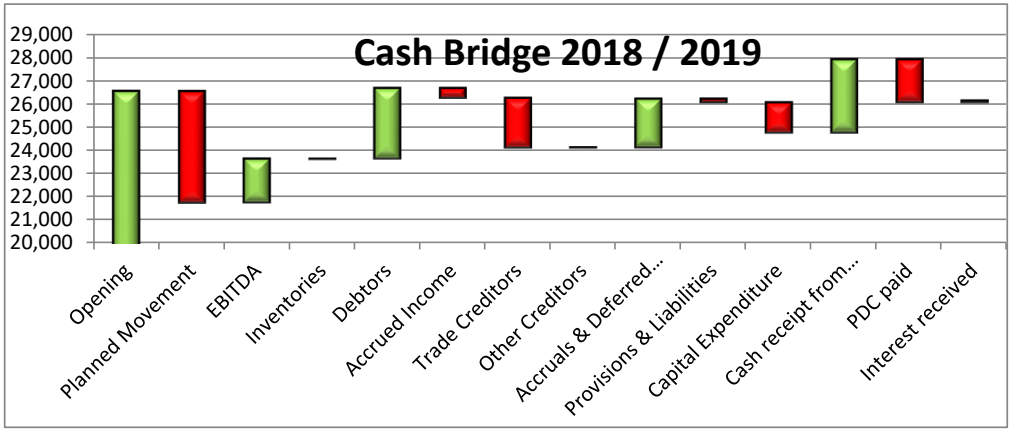
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£34.4m
The lowest balance is:	£23.4m

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)	5,336	7,237	1,901	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(3,000)	43	3,043	3
Accrued Income / Prepayments	0	(427)	(427)	4
Trade Payables (Creditors)	1,050	(1,091)	(2,141)	5
Other Payables (Creditors)	0	8	8	
Accruals & Deferred income	(750)	1,341	2,091	2
Provisions & Liabilities	0	(146)	(146)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(5,619)	(6,927)	(1,308)	5
Cash receipts from asset sales	(1,860)	1,295	3,155	
PDC Dividends paid	0	(1,848)	(1,848)	
PDC Dividends received			0	
Interest (paid)/ received	36	112	76	
Closing Balances	**21,752**	**26,156**	**4,405**	



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 compared to plan.
2. Accruals are higher than plan due to the timing of invoices received. Deferred income is higher than plan primarily due to project income received for Altogether Better.

3. Debtors are lower than plan. This is exceptionally low and is forecast to increase in Qtr 4.

NHS debts are reviewed as part of the month 9 Agreement of Balances exercise. No significant issues have been identified.

Factors which decrease the cash position against plan:

4. Prepayments are higher than plan, mainly due to the timing of payments made for software licences and the lease car insurance. It is Trust policy to not routinely pay in advance for goods and services and therefore these are exceptional cases.

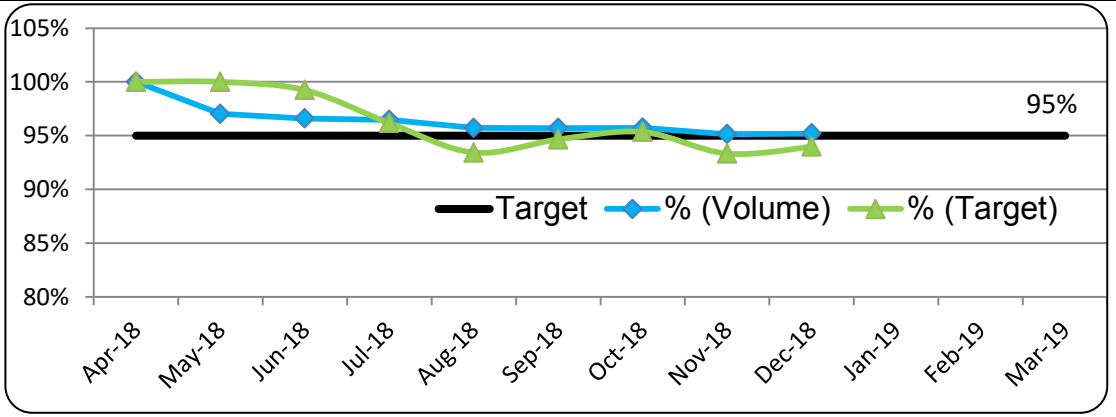
5. Creditors, and capital creditors, are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code and any aged creditors are reviewed and action plans for resolution agreed.

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

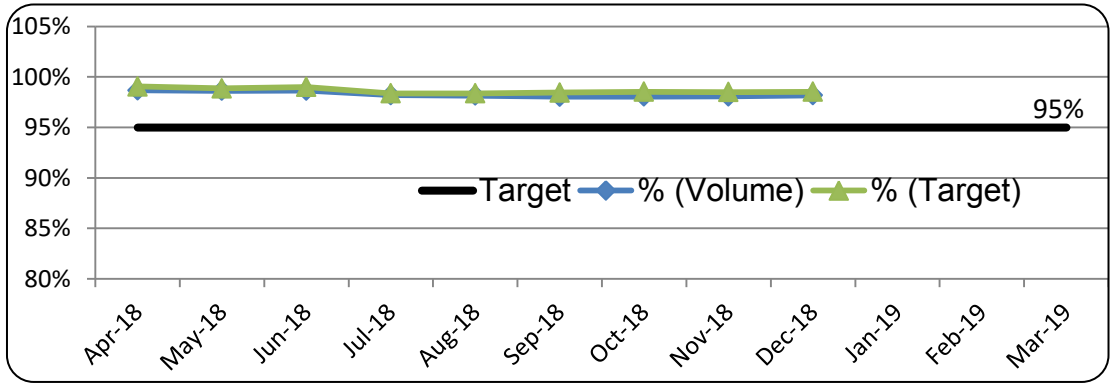
4.0 Better Payment Practice Code

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 November 2018	95%	93%
Year to December 2018	95%	94%



Non NHS	Number %	Value %
Year to November 2018	98%	98%
Year to December 2018	98%	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 sensitive.

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

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Numb	Amount (£)
12/12/2018	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3092875	505,143
03/12/2018	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3090540	148,981
30/11/2018	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3090519	125,196
05/12/2018	Property Rental	Kirklees	Bradbury Investments Ltd	3090909	118,518
05/12/2018	IT Services	Trustwide	Daisy IT Managed Services Limited	3091041	93,125
18/12/2018	CNST contributions	Trustwide	NHS Litigation Authority	3092316	61,855
04/12/2018	IT Equipment	Trustwide	Dell Corporation Ltd	3090776	53,731
25/09/2018	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3084132	44,435
05/12/2018	Drugs	Trustwide	Lloyds Pharmacy Ltd	3090974	42,548
12/12/2018	Property Rental	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	3092875	34,833
04/12/2018	Property Rental	Wakefield	Mid Yorkshire Hospitals NHS Trust	3090650	34,426
04/12/2018	Purchase of Healthcare	Forensics	Cloverleaf Advocacy 2000 Ltd	3090649	31,416
07/12/2018	Property Rental	Barnsley	Community Health Partnerships	3091196	31,178
05/12/2018	Drugs	Trustwide	Lloyds Pharmacy Ltd	3090974	28,269
07/12/2018	Electricity	Trustwide	EDF Energy	3091185	28,246
05/12/2018	Property Rental	Kirklees	Bradbury Investments Ltd	3090910	27,108
27/11/2018	Communications	Trustwide	Virgin Media Payments Ltd	3089904	25,938
31/12/2018	Communications	Trustwide	Virgin Media Payments Ltd	3093002	25,884
04/12/2018	Clinical Services	Wakefield	Mid Yorkshire Hospitals NHS Trust	3090689	25,615
07/12/2018	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	3091340	25,440
19/12/2018	Communications	Trustwide	Vodafone Corporate Ltd	3092372	25,414
16/11/2018	Communications	Trustwide	Vodafone Corporate Ltd	3089106	25,171
07/12/2018	Property Rental	Barnsley	Community Health Partnerships	3091196	25,051

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	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.0%	4.0%	4.2%	4.5%	4.8%	5.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.9%	4.1%	5.10%	6.70%	6.80%	6.10%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	83.50%	87.4%	89.1%	90.2%	96.2%	96.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	16.9%	35.6%	69.30%	77.70%	90.9%	91.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.8%	83.4%	84.5%	83.5%	82.4%	81.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.5%	83.0%	79.6%	79.5%	80.4%	82.5%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	88.9%	87.9%	86.6%	87.3%	88.2%	88.9%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.5%	92.7%	92.4%	92.5%	92.0%	92.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.2%	87.6%	87.3%	85.9%	86.6%	87.5%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	65.70%	70.1%	72.9%	74.1%	77.0%	75.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.0%	87.7%	88.9%	89.8%	90.0%	89.7%
Information Governance	Resources	Well Led	AD	>=95%	91.5%	91.5%	91.1%	90.9%	89.3%	88.6%
Moving and Handling	Resources	Well Led	AD	>=80%	81.3%	81.5%	83.5%	83.5%	85.2%	86.7%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	87.2%	86.5%	85.6%	87.5%	89.0%	89.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	84.7%	84.0%	81.4%	81.1%	85.0%	84.0%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.1%	90.9%	89.7%	89.1%	90.7%	90.9%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.1%	90.1%	90.6%	90.4%	89.4%	89.9%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	96.6%	95.7%	95.3%	95.2%	95.4%	95.8%
Agency Cost	Resources	Effective	AD		£93k	£59k	£71k	£90k	£73k	£68k
Overtime Costs	Resources	Effective	AD		£4k	£1k	£1k	£1k	£0k	£3k
Additional Hours Costs	Resources	Effective	AD		£15k	£17k	£15k	£15k	£17k	£10k
Sickness Cost (Monthly)	Resources	Effective	AD		£109k	£117k	£140k	£187k	£185k	£172k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		91.4	71.1	78.8	77.7	84.4	85.8
Business Miles	Resources	Effective	AD		106k	102k	105k	105k	107k	100k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.7%	4.5%	4.4%	4.4%	4.4%	4.5%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.6%	3.8%	3.9%	4.4%	4.6%	4.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	96.5%	99.4%	99.2%	99.4%	99.7%	99.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	22.5%	54.0%	86.3%	92.8%	95.4%	97.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.1%	83.1%	81.2%	79.2%	80.6%	82.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	85.9%	85.7%	84.2%	80.2%	79.5%	78.4%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	86.8%	86.6%	87.2%	87.7%	87.7%	88.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	90.1%	90.2%	89.8%	89.9%	90.4%	91.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.0%	86.7%	86.5%	88.7%	87.7%	88.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	81.3%	81.4%	83.3%	84.1%	88.1%	87.8%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	87.6%	88.7%	89.2%	88.1%	87.6%	89.9%
Information Governance	Resources	Well Led	AD	>=95%	94.1%	93.2%	94.8%	94.9%	92.7%	91.2%
Moving and Handling	Resources	Well Led	AD	>=80%	87.4%	87.1%	88.7%	88.5%	89.0%	88.8%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.9%	92.9%	92.4%	90.9%	91.4%	91.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	92.1%	90.6%	89.7%	89.6%	89.7%	89.1%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	90.9%	90.8%	90.9%	92.4%	93.6%	94.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	87.2%	86.8%	85.0%	87.4%	86.2%	89.9%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	97.2%	95.8%	95.7%	95.7%	95.2%	95.2%
Agency Cost	Resources	Effective	AD		£89k	£112k	£73k	£103k	£114k	£105k
Overtime Costs	Resources	Effective	AD		£4k	£3k	£6k	£1k	£4k	£2k
Additional Hours Costs	Resources	Effective	AD		£2k	£0k	£0k	£0k	£1k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£104k	£90k	£98k	£108k	£106k	£120k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		66.97	75.42	76.65	78.65	79.51	74.99
Business Miles	Resources	Effective	AD		64k	59k	69k	54k	77k	57k

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	6.5%	7.1%	7.5%	7.6%	7.5%	7.6%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	7.6%	9.7%	9.4%	8.1%	7.3%	8.2%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	83.8%	85.7%	94.8%	94.7%	93.3%	93.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	32.3%	56.0%	87.0%	89.7%	96.9%	97.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	88.4%	87.3%	84.6%	85.6%	86.8%	86.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.5%	85.3%	85.3%	85.0%	85.3%	84.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	85.4%	85.5%	83.8%	82.4%	82.2%	85.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.3%	95.0%	93.6%	94.4%	95.0%	95.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.9%	88.8%	85.3%	85.6%	84.6%	87.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	89.5%	89.2%	87.1%	86.1%	88.1%	84.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	91.6%	90.0%	88.7%	90.2%	90.3%	90.4%
Information Governance	Resources	Well Led	AD	>=95%	94.3%	93.0%	90.4%	91.2%	89.8%	93.1%
Moving and Handling	Resources	Well Led	AD	>=80%	92.1%	91.0%	89.7%	91.4%	91.8%	91.4%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.1%	91.5%	89.5%	89.2%	91.3%	90.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	82.8%	82.1%	80.1%	80.6%	85.4%	83.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.8%	94.3%	93.1%	93.6%	93.5%	95.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	91.3%	91.3%	89.2%	89.5%	87.6%	91.4%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.5%	96.0%	92.6%	95.5%	82.8%	86.7%
Agency Cost	Resources	Effective	AD		£54k	£51k	£57k	£44k	£62k	£76k
Overtime Costs	Resources	Effective	AD		£0k	£0k		£0k		£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£1k	£1k	£3k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£72k	£85k	£77k	£73k	£65k	£77k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		55.59	69.76	73.91	63.16	63.48	57.24
Business Miles	Resources	Effective	AD		7k	9k	7k	5k	4k	9k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.6%	4.5%	4.6%	4.8%	5.1%	5.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.4%	3.9%	5.0%	6.6%	6.7%	5.8%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	72.5%	89.8%	94.8%	95.8%	98.4%	98.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	31.0%	54.1%	67.4%	77.3%	90.5%	90.5%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.6%	80.4%	79.0%	76.6%	77.7%	83.7%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	85.2%	80.6%	78.9%	77.7%	79.0%	78.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	90.2%	91.4%	91.4%	91.9%	92.4%	93.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	85.1%	87.4%	88.2%	88.3%	89.2%	90.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.8%	85.2%	85.2%	86.1%	82.0%	83.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.1%	76.9%	77.8%	70.0%	73.3%	73.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.5%	87.4%	87.9%	89.5%	89.4%	89.3%
Information Governance	Resources	Well Led	AD	>=95%	91.0%	92.8%	92.1%	92.1%	87.4%	87.7%
Moving and Handling	Resources	Well Led	AD	>=80%	85.8%	87.9%	88.4%	89.3%	89.2%	89.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.8%	92.6%	91.4%	92.7%	95.1%	94.4%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.7%	87.7%	86.9%	86.4%	88.7%	86.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	89.9%	88.6%	89.2%	92.4%	93.6%	93.9%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	88.7%	89.4%	90.4%	91.5%	92.1%	93.4%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.5%	95.3%	94.4%	94.0%	92.3%	92.8%
Agency Cost	Resources	Effective	AD		£187k	£231k	£197k	£221k	£202k	£202k
Overtime Costs	Resources	Effective	AD		£0k	£0k	£0k	£0k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£2k	£1k	£1k	£0k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£44k	£45k	£60k	£81k	£76k	£68k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		50.3	52.67	62.89	63.85	57.17	57.68
Business Miles	Resources	Effective	AD		41k	40k	35k	37k	44k	43k

Appendix 2 - Workforce - Performance Wall cont….

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	3.9%	4.0%	3.9%	4.0%	4.1%	4.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	4.1%	4.0%	3.9%	4.2%	5.1%	4.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	92.2%	96.0%	99.0%	99.5%	99.5%	99.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	17.7%	51.7%	83.6%	96.0%	98.3%	98.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	78.1%	80.6%	80.6%	79.6%	77.3%	74.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	92.0%	92.0%	87.5%	77.8%	75.0%	85.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	33.3%	33.3%	33.3%	25.0%	0.0%	100.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	86.8%	85.9%	85.1%	86.0%	87.2%	87.5%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.3%	89.2%	87.3%	87.7%	89.1%	91.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	95.1%	95.7%	95.1%	94.4%	96.5%	95.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	87.2%	88.9%	88.5%	88.1%	87.2%	88.3%
Information Governance	Resources	Well Led	AD	>=95%	89.2%	91.9%	91.5%	91.8%	90.4%	94.4%
Moving and Handling	Resources	Well Led	AD	>=80%	91.3%	90.8%	90.5%	89.0%	91.6%	91.4%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.3%	99.0%	99.0%	99.0%	99.2%	99.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	90.0%	85.7%	85.7%	82.6%	85.7%	87.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.7%	95.5%	95.6%	95.3%	95.1%	96.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	96.0%	96.4%	96.2%	95.2%	94.2%	95.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%
Agency Cost	Resources	Effective	AD			£-9k	£0k	£5k	£16k	£8k
Overtime Costs	Resources	Effective	AD		£1k	£1k	£1k	£1k	£1k	£1k
Additional Hours Costs	Resources	Effective	AD		£10k	£11k	£12k	£12k	£9k	£7k
Sickness Cost (Monthly)	Resources	Effective	AD		£59k	£61k	£63k	£70k	£80k	£71k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		31.96	33.31	36.87	42.92	41.1	46.27
Business Miles	Resources	Effective	AD		36k	25k	25k	32k	28k	32k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.1%	4.5%	4.7%	4.7%	4.8%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	6.0%	5.8%	5.7%	4.9%	5.3%	5.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	92.7%	94.7%	95.8%	97.4%	98.9%	98.9%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	24.1%	55.7%	79.1%	89.9%	93.4%	93.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	81.5%	82.7%	83.6%	83.8%	83.1%	85.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	81.0%	79.8%	79.7%	79.2%	78.3%	83.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	77.8%	78.9%	79.2%	78.2%	78.4%	80.9%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.2%	87.8%	89.0%	89.2%	90.8%	91.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.2%	85.9%	83.6%	85.9%	87.0%	88.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	71.0%	72.7%	67.9%	70.9%	69.7%	67.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	87.2%	89.5%	91.7%	91.1%	91.2%	91.3%
Information Governance	Resources	Well Led	AD	>=95%	91.6%	91.4%	91.9%	92.7%	90.0%	90.5%
Moving and Handling	Resources	Well Led	AD	>=80%	79.9%	83.2%	85.2%	87.1%	88.7%	89.2%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.8%	90.7%	90.0%	91.5%	92.5%	92.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	88.1%	88.1%	86.9%	86.7%	87.6%	87.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	88.9%	89.7%	91.7%	92.5%	93.5%	93.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	87.0%	88.6%	89.0%	89.0%	87.1%	89.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	93.4%	93.3%	91.9%	92.3%	93.3%	94.2%
Agency Cost	Resources	Effective	AD		£103k	£123k	£124k	£73k	£68k	£70k
Overtime Costs	Resources	Effective	AD		£2k	£0k		£0k		£1k
Additional Hours Costs	Resources	Effective	AD		£2k	£1k	£0k	£1k	£2k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£74k	£71k	£70k	£61k	£68k	£72k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		47.15	51.62	48.13	42.47	45.36	45
Business Miles	Resources	Effective	AD		37k	35k	37k	34k	39k	38k

Glossary

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

KEY for dashboard Year End Forecast Position / RAG Ratings	
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

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Trust Board 29 January 2019
Agenda item 9.1

Title:	**Estate Strategy update**
Paper prepared by:	Director of Human Resources, Organisational Development and Estate
Purpose:	This paper updates the Board on progress on the Estate Strategy.
Mission/values:	The Estate Strategy was developed to ensure that the Trust's buildings and properties are of a high quality, fit for purpose and offer best value.
Any background papers/ previously considered by:	The current Estate Strategy is designed to be a 10 year strategic plan for the management and development of the estate. The Trust Board agreed the strategy in 2012 and has over this period received regular updates.
Executive summary:	The Trust has already delivered on large parts of its Estate Strategy and since 2012 has spent over £65m on the estate and equipment (excluding information technology). This investment has resulted in: the modernisation of all the inpatient areas; the development of community hubs in all districts; and the disposal of properties that were not fit for purpose and surplus. These were the 3 key aims of the Estate Strategy. A part of the inpatient modernisation programme was the development of the Unity Centre on the Fieldhead site which consists of new purpose built adult acute mental health wards. The overall scheme was approximately £17m and two phases are complete and operational. The final phase of the programme is due to complete in April 2019. The Trust has spent over £9m to create Community Hubs in all the districts. The latest of which are Baghill House in Pontefract and Drury Lane in Wakefield. Over the course of the Strategy there have been a number of key disposals which have supported the capital programme. To date the disposal of surplus estate has amounted to about £9m with a further £6m planned over the next 3 years. The planned future disposals include Mount Vernon, Keresforth and Ossett and timescales are updated in the report. As well as the strategic projects the Trust continues to invest in maintaining the estate to a safe and effective standard with a combination of revenue and capital investments. **Risk Appetite** The Estate Strategy risk appetite is consistent with the levels agreed for service and financial plans.
Recommendation:	**The Trust Board is asked to NOTE the content of the report.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019

Estate Strategy Update

1. Introduction

The Trust's Estate Strategy was agreed by the Board in 2012, as a 10-year strategic plan for the management and development of its properties and buildings, linked to the service and financial plans. There were 3 key aims of the Estate Strategy:

- Modernisation of the inpatient estate
- Development of a community infrastructure to support care closer to home
- Disposal of estate surplus to requirement

Underpinning these key aims was a set of goals:

- To create a safe and effective environment for staff and service users
- To deliver community services from non-stigmatising facilities
- To have as many support services co-located as practical
- To have an affordable estate
- To dispose of surplus assets in a manner which offers the best results for the Trust

The Estate Strategy was developed with service users, carers, clinicians and service managers input.

The strategy has been in operation for over 6 years and a high level summary of some of the main achievements are detailed below:

- Investment of approximately £65m in Estate and equipment over the 6 year period
- Capital spend during the period of the strategy is £47 million on major developments.
- Capital receipts of £9.3 million to date
- Saving in leases totalling £1.2million
- Removal £2.58million of back log maintenance.

2. Developments

2.1 Modernisation of inpatient estate

The Trust has over the past 6 years invested over £30m across all its inpatient areas as part of the Estate Strategy.

The development of the Unity Centre is the latest major capital programme for inpatient areas and the scheme has delivered award winning purpose built adult acute mental health wards. Interserve is the Trust's P21+ partner on the £17m scheme which is nearing completion. Two phases of the scheme have already been completed and the final phase is due for handover in April 2019.

This project is being delivered by Interserve Construction Limited who are part of the wider Interserve group. The company is reported as having some financial difficulties and there is a degree of concern about their

long term position. Government advice is that the company will recover and business should continue as usual. Given that the project is almost complete the risk is felt to be low. However, with P21+ projects a 2-year defects liability is standard along with long term warranties on key items. It is the warranty period which carries a higher risk and may leave the Trust exposed to some additional expenditure.

2.2 Community hubs

The Estate Strategy recognised that in order to support the delivery of better and more local services that it had to develop its community infrastructure through the creation of Service Hubs.

Barnsley had already, through its LIFT (Local Initiative Financial Trust) programme, a number of newly built community properties and the challenge was to ensure they were fully utilised. The utilisation by Trust services of LIFT buildings over the past 6 years have increased significantly, allowing the disposal of a number of small outdated buildings. However, Barnsley town centre was not covered by one of the LIFT buildings and therefore the Trust invested over £2m on the redevelopment of New Street.

In Calderdale a purpose built and again award-winning community hub, Laura Mitchell, came into operation in 2016. This development again allowed the disposal of a number of leases and buildings not fit for purpose.

A major redevelopment of Baghill House was undertaken in Pontefract to convert this into a community hub, at a cost of again over £2m, to serve the eastern side of the Wakefield district.

A new purpose built community hub was developed at Drury Lane in the centre of Wakefield City.

These developments have all been completed and are fully integrated into the operational estate and they provide modern and effective spaces for staff and service users alike. Drury Lane has provided the most challenges and some adaptions to the initial design have removed the initial concerns staff had when operating from the building. The main hubs have benefitted from local management groups which ensure the resource is used to its maximum efficiency and any issues are highlighted and resolved as quickly as possible.

In appendix 1 and 2 are summaries of the initial 12 months post-project evaluation reports for Baghill House and Drury Lane. A full evaluation report will be completed once the building has been fully operational for two years. This evaluation has now commenced and will include service user feedback.

2.3 Disposal of surplus estate

The Trust since 2012 has disposed of over £9m of surplus estate and has a further £6m as part of the plan moving forward. In 2018/2019 the Trust sold the following properties:

Year	Value
2018/19	
Castle Lodge, Wakefield	£773,000
Keresforth Houses	£600,000

The outstanding disposals are all in progress with scheduled completion dates as follows:

- Mount Vernon Hospital Scheduled Completion September 2019
- Keresforth Site (One Public Estate disposal with Barnsley Council) early 2021
- Ossett Health Centre September 2019

3. Recommendation

The Trust Board is recommended to:

- Note the contents of this report

Alan Davis
Director of Human Resources, Organisational Development and Estate

Baghill House 12 Month Initial Post Project Evaluation

Introduction

This paper is intended to update Board on the effectiveness of the Baghill House community hub. The project was approved on October 2015 and completed on September 2016 and a 12 month Post Project Evaluation (PPE) was received at Estates TAG in March 2018. This is a summary of the 12 months PPE.

The initial 12 month project evaluation represents a more technical review of the scheme to ensure that any short-term building issues are addressed. It was agreed a full project review including service user feedback and service outcomes will be completed after the building has been operational for two years. The work on the full post project evaluation has now commenced.

The Baghill House scheme utilised an existing Trust base which was completely refurbished and considerably extended in order to meet the Trust's current and future needs.

Finances

Pontefract Hub

NHS South West Yorkshire Partnership NHS Foundation Trust

	Business Case £k	Actual £k	Variance £k	Notes
Capital Expenditure	2,953	2,981	28	1% spend over plan
Impairment	1,125	926	(199)	Lower impairment than plan. Less I & E impact
Capital Receipts	(394)	(385)	9	Less income than plan (2 out of 2 disposals)
Revenue Expenditure	133	148	15	Additional revenue costs not in plan
Revenue Savings	(129)	(129)	0	Revenue savings now realised in full as disposed – 17/18 £k
Capital Charges	145	124	(21)	
Total Revenue Impact	**149**	**129**	**(6)**	

Overall the scheme delivered effectively against its key financial targets. There were some areas where the actual effect was slightly less than anticipated but these were offset by improvements in other areas.

Delivery against full business case drivers

Overall the project had the following key benefits set out in the business case:

1. Closed buildings that were marked as unfit for purpose and had high risk backlog

2. Facilitate the co-location of services to enhance the provision of ‘ageless’ services and the community team Transformation to ‘Core’ & ‘Enhanced’ pathways
3. Support the implementation of agile working and efficiencies of this
4. Central location convenient for service users improving access
5. Provides good quality accommodation for the delivery of therapy without stigma
6. Facilitates the disposal of the Castleford site

These objectives were all marked as achieved in the 12 month post project evaluation. Bringing together the teams under one roof has given benefits to service users in that they identify the site with their overall wellbeing and not simply certain aspects. An additional benefit has been that service spokes in GP properties are now being developed further which further reduces the perceived stigma around mental health

Project effectiveness

- Site visits for clinical teams during the construction works were warmly welcomed. Improved service ‘buy-in’ and ownership for the scheme. Ensure that the offer of site visits during construction is continued for future schemes.
- Involvement of all clinical teams in the detailed design and individual room layouts was a positive. Teams felt involved and their needs recognised.
- On-site IT support on move dates was very useful and meant that teams were functioning more quickly from the new Hub
- The ability to introduce agile working in a phased manner during the interim team re-locations gave the teams the opportunity to gradually implement new ways of working.
- The Community Hub has benefitted from the Locality Resource Manager post and the facility is well managed.
- Baghill House feel that the separate agile working areas makes that unit more practicable from a noise perspective, whilst others see it as a barrier to co-working retaining a separation of the teams who are based there.
- The introduction of the Trust-wide room booking system has helped the standardised approach to bookings

Project challenges and learning

- Some staff have found that some spaces were smaller than envisaged during design process. Estates now consider the use of ‘mock-up’ spaces and 3D drawings to get a more practical understanding of key rooms, or make this option available to those involved from a service perspective.

- Initial programme did not include a training and familiarisation period, this should be included in future projects – not just move dates. Services are impacted more by late changes to move dates than waiting slightly longer than necessary to ensure a smooth move process.
- The process for vacating promises should be followed. Workstreams to stress the responsibility of Team Managers re the clearance of former units and submission of vacating forms.
- The Trust policy for agile working with strict application of 1:3 desk ratios was felt by staff not reflecting the working patterns of all teams.
- With additional capacity modelling post project it is felt the hotdesk and admin areas should have been larger. The consulting spaces are able to support bids for additional services but the office accommodation areas cannot support additional teams located there. A general review of agile working and how it has been implemented may provide some solutions to these issues. This review will form part of the follow up work currently being undertaken on the longer term evaluation of the hub in use, which includes more staff and service user feedback.

Summary

Overall the project has met its objectives although they do differ slightly from the results predicted in the business case.

In terms of space utilisation, clinical space has some capacity although support rooms are believed to be at capacity. The local Building Management Group are continuing to explore how to most effectively use the space.

Nick Phillips
Head of Estates and Facilities

Drury Lane 12 Month Initial Post Project Evaluation

Introduction

This paper is intended to update Board on the effectiveness of the Drury Lane project. The project was approved in October 2015 and completed in October 2016, the 12 month Post Project Evaluation (PPE) was received at Estates TAG in March 2018 and this is an abbreviated version of that report.

The initial 12 month project evaluation represents a more technical review of the scheme to ensure that any short-term building issues are addressed. It was agreed a full project review including service user feedback and service outcomes will be completed after the building has been operational for two years. The work on the full post project evaluation has now commenced.

The Drury Lane site is a new build project which is rented from a developer.

Finances

Wakefield Hub

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

	Business Case £k	Actual £k	Variance £k	Notes
Capital Expenditure	735	843	108	Additional spend
Impairment	0	0	0	
Capital Receipts	(1,300)	(1,077)	223	Disposal of 3 out of 4. Ossett HC pending (£500k in plan)
Revenue Expenditure	528	538	10	Additional £150k in year 1 & 2 for negotiated rent reduction.
Revenue Savings	(480)	(450)	30	Ongoing revenue costs for Ossett.
Capital Charges	73	104	31	Continued capital charges for Ossett
Total Revenue Impact	**121**	**154**	**71**	

Overall, the scheme has yet to meet its financial goals as Ossett remains unsold. However, a sale has been agreed on Ossett and it is due to complete in September 2019.

Delivery against full business case drivers

Overall the project had the following key benefits set out in the business case:

1. Closed buildings that were not fit for purposes under the 6 facet survey assessments
2. Facilitate the co-location of services to enhance the provision of ‘ageless’ services and the community team transformation to ‘core’ & ‘enhanced’ pathways
3. Support the implementation of agile working and efficiencies of this
4. Central location convenient for service users
5. Provides good quality accommodation for the delivery of therapy without stigma
6. Facilitates the disposal of the Castleford, Normanton and District Hospital site

The initial post project evaluation has marked goals 1,2,4 and 6 as fully achieved with the other two items as achieved but with some outstanding issues which are being resolved specifically. These were:

- Staff car parking from the Hub sometimes takes considerable time out of the working day.
- The staff feel the 1:3 desk ratios do not reflect that some services are more tied to the building for service delivery than others.
- The remaining comments were around some defects works required to correct sound attenuation faults in some consulting/meeting areas. These are now resolved.

Project effectiveness

- Appointment of a service side project manager enabled consistent decision making between the 2 Wakefield District hub developments (Baghill & Drury Lane)

- Involvement in site selection was welcomed – however the Drury Lane site was a late addition to the process (having just come on the market) and it is felt that the scoring of the additional sites after the group scoring meetings had taken place, could have been more inclusive and transparent.

- Site visits for clinical teams during the construction works were warmly welcomed. Improved service ‘buy-in’ and ownership for the scheme. Ensure that the offer of site visits during construction is continued for future schemes.

- On-site IT support on move dates was very useful and meant that teams were functioning more quickly from the new hub

- The community hub has benefitted from the Locality Resource Manager post.

- Teams feel that co-location with many other services is positive to patient centred care, improving communication and liaison across team boundaries.

- Teams are taking on the full meaning of ‘agile working’ utilising several sites, including Drury Lane and Fieldhead hotdesk zones as their work patterns allow.

Project challenges and learning

The Drury Lane project was delivered as a bespoke rented scheme due to a number of factors, the main one being the availability of development land in Wakefield City Centre. In addition, the Trust had a complex disposal schedule aligned to the scheme and the Ossett Health Centre disposal has continued to be challenging as the original sale identified as part of the business case was not achieved. Ossett is scheduled for disposal in September 2019. If that is achieved then the red items in the financial report, apart from the project overspend, will change and the overall finance envelope will have been achieved.

Each facility to be treated individually – decisions for one facility may not be the most applicable for another. The larger scale of Drury Lane hub may have required a different approach to some zones.

- Wider service involvement in design works was welcomed but limited due to timeframes from the developer. Input was limited to service managers and the Service Project Manager.
- Some users of the facility have found that some spaces were smaller than envisaged during design process. Consider the use of 'mock-up' spaces or 3D plans to get a more practical understanding of key rooms, or make this option available to those involved from a service perspective.
- Initial programme to ensure training and familiarisation period should be included in future – not just move dates. Services are impacted more by late changes to move dates than waiting slightly longer than necessary to ensure a smooth move process.
- The process for vacating promises should be followed. Workstreams to stress the responsibility of Team Managers re the clearance of former units and submission of vacating forms need to be in place.
- The Trust policy for agile working with strict application of 1:3 desk ratios was felt by staff not reflecting the working patterns of all teams.
- Unlike Baghill House, the Drury Lane teams did not have the opportunity for a gradual 'soft landing' into agile working principles and this created more difficulties.
- The co-location of a very high number of staff has made team cohesion difficult to maintain. Individual team members can be difficult to locate at short notice and in the large space it is difficult to undertake 'quiet working'.
- Ensure plans for IT wifi installation are followed exactly to ensure full coverage.
- With so many teams in the facility there is often a management by consensus-leaving smaller teams feeling that they have a limited voice.

- Some aspects of the agreed design did not work and changes have had to be made.
- The open plan areas have caused issues with some team members who have had difficulty adjusting.
- The service has not adapted the working patterns anticipated in the business case putting pressure on the clinical space at key times.
- Car Parking is restricted on the site and off-site parking is at a cost to staff. This has caused some ill feeling from staff who previously parked free of charge.

Summary

Overall the project has met its performance objectives but has not as yet met its financial objectives. This will change with the disposal of Ossett where a sale has been agreed and is due to be completed in September 2019.

Overall staff have had more issues at Drury Lane than any other hub. This is due in part to some design challenges but these issues have been increased in intensity due to the restricted free parking and staff having to pay to park. The Trust has been part of an agreement to obtain heavily discounted, safe car parking in the city centre to reduce the impact of parking costs. Staff who do multiple journeys do have priority for the on site parking and short term bays have been introduced for staff visiting the site between community clinical visits. This has improved the situation but car parking remains an area that requires management through the building user group (BUG)

The effective use of the clinical space continues to be an issue and further work is being undertaken on utilisation in this area. The location does benefit service users so use of the space must be as effective as possible.

With regard to the key design issues, the learning from the hub is incorporated into the Trusts standard design requirements which form part of the brief for future capital projects in order to capture the learning. The second stage evaluation currently being undertaken involves wider staff and service user consultation on how the hub works and what the effect of the alterations to the initial design has had on the operation of the building, the agile working patterns will be part of that process.

The building user group is dealing with the ongoing operational challenges which come up an a day to day basis and is responsible for ensuring the facility is used to its maximum potential.

The move from many different sites to one site whilst giving operational and financial benefits has caused a large amount of disruption to the working of teams. It would be beneficial if any future scheme should have a dedicated change management workstream.

Nick Phillips
Head of Estates and Facilities

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 10.1

Title:	**Operational Plan 2019/20**
Paper prepared by:	Director of Finance and Resources
Purpose:	To advise the Trust Board of the key points identified in the operating plan guidance for 2019/20 and the process for Board engagement, input and approval
Mission/values:	All Trust values
Any background papers/ previously considered by:	An initial presentation was made to Trust Board members at the Trust Board strategy session on 27 November 2018. An initial paper was provided to the December 2018 Trust Board when outline guidance was available
Executive summary:	➢ Final planning guidance was issued in January 2019 following on from the outline planning guidance provided in December ➢ Key milestones and timescales identified ➢ The key roles the ICSs have to play in plan development is specified in the guidance with aggregate system plans to be completed in addition to individual plans ➢ Control totals remain in place for 2019/20 which have been re-based ➢ Financial settlement is a net 2.7% (3.8% uplift less 1.1% efficiency requirement) uplift prior to additional investment in mental health, learning disability and community health services ➢ This settlement also excludes changes to the CQUIN income scheme and national procurement changes. ➢ Mental Health investment to be at least in line with growth in commissioner allocations ➢ 1 year plan for the Trust for 2019/20 required ➢ Contracts need to be agreed and signed by 21 March 2019 ➢ Operational requirements and deliverables for all services are included in the guidance. Some of these are additional deliverables compared to what is currently required ➢ Workforce plans in terms of increasing staffing numbers, and reducing agency costs are identified ➢ Activity, workforce and financial plans need to be aligned and to triangulate ➢ A suggested approach and timeline for board input and approval of the plan including the initial draft plan submission required for 12 February 2019 is outlined in the body of the report. ➢ Final plan submission date of 4 April 2019 to be approved at the March 2019 Trust Board

	Risk appetite. Trust risk appetite statement which aims for financial risk of 4-6. Any implications on clinical risk must also be taken into account. .
Recommendation:	**Trust Board is asked to:** ➢ **REVIEW and COMMENT on this paper recognising the requirements and guidance associated the annual operating plan development and submission; and** ➢ **CONSIDER the governance and approval arrangements outlined and CONFIRM agreement to them or advise of any required changes.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019

Operating Plan 2019/20

Introduction

The purpose of this report is to provide the Trust Board with the final details of the planning guidance for the 2019/20 operating plan process, how it impacts the Trust and what the Trust and the Board need to do in order to meet the requirements of the guidance. This paper follows up an initial report provided to Trust Board in December 2018 which highlighted what the draft outline guidance stated in relation to the development of the plan. This report follows the same format and structure as the formal guidance, taking the key points for board members to be aware of. To ensure the context of the message in the guidance is not open to significant interpretation much of the language used in this report is taken directly from the guidance document

System planning

Evident in the plan is the focus on system leadership and working. Each Sustainability & Transformation Partnership(STP)/Integrated Care System(ICS) need to be develop an operating plan comprising of a system overview and system data aggregation (activity, workforce, finance, contracting). These need to include agreed collective priorities, realistic shared capacity and activity assumptions and be demonstrably aligned across providers and commissioners. An “open book” approach between partners is expected.

Organisations within an STP/ICS are expected to take collective responsibility for the delivery of their system’s operating plan. NHS England and NHS Improvement regional teams will play a key role in the development and review of system-wide plans.

There will be a system control total for each STP/ICS which will be the sum of individual organisation control totals. Each STP/ICS has the opportunity to propose net-neutral changes agreed by all parties. This is intended to support service improvement and collective financial management. All providers and CCGs need to be included in the system operating plan and control total. It is expected all CCGs and most providers are included in only one system. The guidance does state though “Where a significant proportion of a provider’s clinical income flows from organisations within another STP/ICS it may be included pro-rata in more than one system if agreed by the provider, the relevant STP/ICS leaders and relevant regional director”. The organisations included in each system must be finalised before final system operating plans are submitted.

Delivery of system-wide efficiencies is encouraged and these should be the focus as opposed to cost-shifting between organisations

Financial Settlement

The financial settlement is largely as identified in the December board paper. The key points are highlighted in this section of the report.

The tariff uplift for 2019/20 is set at 3.8% subject to consultation. This uplift includes the cost of agenda for change pay awards that were paid directly to providers in 2018/19 as well as pay inflation and agenda for pay awards for 2019/20. Offsetting this uplift is required efficiency of 1.1% thereby leaving a net 2.7%. Excluded from the uplift are the costs of the new centralised procurement arrangements and the transfer into local prices of 1.25% from CQUIN. Trusts in deficit will be expected to deliver a further 0.5% efficiency requirement, which will be factored into the control total.

An updated Market Forces Factor (MFF) is being implemented given the fact it has not been updated for 10 years and considered to be out-of-date in some areas. These changes will be phased over 5 years.

2019/20 will include re-based financial control totals with intent to remove them from 2020/21. All trusts with a deficit control total will be expected to deliver additional efficiency of 0.5%. As previously indicated £1bn of the £2.45bn Provider Sustainability Funding (PSF) will transfer from into urgent and emergency care tariff. £155m of the remaining PSF is allocated to the non-acute sector, which is the same value as 2018/19. Receipt of PSF will again be dependent on acceptance and delivery of financial control totals.

A £1.05bn fund is being created to support the sustainability of essential NHS services. The aim of this is to support those trusts in deficit to secure financial sustainability of essential services and able to cover day-to-day running costs. It will be allocated on a non-recurring basis and is only available to trusts in deficit who sign up to their control total. It is expected the number of trusts in deficit reduce as the sustainability of services improves. All systems with deficit trusts need to have recovery plans in place by December 2019.

All trusts are expected to implement proven initiatives including the Model Hospital, RightCare and Get It Right First Time (GIRFT) as well as the big opportunities identified in the long term plan.

CCG allocations have recently been published and include a level of funding to ensure they are able to meet commitments to the mental health investment standard.

It is worth board members having knowledge of the key points in the CCG financial framework. They will also have a financial control total which they are expected to deliver. Collectively this will be a break-even position after the deployment of Commissioner Sustainability Funding (CSF). CCGs are being asked to deliver a 20% real terms reduction against their 2017/18 running cost allocation in 2020/21, which forms part of the overall £700m admin savings requirement for commissioners and provider by 2023/24.

The focus on productivity is identified and this will need to amount to at least 1.1% year on year efficiency improvement for the next five years. There is a separate board paper on the long term plan where this is covered in more detail. System-wide solutions, staff productivity, use of digital technology, wider infrastructure and transforming models of delivering services to patients are all highlighted.

Key focus is expected in relation to:

- Working across STPs/ICSs to develop proposals to transform outpatient services by introducing digitally-enabled operating models.

- Improve quality and productivity of services delivered in the community across physical and mental health by making mobile devices and digital services available to a significant proportion of staff
- Focus on concrete steps to improve the availability and deployment of clinical workforce to improve productivity
- Accelerate the pace of procurement savings by increasing standardisation and aggregation, making use of the NHS's collective purchasing powers
- Make best use of estate including improvements to energy efficiency, clinical space utilisation and modern operating models for community services
- Improving corporate services including commissioners and providers working together to simplify the contracting processes and reducing the costs of transactional services

Mental Health Investment

For 2019/20 the Mental Health Investment Standard (MHIS) requires CCG investment to result in an increase in spend by at least their overall programme allocation growth plus an additional percentage increment to reflect the additional mental health funding included in CCG allocations. They will also need to increase the share of mental health expenditure that is spent with mental health providers. To ensure value for money contracts must include clear deliverables supported by realistic workforce planning.

Within each STP/ICS a nominated mental health provider will review each CCG's mental health investment plan to ensure it covers all of the priority areas for the programme and related workforce requirements. NHSE will look at mental health spend per head and as a percentage of CCG allocations as part of their assessment.

Spend on children and young people's mental health must also increase as a percentage of each CCG's overall mental health spend. Historical underspends against CYP allocations will need to be made good.

Specialised Services and other Direct Commissioning

Of particular note to our Trust is the focus on the following over the next two years:

- Providing high quality specialised mental health services that are integrated with local systems and are delivered as close to home as possible, driving further reductions in inappropriate out-of-area placements
- Reducing the number of people with learning disability and autism who are treated in inpatient settings and supporting local health systems to manage the learning disability and autism care of their whole population

Contracts

A draft standard NHS contract has recently been published for consultation with a final version due for publication in February.

The national deadline for contract signature is 21 March. If agreement cannot be agreed by this date there will be a nationally co-ordinated process for dispute resolution. Entry into such a process will be viewed as a failure of local system relationships and leadership.

CQUIN schemes are being reduced by half to 1.25% with the remaining 1.25% being included in tariff. How this works for trusts in block contract arrangements needs to be verified.

Operational Requirements

There are a number of operational requirements included in the guidance. This paper purely focuses on those relating to mental health, learning disability & autism and community health services.

Mental Health

Funding highlighted in the long term plan will begin to flow into CCG baselines from 2019/20 and this funding must deliver improved services as set out in the long term plan including community mental health teams for people with severe mental illness, enhanced crisis services for adults and for children and young people, and perinatal mental health services.

Working through ICSs commissioners and providers are expected to prioritise

- Mental health workforce expansion including training and retention schemes to meet existing demand and provide additional workforce to meet the five year forward view and long term plan
- Ensuring all providers submit comprehensive data to the mental health services dataset (MHDS)/Improving Access to Psychological Therapies (IAPT) dataset
- Ensuring a comprehensive understanding of data and information on local health inequalities and their impact on service and delivery
- Ensuring a clearly defined mental health digital strategy is in place and supported by a service transformation programme

Deliverables specified in the in relation to mental health in the guidance are:

- By March 2020 IAPT services should be providing timely access to treatment for at least 22% of those who could benefit (people with anxiety disorders and depression)
- At least 50% of people who complete IAPT treatment should recover
- At least two thirds of people with dementia, aged 65 and over, should receive a formal diagnosis
- At least 75% of people referred to the IAPT programme should begin treatment within six weeks of referral
- At least 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral
- At least 56% of people aged 14-65 experiencing their first episode of psychosis should start treatment within two weeks
- At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service, representing an additional 63,000 receiving treatment each year.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within one week of an urgent referral.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within four weeks of a routine referral.

- Continued reduction in out of area placements for acute mental health care for adults, in line with agreed trajectories.
- At least 60% people with a severe mental illness should receive a full annual physical health check.
- Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two thirds of the increase in access to be delivered through IAPT-Long Term Conditions services
- Nationally, 4,500 additional mental health therapists should be recruited and trained by 2020/21.

- The further deliverables for mental health outlined in the technical annex must also be delivered during 2019/20, most notably for: perinatal mental health; all age crisis and liaison services; 50% of early intervention in psychosis services graded at level 3; and reducing suicides

Learning Disability & Autism

Focus is very much on providing increasing treatment, care and support in the community as opposed to hospitals. Hospital stays should be as short as possible with improved quality of care and reduced use of restraint. Reducing inequalities through increased uptake of annual health checks and continued learning from mortality reviews are also highlighted within the ambition to transform care. National deliverables are identified as being:

- Reduction in reliance on inpatient care for people with a learning disability and/or autism (CCG funded) to 18.5 inpatients per million adult population by March 2020.
- Reduction in reliance on inpatient care for people with a learning disability and/or autism (NHS England funded) to 18.5 inpatients per million adult population by March 2020.
- At least 75% of people on the learning disability register should have had an annual health check.
- CCGs are a member of a Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility.
- There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.
- CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.
- An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.

Primary Care and Community Health Services

It is noted that investment in primary care and community health services will grow faster than CCGs' overall revenue growth. In recognition of this investment plans need to be established towards implementing the new service models as set out in the long term plan, including urgent response standards for urgent community support.

As part of a primary care strategy local workforce plans need to be generated which support the development of an expanded workforce and multi-disciplinary teams and sets out a strategy to recruit and retain staff within primary care and general practice. There also needs to be local investment in transformation with the local priorities identified for support.

Workforce

Provider workforce plans need to consider the significant workforce supply and retention challenges with plans updated to reflect latest projections of supply and retention. Specifically required in the plan are the steps to be taken to move towards a "bank first" temporary staffing model and identification of opportunities for improved productivity and workforce transformation through new roles and/or ways of working. Unnecessary agency staffing spend needs to be eliminated e.g. shifts procured at above agency price caps or off-framework unless there is an exceptional patient safety reason to do so. Clarity on steps being taken to reduce temporary staffing costs compared to 2018/19 need to be clear in the plan narrative.

Other key points to note are:

- Providers to ensure they have systems in place to offer full time employment to all student nurses trained locally, where they are suitably qualified and pass assessment centres
- Actions to improve retention of staff linked to the national retention programme need to be identified
- There needs to be a focus on health and wellbeing mechanisms to address bullying and harassment, consideration to diversity and risks associated with brexit

Workforce plans need to be detailed and well-modelled and align with finance and activity plans.

Data and Technology

There is a separate section on digital technology in the long term plan and there are a couple of points highlighted in the planning guidance for the Trust Board to be aware of. In particular the expansion of the Global Digital Exemplar and Local Health & Care Record Exemplar programmes will be expanded to include more organisations and localities. In 2019 core standards across interoperability, cyber security, design, commercial etc. will be mandated.

ICSs, trusts and commissioners are all asked to support an increase in uptake of the NHS app

National Timetable

The timetable for completion of the plan and various milestone has now been finalised with the key dates shown below. timetable has been developed and shared with trusts. The key dates and milestones are as follows:

Milestone	**Date**
NHS long term plan	7 January
19/20 deliverables, indicative CCG allocations, trust financial regime and control totals and associated guidance	Early January
19/20 CQUIN guidance published	January
19/20 initial plan submission – activity*	14 January
19/20 national tariff section 118 consultation	17 January

Milestone	Date
STP/ICS net neutral control total changes agreed by regional teams	1 February
Draft 19/20 organisation operational plans	12 February
Aggregate 19/20 system plans and ICS led contract/plan alignment submission	19 February
Final publication of standard contract	22 February
Local decision whether to enter mediation and communication to NHSE/I and boards/governing bodies	1 March
2019/20 ICS led contract/plan alignment submission	5 March
2019/20 national tariff published	11 March
Deadline for contract signature	21 March
Parties entering arbitration to present themselves to the Chief Executives of NHS Improvement and England	22-29 March
ICS net neutral control total changes agreed by regional teams	By 25 March
Local Board approval of 19/20 budgets	29 March
Arbitration panel and/or hearing (written findings within two working days)	2-19 April
Final 19/20 organisational plan submission	4 April
Aggregate system plan submission, system operating plan overview and ICS led contract/plan alignment	11 April
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 30 April
Capital funding announcements	Spending review 2019
System 5 year plan submission	Autumn 2019

*Acute trusts only

Local Board Requirements and Governance

In terms of the key areas of focus for the Trust Board there are some pressing requirements. The most notable is approval of the draft plan by February 12th. The draft plan submission due by this date will include:

- Financial templates
- Workforce templates
- Triangulation return – finance, activity and workforce with accompanying commentary if not clearly aligned
- Plan narrative (maximum of 20 pages)
- Assurance statements

It should be noted that the format and section length for the plan narrative is fairly prescriptive. The Trust will need to follow this format and ensure it includes the relative points required.

Within the draft submission the Trust has to be clear if it is accepting the financial control total or not. A separate paper is provided on the control total and progress the Trust has made in developing a financial plan in the private session of the Board. In order to ensure

sufficient time for Board engagement and input to the plan as well as providing management with sufficient time to develop as comprehensive and robust plan as possible the following process will be used:

- Initial draft to be provided at the January Trust Board. This may not be fully complete
- Following further work and Board comment an updated version to be circulated to Board members by February 4th
- Final draft to be circulated to Board members by February 8th
- Board members to be invited to a meeting/call to approve the final submission on February 11th.

Following submission of the draft plan any feedback and updates will be factored in to the final plan submission which will be an agenda item at the March Board meeting.

Longer Term Deliverables

An appendix stating longer term deliverable is included in the planning guidance. Key points are included as an appendix to this paper

Conclusion and Recommendations

This report provides the headlines from the 2019/20 operating plan guidance. There are clear requirements in terms of what needs to be submitted and by when. In addition the role of ICSs, the financial settlement and operational requirements are articulated in the guidance. These all need to be included in our plan submission with the initial plan due for submission by February 12th. The development of the operating plan needs to be considered along with system-wide plans and the NHS long term plan. A process has been identified to ensure Trust Board members are fully engaged and can input to the plan along with ensuring they are in a position to approve the final plan and determine whether the Trust can accept its financial control total or not. An initial draft of the plan and status update is included in the Board papers for the private meeting of the Trust Board.

In addition to the formal requirements of the plan the Trust Board needs to consider the impact of what is included in the guidance and how it best can meet the requirements identified. In particular this relates to the additional operational requirements highlighted the achievability of the financial plan to meet the financial control total. The plan needs to be developed consistently with commissioner and system-wide plans as well as being aligned to the direction identified in the long term plan.

It is recommended that Trust Board members review and comment on this paper recognising the requirements and guidance associated the annual operating plan development and submission.

It is recommended that Trust Board members consider the governance and approval arrangements outlined and confirm agreement to them or advise of any required changes

Appendix 1 – Longer Term Deliverables

Health Inequalities

- All health systems will be expected to set out during 2019 how they will specifically reduce health inequalities by 2023/24 and 2028/29, including clearly setting out how those CCGs benefiting from the health inequalities adjustment are targeting that funding to improve the equity of access and outcomes

Mental Health

- By 2020/21 the NHS will ensure that at least 280,000 people living with severe mental health problems have their physical health needs met
- Continue to deliver enhanced access to mental health services for children and young people
- Begin roll out of mental health support teams working in schools and colleges in trailblazer areas to cover one fifth to a quarter of the country by the end of 2023
- Continue to expand access to IAPT services for adults and older adults with common mental health problems, with a focus on those with long term conditions
- Continue to progress delivery of standards for early intervention in psychosis, IAPT and services for young people with eating disorders by 2021
- Delivering against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21

Learning Disability and Autism

- Expand the STOMP-STAMP programme to stop the overmedication of people with a learning disability, autism or both by 2023/24
- Continue to reduce the number of people with a learning disability or both in inpatient care

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 10.2

Title:	**Review of the Trust Constitution and Scheme of Delegation**
Paper prepared by:	Director of Finance & Resources Company Secretary
Purpose:	To support the proposal that the next review of the Trust's Constitution takes place at the end of Quarter 2 2019/20.
Mission/values:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Any background papers/ previously considered by:	The current version of the Constitution was approved by Trust Board in January 2017 and Members' Council in February 2017 following review by a subgroup of the Members' Council, the Executive Management Team and the Audit Committee. A further review of the Scheme of Delegation took place which was approved by the Trust Board and Members' Council in August 2017.
Executive summary:	**Background** The Trust is required to have a Constitution in place that sets out how it is accountable to local people, who can become a member and what this means, the role of the Members' Council, how Trust Board and the Members' Council are structured and how Trust Board works with the Members' Council. It also contains a set of model rules that provide the basis for elections to the Members' Council. The Scheme of Delegation forms an appendix to the Constitution and describes the powers that are reserved to the Trust Board (generally those matters for which the Trust is accountable to the Secretary of State or to NHS Improvement) and any delegation of these functions to committees, directors or other officers of the Trust. The Trust's Constitution is based on Monitor's (now NHS Improvement) Model Core Constitution (2014) and takes into account Monitor's Code of Governance for NHS Foundation Trusts (2014). Since the last update to the Trust's Constitution the new UK Corporate Governance Code (2019) has come into effect and guidance is awaited from NHS Improvement on when they plan to review their documents in line with this update. Integrated Care Systems (ICS) are being formed and the NHS Long Term Plan has also been published which may impact the Trust's Scheme of Delegation. Historically the Trust has reviewed its Constitution every two years. The current version was approved by Trust Board in January 2017 and

	Members' Council in February 2017 and therefore is now due for review. It is recommended that the review takes place at the end of quarter 2 2019/20 to take into account any changes required as a result of national guidance. **Risk appetite** The delivery of the Trust's Constitution supports the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to SUPPORT the proposal to review the Constitution (including the Standing Orders) and Scheme of Delegation at the end of quarter 2 2018/19.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019
Agenda item 10.3

Title:	**Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)**
Paper prepared by:	Director of Finance & Resources
Purpose:	To enable Trust Board to approve the Policy on Policies, a core policy for the Trust and reserved for Trust Board consideration and approval.
Mission/values:	Policies and procedures covering core Trust systems and processes are a key part of the Trust's governance arrangements, supporting the Trust to achieve its mission and adhere to its values.
Any background papers/ previously considered by:	The policy was approved by Trust Board in July 2011, October 2012 (as part of the changes recommended to achieve NHS LARMS level I), July 2014 and January 2017. Clinical leads, Human Resources and the Trade Union were consulted in the development of the policy. The revised policy has been reviewed and supported by the Executive Management Team for approval by Trust Board.
Executive summary:	**Background** The purpose of the Policy on Policies is: ➢ to describe the approach to development and approval of policies and procedural documents; ➢ to provide a standard template for policy documents; ➢ to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure; ➢ to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance; ➢ to describe the process for version control to ensure people have access and are operating to the most current version; and ➢ to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements. The current policy has been reviewed to ensure it remains fit for purpose, with minor amendments made to job titles and the addition of the policy template. Clinical leads have requested a further review to be conducted by clinical and operational staff following this update. Therefore EMT have recommended that the next date for review January 2020, with the aim to complete earlier.

	Risk Appetite The Policy on Policies supports the Trust in its endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the update to the policy.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)
Document type:	Policy
What does this policy replace?	Update of previous policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	Version 10 January 2019
Next review:	January 2020
Approved by:	Executive Management Team 10 January 2018 prior to Trust Board 29 January 2019
Developed by:	Director of Finance & Resources Company Secretary
Director leads:	Director of Finance & Resources
Contact for advice:	Company Secretary Corporate Governance Manager

Policy for the development, approval and dissemination of policy and procedural documents

1. Introduction

Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust.

A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies and procedures in use are current and reflect an organisational approach.

2. Purpose

The purpose of this document is:

- to describe the approach to development and approval of policies and procedural documents.
- to provide a standard format and content for policy and procedure documents.
- to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure.
- to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance.
- to describe the process for version control to ensure people have access to – and are operating to – the most current version.
- to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.

3. Definitions

3.1 A **POLICY** is a high level statement. Each policy should specify its purpose and may also include a procedure setting out how the policy will be achieved. A policy enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.

3.2 A **PROCEDURE** is often incorporated into a policy or can be a 'standalone' document. Procedures are the practical way in which a policy is translated into action. They explicitly outline how to accomplish a task or activity, giving detailed instructions. A procedure often allocates specific roles that specific individual must undertake.

4. Duties

It is the policy of the Trust that all policy documents and procedure documents will:

- have an identified Director lead;
- have a designated contact for advice; and
- identify who is responsible for taking what action.

The following duties apply to this policy.

4.1 Trust Board

Trust Board is responsible for approving the policy for the approval, dissemination and implementation of policies and procedures as outlined in this document.

Policies that require Trust Board approval are outlined in the Scheme of Delegation. These include policies which are likely to be of major strategic or political significance, such as those relating to the appointment, remuneration and dismissal of staff, policies relating to the management of financial or clinical risk and policies for management of complaints and claims. Approval may also be delegated by the Trust Board for approval by a committee through their Terms of Reference and the Scheme of Delegation.

4.2 Executive Management Team (EMT)

The Executive Management Team (EMT) will approve all other policies (however, see 4.3 below). The EMT will be responsible for ensuring the policy document has been developed according to this policy.

4.3 Directors

Each policy will have an appointed lead Director. The lead Director lead is responsible for the development of new policies and timely review of policies in accordance with this policy.

The lead Director will be responsible for engaging relevant stakeholders in the development of the policy and ensuring appropriate arrangements are in place for managing any resource implications, including dissemination and training and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation.

It is the responsibility of the lead Director for a policy to ensure that the document is appropriately consulted on during the development process by key stakeholders (see section 6.2) and to agree the most appropriate way to undertake such consultation.

Multi agency policies will have a lead Director who will be responsible for ensuring the policy has gone through the necessary approval process.

In the case of policies relating to medicines management, with the exception of the overarching medicines management policy and the medicines code, approval is delegated to the Drugs and Therapeutics sub-committee of the Clinical Governance and Clinical Safety Committee and it is the responsibility of the lead Director to ensure that these policies adhere to this policy.

Other policies that are specific or relevant to local clinical arrangements can be approved locally by appropriate mechanisms within Business Delivery Units (BDUs); however, where there are implications across the Trust or a policy will have an impact on resources, staffing, Trust strategy, reputation, etc., approval remains reserved for the EMT. Directors should seek the advice of the Company Secretary or the Corporate Governance Manager if in doubt.

Procedures and guidance notes may be developed and issued by the lead Director using the principles included in this document. The lead Director is responsible for engaging relevant stakeholders in developing the procedure or guidance note, communicating the procedure and ensuring its implementation.

4.4 Director of Finance & Resources

The Director of Finance & Resources supported by the Company Secretary will, on behalf of Trust Board, ensure this Policy is implemented and that documents are controlled in accordance with non-clinical records management requirements.

4.5 Business Delivery Units (BDUs) and Trust Action Groups (TAGs)

Directors may engage BDUs (including the Operational Management Group (OMG)) and TAGs in developing and implementing policies or procedural documents. They have no authority to approve policies.

4.6 Specialist staff

Specialist staff have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures. Specialist staff include areas such as Safeguarding, Infection Prevention and Control, and Equality & Engagement Development Managers.

4.7 Service managers

Service managers have a role in developing and implementing policies and procedures but have no authority to approve policies or procedures.

4.8 Staff

All staff need to be aware of policies and how they impact on their practice. All new policies approved by Trust Board, its committees and / or EMT are communicated through the staff briefing and via the intranet. Staff have an individual responsibility to seek out this information.

4.9. Duties for this policy

The Trust Board is responsible for approving this policy.

The lead Director is the Director of Finance & Resources.

All staff who write policies need to be aware of this policy.

The Company Secretary, supported by the Corporate Governance Manager, is responsible for overseeing the administration of this policy. This includes ensuring policies for approval are included in the relevant Trust Board or EMT agenda in a timely way, maintaining a corporate record of all current and past policy and procedure documents, and notifying lead Directors when a policy or procedure is due for review.

5. Style and format

All policies and procedures should be written in a style that is clear, concise and unambiguous. Titles should be kept simple to assist easy identification of the document.

Policy and procedural documents should follow Trust Branding Guidance. The standard font is Arial 12 point. Uppercase and underlining should be avoided except in headings. Page numbers should be used.

A template showing the structure and sections to be included is provided in appendix A.

5.1 An explanation of any terms use in documents developed

Acronyms and technical language should be explained or a glossary included.

5. 2 Contents

A checklist is provided at Appendix C. This should be completed and submitted to the EMT, committee or Trust Board at the time of final approval.

6. Development process

6.1 Identification of need

The need for a new policy or procedure may be prompted by a change in national legislation, policy or guidance or it may be identified within the Trust either as a result of learning from experience, such as complaints or incidents, or as a result of a risk being identified by a specialist advisor or TAG. New policies may also be required as a result of the development of a new service or new way of working.

The first step should be to establish whether a new policy or procedure is required or whether the requirement can be met by amending an existing policy or procedure.

The aim should be to keep the number of policies to a minimum. The lead Director should be able to provide a clear justification for the development of any new policy.

This policy has been developed to minimise risks associated with policies and procedures being written without appropriate authority or consideration of the impact of the policy and to prevent inconsistent application of policies as a result of failure to effectively communicate or disseminate a policy or procedure. No other document already in existence in the Trust covers this subject.

6.2 Stakeholder involvement

Consultation with relevant stakeholders secures 'buy in' and provides an opportunity to identify and eliminate potential barriers to implementation.

The lead Director is responsible for ensuring relevant stakeholders have been consulted during the development of the policy. The following identifies some of the individuals or groups who might be consulted with. This is not an exhaustive list.

Stakeholder	Level of involvement
Executive Management Team (EMT)	Approval – (may also be involved at the outset in confirming the requirement for a new policy or agreeing the development process)
Directors	Initiation, lead, development, receipt, circulation
Business Delivery Units (BDUs) (including the Operational Management Group (OMG))	Development, consultation, dissemination, implementation, monitoring
Specialist advisors	Development (including EIA), consultation, dissemination, implementation
Service user and carers	Development, consultation
Professional groups and leaders	Development, consultation, dissemination, implementation
Trust Action Groups (TAGs)	Development, consultation, dissemination, implementation
Staff side	Development, consultation, dissemination
Trust learning networks	Consultation
Local Authorities	Development, consultation
Police	Development, consultation
Other NHS Trusts	Development, consultation
University	Consultation

For this document, the clinical leads, Human Resources, staff side, and the EMT were consulted. The Trust Board agreed when developing the Scheme of Delegation that responsibility for determining policy approval arrangements should be a decision reserved to the Trust Board.

6.3 Equality Impact Assessment

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer.

All new policies and procedures should be subject to an Equality Impact Assessment (EIA). For revised policies an update of the EIA needs to be undertaken. A tool to support this process is included at appendix B to this document.

As part of stakeholder involvement, Equality & Engagement Development Managers should be involved in the development or review of a policy to ensure all equality and diversity requirements are included in the policy as well as in the EIA. If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

7. Approval and ratification process

Procedures and guidance notes may be approved and issued directly by the lead Director.

Policies for approval that have not been identified as requiring Trust Board approval should be submitted by the lead Director to the EMT. The checklist at appendix C should be completed by the lead Director.

Policies where authority to approve is reserved to the Trust Board should be submitted to the Trust Board by the lead Director after they have been discussed by the EMT.

Policies for approval should be submitted to EMT with a completed proforma (appendix B) and will be subject to peer review by another Director.

8. Process for review

At the time of approval, all policies should have a clearly defined review date. This may be brought forward if earlier review is required, for example because of an identified risk or change in national policy.

The Corporate Governance Manager will notify the lead Director three months before the policy is due for review.

The lead Director will check the policy. If no amendment is required, this should be reported to the EMT or Trust Board for ratification by the review date and the policy will be reissued.

If the policy requires minor amendments, the revised policy should be presented to the EMT or Trust Board.

If significant amendment is required, the process described in section 5 should be followed.

An EIA must be completed for all policies that have not previously been subject to EIA. For revised policies an update of the EIA needs to be undertaken.

It should be noted that, for services that came to the Trust as part of transformation, there may be a number of policies that, over time, will need to be aligned. Existing policies will continue to be followed until this work takes place. Each appointed lead Director for a policy will need to ensure that reviews include all existing policies that have been produced by previous organisations and that new / updated polices are clear which policies they replace.

9. References

Documents referred to in the development of the policy and documents that should be read in conjunction with the policy should be listed.

10. Version control

All policies and procedures must have the version number, date of issue and the review date clearly marked on the front cover and as a footnote.

Draft policies should be marked v1 draft, v2 draft etc during the consultation phase. Once approved the document becomes Version 1. Each time the policy or procedure is updated the version number must be changed.

The introduction to the Policy should make it clear whether a document replaces or supersedes a previous document, including the title(s) of any superseded or replaced documents.

11. Dissemination

Once approved, the Corporate Governance Manager will be responsible for ensuring the updated version is added to the Document Store on the intranet and is included in The Headlines weekly communication to staff.

The Corporate Governance Manager is responsible for ensuring the document being replaced is removed from the Document Store and that an electronic copy, clearly marked with version details, is retained as a corporate record.

Directors are responsible for ensuring that staff within their area of responsibility are aware of new or amended policies and procedures related to their work.

If local teams download and keep a paper version of procedural documents, the responsible manager must identify someone within the team who is responsible for updating the paper version when a policy change is communicated via the staff brief.

12. Implementation

All policies and procedures must identify the arrangements for implementation, including:

- Any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training.
- Any resource requirements, including staff, and how these will be met.
- Support available to assist implementation.
- Arrangements for ensuring the policy or procedure is being followed.
- Monitoring and audit arrangements.

13. Document control and archiving

13.1 Current policies and procedures

Current policies and procedures will be available on the intranet in read only format.

13.2 Historic policies and procedures

A central electronic read only version will be kept in a designated shared folder to which all staff can request access.

Documents will be retained in accordance with requirements for retention of non-clinical records.

14. Monitoring compliance with the policy

All policies and procedure must identify the arrangements that are in place for ensuring and monitoring compliance. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission (CQC) standards, NHS Resolution frameworks and Monitor (or successor organisation) compliance.

Methods may include:

- Monitoring and analysis of incidents, performance reports and training records.
- Audit.
- Checklists.
- Monitoring of delivery of actions plans through TAGS or BDUs.

The document should identify the methods that will be used to ensure timely and efficient implementation.

For this policy implementation:

- is the responsibility of the lead Director for individual policies to ensure that this policy is followed in the development and presentation of individual policies
- is monitored through presentation to EMT and / or Trust Board, evidenced by the minutes of meetings where policies are approved, or the appropriate ratifying body, again evidenced by the minutes of meetings where policies are approved
- is monitored by the ratifying body through the policies checklist
- is assured through occasional audit by the Trust's internal auditors.

15. Associated documents and supporting references

This document has been developed in line with guidance issued by the NHS Resolution and with reference to model documents used in other trusts. It should be read in conjunction with

- the Trust Branding Policy
- the Records Management Strategy, Non-Clinical Records Management Policy and non-clinical records retention and disposal schedule.

Appendix A

Style and format template for policies and procedural documents (Policy Template)

Document name:	Name of the policy
Document type:	Policy
What does this policy replace?	New policy / Updated version
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	Version No. Month Year
Next review:	Month Year
Approved by:	Executive Management Team
Developed by:	Job title
Director leads:	Job title
Contact for advice:	Job title

Contents

1. Introduction

This section should include a brief explanation of the reason for the policy.

2. Purpose and scope of the policy

This section should include why the policy needed, the rationale for development, what will it cover and an outline of the objectives and intended outcomes.

3. Definitions

This section should include a list and/or description of the meaning of terms used in the context of the policy or procedure.

4. Duties

This section should include the following:

- who is responsible for developing and implementing the policy
- who in the organisation is required to do what
- who is responsible for communicating the policy
- who is responsible for consultation with stakeholders
- who is responsible for approving the policy/procedure

5. Principles

This section should include the fundamental action points of the policy or procedure to be adopted.

6. Equality Impact Assessment

New or updated Equality Impact Assessment to be completed (Appendix A).

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer. All new policies and procedures should be subject to an Equality Impact Assessment (EIA). For revised policies an update of the EIA needs to be undertaken.

If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

7. Dissemination and implementation arrangements (including training)

This section should describe the methods that will be used to ensure timely and efficient dissemination and implementation arrangements including training. This should include:

- any training requirements, including which staff groups this affects and the arrangements and timescale for delivering training;
- any resource requirements, including staff, and how these will be met; and
- support available to assist implementation;

Directors are responsible for ensuring that staff within their area of responsibility are aware of new or amended policies and procedures related to their work and the change is communicated in The Headlines. If local teams download and keep a paper version of documents, the responsible manager must identify someone within the team who is responsible for updating the paper version.

8. Process for monitoring compliance and effectiveness

This section should identify the arrangements for compliance and effectiveness, responsibility for conducting any audit, review or monitoring, the methodology to be used for audit, review or monitoring, its frequency, the process for reviewing the results and monitoring of key performance indicators. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission (CQC) standards, and Monitor/NHS Improvement compliance. Methods may include:

- monitoring and analysis of incidents, performance reports and training records;
- audit by the Trust's internal auditors;
- checklists; and
- monitoring of delivery of actions plans through TAGs or BDUs.

9. Review and revision arrangements (including archiving)

This section should identify the arrangements for the review and revision of the policy. If an update to a policy has taken place it should describe the process undertaken.

10. References

This section should list any other documents referenced within the policy.

11. Associated documents

This section should list any other documents to be read in association with the policy. This could include other policies, procedures and guidance documents.

12. Appendices

As a minimum all policies should include completed versions of the following:

- Equality Impact Assessment (see appendix A);
- Checklist for the Review and Approval of Procedural Document (see appendix B);
- Version control sheet (see appendix C).

Template for Appendix A - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment:

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	Name of the document that you are Equality Impact Assessing		
2	Describe the overall aim of your document and context? Who will benefit from this policy/procedure/strategy?		
3	Who is the overall lead for this assessment?		
4	Who else was involved in conducting this assessment?		
5	Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy? What did you find out and how have you used this information?		
6	What equality data have you used to inform this equality impact assessment?		
7	What does this data say?		
8	Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:	Yes/No	Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.
8.1	Race		
8.2	Disability		
8.3	Gender		

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.4	**Age**		
8.5	**Sexual orientation**		
8.6	**Religion or belief**		
8.7	**Transgender**		
8.8	**Maternity & Pregnancy**		
8.9	**Marriage & Civil partnerships**		
8.10	**Carers*Our Trust requirement***		
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		
9c	**Promotes good relations between different equality groups;**		
9d	**Public Sector Equality Duty – "Due Regard"**		
10	**Have you developed an Action Plan arising from this assessment?**		
11	**Assessment/Action Plan approved by**		**Signed:** **Date:** **Title:**
12	***Once approved, you must forward a copy of this Assessment/Action Plan to Equality & Engagement Development Managers - Aboo Bhana (Aboobaker.Bhana@swyt.nhs.uk) and Zahida Mallard (Zahida.Mallard@swyt.nhs.uk)***		

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	Please note that the EIA is a public document and will be published on the web. **Failing to complete an EIA could expose the Trust to future legal challenge.**	

If you have identified a potential discriminatory impact of this policy, please refer it to the Equality & Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Equality & Engagement Development Managers.

Template for Appendix - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
	Is it clear in the introduction whether this document replaces or supersedes a previous document?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are people involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are supporting documents referenced?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint Human Resources/staff side committee (or equivalent)		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?		
	Is there a plan to review or audit compliance with the document?		
10.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so is it acceptable?		
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?		

Template for Appendix - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes

Appendix B

South West Yorkshire Partnership NHS Foundation Trust

PROFORMA FOR APPROVAL OF POLICIES BY THE EXECUTIVE MANAGEMENT TEAM (EMT)

The following should be completed to support submission of policies for approval to EMT.

Policy name	
EMT date	
Purpose of the policy	
What has changed and why?	
What policy(ies) does it replace or update, if any?	
Confirm that the policy has been developed / updated in accordance with the 'Policy for the development, approval and dissemination of policy and procedural documents' (Policy on Policies). Refer to the intranet page: http://nww.swyt.nhs.uk/Pages/Policies-and-procedures.aspx	e.g. correct Trust logo, font is Arial 12pt, stakeholder consultation completed (see below), EIA completed / updated (see below), checklist for the review and approval of procedural document completed, version control appendix updated
Provide evidence of consultation with appropriate stakeholders (who, how and when). For clinical policies this must include the Clinical Policies and Procedures Group.	
Provide the date that the Equality Impact Assessment (EIA) was completed / updated in consultation with an Equality & Engagement Manager. Refer to the intranet page: http://nww.swyt.nhs.uk/equality-impact-assessments/Pages/default.aspx	
Identify any risks	

Are there any implications for: • **Finance** • **Governance** • **Training** • **Other**	

Appendix C - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment: 2 January 2019

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Policy for the development, approval and dissemination of policy and procedural documents
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		The overall aim of the policy is to describe the Trust's approach to the development and approval of policies and procedural documents. All staff
3	**Who is the overall lead for this assessment?**		Director of Finance & Resources
4	**Who else was involved in conducting this assessment?**		Company Secretary Corporate Governance Manager
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		Clinical Leads, Human Resources, Trade Union, and the Executive Management Team were consulted on the ~~d~~evelopment of the policy. N/A
6	**What equality data have you used to inform this equality impact assessment?**		This policy impacts on everyone therefore no equality data required.
7	**What does this data say?**		N/A
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**Yes/No**	**Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.**
8.1	**Race**	No	N/A
8.2	**Disability**	No	N/A
8.3	**Gender**	No	N/A
8.4	**Age**	No	N/A

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.5	**Sexual orientation**	No	N/A
8.6	**Religion or belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		This policy aims to standardise the approach to policy development, approval and dissemination and requires adoption of the Equality Impact Assessment throughout the organisation.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		As above.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		As above.
9c	**Promotes good relations between different equality groups;**		As above.
9d	**Public Sector Equality Duty – "Due Regard"**		As above.
10	**Have you developed an Action Plan arising from this assessment?**		N/A
11	**Assessment/Action Plan approved by**		**Signed:** Mark Brooks **Date:** ~~2 January 2019~~ **Title:** Director of Finance & Resources
12	***Once approved, you must forward a copy of this Assessment/Action Plan to Equality & Engagement Development Managers - Aboo Bhana (Aboobaker.Bhana@swyt.nhs.uk) and Zahida Mallard (Zahida.Mallard@swyt.nhs.uk)*** **Please note that the EIA is a public**		

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	document and will be published on the web. **Failing to complete an EIA could expose the Trust to future legal challenge.**	

If you have identified a potential discriminatory impact of this policy, please refer it to the Equality & Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Equality & Engagement Development Managers.

Appendix D - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent)	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix E - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	June 2008	Director of Corporate Development	Final	Final version approved by Trust Board
2	March 2009	Director of Corporate Development		Changes made to ensure clarity on superseded or replaced documents and to reflect change in guidance for 2009/10
3	March 2010	Integrated Governance Manager	Final draft	Changes made following review and subsequent recommendations made during NHS LARMS review
4	Decemb er 2010	Integrated Governance Manager	Final	Inclusion of Equality Impact Assessment
5	July 2011	Integrated Governance Manager	Final	Changes made to accommodate comments made during NHS LARMS review and transfer of services from NHS Barnsley
6	October 2012	Integrated Governance Manager	Final draft	Changes made to meet requirements of NHS LARMS
7	October 2013	Integrated Governance Manager	Final	Revised equality impact assessment added (approved by lead Director 3 October 2013)
8	July 2014	Integrated Governance Manager	Final	Review by Lead Director; agreed no changes required. Approval of review date extension for further two years
9	January 2017	Integrated Governance Manager	Final	Reviewed with minor amendments and approved by Trust Board.
10	January 2019	Company Secretary Corporate Governance manager	Draft	Reviewed with minor amendments for approval by EMT and Trust Board.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019

Agenda item 11 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	Next meeting scheduled for 5 February 2019
Member	Chief Executive / Director of Strategy
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	Next meeting scheduled for 21 February 2019
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=25857

Kirklees Health and Wellbeing Board

Date	Next meeting scheduled for 31 January 2019
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159

Wakefield Health and Wellbeing Board

Date	17 January 2019
Member	Chief Executive / Director of Provider Development
Items discussed	➢ West Yorkshire & Harrogate Health and Care Partnership Update ➢ Health and Care Planning ➢ Long Term Plan ➢ Healthy Hearts ➢ Public Health Annual Report ➢ Cancer ➢ Children and Young People Update - Commissioners Report ➢ Annual Report of the Wakefield and District Safeguarding Adults ➢ MYHT CQC Inspection

Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	To be confirmed (last update from meeting 19 October 2018)
Member	Chief Executive
Items discussed	➢ To be confirmed
Minutes	Approved Minutes of previous meetings are available at: http://www.healthandcaretogethersyb.co.uk/index.php/about-us/how-were-run/minutes-and-meetings

West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group

Date	21 January 2019
Member	Chief Executive
Items discussed	➢ Programme updates ➢ Review of System Performance and Delivery ➢ Wider system risks and issues
Further information:	Further information about the work of the System Oversight and Assurance Group is available at: https://www.wyhpartnership.co.uk/blog

West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive

Date	To be confirmed (last update from meeting 4 December 2018)
Member	Chief Executive
Items discussed	➢ To be confirmed.
Further information:	Further information about the work of the System Leadership Executive is available at: https://www.wyhpartnership.co.uk/blog

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 29 January 2019

Agenda item 12 – Assurance from Trust Board Committees

Audit Committee

Date	8 January 2019
Presented by	Laurence Campbell, Non-Executive Director
Key items to raise at Trust Board	➢ Data breaches - The Committee asked management for a deep dive on Information Governance (IG) breaches and to look at new ways to improve our performance in avoiding the often serious consequences of these breaches; ➢ Cyber risk - review of cyber risks and mitigations in the light of the matters raised in the Board training session of 8 January 2019; ➢ Triangulation report - There were three areas in the Integrated Performance Report (IPR) and not the organisational level risk register for consideration by the Executive Management Team (EMT); ➢ Committee annual self-assessment - two new questions added for the Audit Committee's self-assessment focusing on effective coverage of Terms of Reference and the effectiveness of division of duties between committees; ➢ Clinical risk - possible quality risk in relation to Community Service staffing levels; ➢ Complaints Internal Audit (Limited Assurance) - Issues around Datix fit-for-purpose question, key performance indication (KPI) coverage and possible solutions at other Trusts; ➢ Clinical records system (SystmOne) - Internal Audit phase 2 report required before go-live.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 16 October 2018 (attached)

Workforce & Remuneration Committee

Date	18 December 2018
Presented by	Rachel Court, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Ratification of Clinical Excellence Awards.
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meetings held on 23 October 2018 and 18 December will be approved at the next meeting on 12 February 2019.

West Yorkshire Mental Health Services Collaborative Committees in Common

Date	To be confirmed (meeting scheduled for 8 January 2019 cancelled)
Presented by	Angela Monaghan, Chair (member of the Committee)
Key items to raise at Trust Board	➢ To be confirmed.
Approved Minutes of previous meeting/s for receiving	➢ To be confirmed.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Audit Committee held on 16 October 2018

Present:	Laurence Campbell	Non-Executive Director (Chair of the Committee)
	Rachel Court	Non-Executive Director
	Sam Young	Non-Executive Director
Apologies:	Members	
	Erfana Mahmood	Non-Executive Director
	Other	
	Tony Cooper	Head of Procurement
	Emma Jones	Company Secretary
	Olivia Townend	Assistant Anti-Crime Manager, Audit Yorkshire
In attendance:	Rob Adamson	Deputy Director of Finance
	Mark Brooks	Director of Finance (lead Director)
	Leanne Hawkes	Deputy Director, 360 Assurance
	Paul Hewitson	Director, Deloitte
	Steve Moss	Head of Anti-Crime Services, Audit Yorkshire
	Jane Wilson	PA to the Director of Finance (author)
	Salma Yasmeen	Director of Strategy [items 8 & 15]

AC/18/80 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Laurence welcomed everyone to the meeting, in particular, Sam Young (SY), attending her first meeting as newly appointment Non Executive Director.
The apologies, as above, were noted.

AC/18/81 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/18/82 Minutes from the meeting held on 22 May & 10 July 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meetings held on 22 May & 10 July 2018 as a true and accurate record with the amendment of a typographical error in the 22 May minutes.

AC/18/83 Matters arising from the meeting held on 10 July 2018 (agenda item 4)

AC/18/56a Action log (agenda item 4.1)
The action log was noted. The following actions were discussed:

AC/18/65 Cyber security update
LC asked for an amendment of a typographical error in this action point. Change “discovered” to “discussed”.

AC/18/69 Delivering service change

LC raised the question of whether this should be a standing item on the agenda. MB commented that he recalled at the previous meeting it was agreed there needed to be further programme completions including post implementation reviews to have a more meaningful update and suggested this be added to the work programme. MB suggested this be brought back to the April meeting, at which point sufficient data would be available.

ACTION: Salma Yasmeen

AC/18/08 Annual review of Treasury Management strategy and policy

This item is now completed.

AC/18/84 Consideration of items from the organisational risk register relevant to the remit of the Audit Committee (agenda item 5)

MB reported that the paper included risks from the Organisational/Corporate Risk Register (ORR) that had been allocated to the Audit Committee, with a summary on any changes since the Audit Committee meeting on 10 July 2018. All risks from the trust-wide ORR graded 15 and above were reported to the Trust Board on 31 July 2018. There were two 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. In relation to risk 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). LC suggested the scoring be reviewed. Rachel Court (RC) raised the question of whether this risk would be better aligned with the Workforce & Remuneration Committee (WRC).

MB explained that the risk register has been reviewed comprehensively at EMT and a number of additional risks have been considered. These include the admission of children and young people to adult wards and the impact of a no-deal Brexit. The former would sit within the remit of the Clinical Governance and Clinical Safety Committee with the latter likely to be aligned to the Audit Committee.

An updated version of the full risk register report will be presented at the next Trust Board on 30 October 2018.

- SY questioned whether risk 1212 identified above was a tender risk or staff morale risk. MB explained it was initially a risk identified as a result of continued individual service tendering in Barnsley and the impact that was having on staff morale. There are other examples of tender activity taking place and he noted that the bids and tenders report being taken to the October Trust Board consists of approximately 60 pages.

- It was noted that the risk relating to SystemOne implementation has moved to amber. It was also noted that the date quoted should be July and not April.

- Risk on cyber security

  SY raised a question relating to the risk appetite associated with cyber-crime and whether it is possible to achieve that score based on the current actions identified. MB explained that he felt the consequence of a breach in cyber security certainly had the potential to be catastrophic and given recent history and the sophistication of cyber criminals the likelihood is possible. He emphasised a number of positive controls and assurances the Trust has in place, but acknowledged the scoring sits outside the Trust's stated risk appetite. He suggested this needs to be a Board discussion as it is not the only risk where the target score is not necessarily achievable in the short term. LC agreed with this and stated this is an ongoing conversation in relation to risk management.

MB suggested to committee members it would be useful if they could consider if they felt any risks or issues are missing from the corporate risk register. RC stated there is a lot of discussion regarding inconsistency in commissioning and therefore services provided in different places. MB noted this was captured on the Board Assurance Framework. RC noted she felt more assured regarding the risk register process given the comments and potential additional risks identified in the cover sheet.

ACTION: Mark Brooks/Emma Jones

It was RESOLVED to NOTE the current Trust-wide Corporate/Organisational level risks relevant to this Committee.

AC/18/85 Triangulation of risk, performance and governance (agenda item 6)

The report covering the triangulation of risk, performance and governance was recognised as being helpful and serving its purpose. LC commented he felt there could be more narrative in respect of the triangulation with the Board Assurance Framework (BAF). Emma Jones (EJ) to reference in documentation. LC also stated he felt this was a very useful report.

ACTION: Emma Jones

It was RESOLVED to RECEIVE the report as part of the evidence of assurance on the operation of risk processes within the Trust.

AC/18/86 Committee meeting dates for 2019 (agenda item 7)

The meeting dates for the following year were discussed and agreed. MB to check quoracy of the January meeting as RC is unable to attend.

ACTION: Mark Brooks

It was RESOLVED to APPROVE the meeting dates for 2019.

AC/18/87 Approval of Charitable Funds annual reports and accounts (agenda item 8)

Salma Yasmeen (SY) confirmed the Charity has had a significant year, with the launch of the new brand EyUp! and the appointment of the part-time fundraiser. SY stated that 142 projects had been supported by both the main charity and the linked charities, and confirmed examples of these were detailed within the report. SY stated the committee had been working on a detailed business plan and cashflow for the charity to ensure sustainability in the future. LC stated that the report was more eye-catching and looked very different from previous years. Paul Hewitson (PH) Deloittes independently examined the report and confirmed he had no issues to report.

It was RESOLVED to APPROVE the annual report and accounts for 2017/18 subject to minor amendments being made.

ACTION: Rob Adamson

AC/18/88 Reference costs (agenda item 9)

RA confirmed the reference costs submission had taken place. The most likely date for receiving our results is mid-November. It was agreed a formal report would be brought back to the Audit Committee in January 2019.

ACTION: Rob Adamson

It was RESOLVED to NOTE the update.

AC/18/89 GDPR update (agenda item 10)

MB presented the General Data Protection Regulations (GDPR) update and stated the Trust is working well towards achieving full compliance by 31 October 2018.
One issue relates to legacy systems which do not automatically delete personal details when the time limit has elapsed. Mitigations are in place and there are plans to address in future.
MB also noted that as yet there is no national guidance on pseudonmysation. The Trust will act on any guidance when received and in the meantime will follow existing pseudonymisation rules and guidance. MB highlighted that information asset owners are in place for all information assets and there is reasonable assurance in place that GDPR is being complied with.
LC asked if the change in deadlines for subject access requests can be met. MB stated that a re-structure of staff with a central approach being taken which is expected to enable us to meet the SAR requirements, depending on the volume.

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.

AC/18/90 Accounting standards (agenda item 11)

RA presented an update on the changes in accounting standards which the Trust are required to implement during the current financial year (2018/19). RA confirmed the updated Trust accounting policy wording would be included in the full review to be undertaken at the January 2019 committee.

The change being brought before the committee related to the calculation of bad debt provisions following a review of IFRS 9 – financial instruments. PH was asked for his views and commended the Trust on being the first he has seen to recognise this change, which is not hugely significant. The financial impact is likely to be to reduce the bad debt provision from the current £120k to £70k. LC asked if ex staff debts continue to be the main issue in terms of write off. RA confirmed this is the case.

It was RESOLVED to NOTE the update.

AC/18/91 Asset valuation (agenda item 12)

MB explained that the Trust has reviewed its asset valuation methodology based on the fact it has one of the highest deprecation charges compared to asset values in the north of England. A number of Trusts are looking at the indices used at the end of each year which are based on an actual indices at the time of valuation. This can result in significant year on year movements and a rolling average approach is being considered. MB explained that this has been discussed with PH and it is felt a rolling average approach would not meet the accounting standard. MB stated therefore that unless the Audit Committee wished to pursue this option other options for asset valuation are still being considered and assessed.

It was RESOLVED to NOTE progress with a rolling average indices approach to year-end asset valuations but to CONSIDER and REVIEW other approaches to the year-end valuation of property, plant and equipment.

AC/18/92 Quality Assessment referral tool (agenda item 13)

MB confirmed the Trust had completed a counter fraud self-assessment in April 2018 and reported The Trust had been selected at random for a quality assessment by Counter Fraud Authority (CFA).

With one exception the CFA agreed with the self-assessment the Trust submitted, but it was identified the previous counter fraud provider had not fully complied with the rules relating to documenting fraud investigations on the FIRST system. This resulted in the holding to account section being classified as red by the CFA. MB noted that the CFA were very clear the current counter fraud provider is known to comply with the use of FIRST so did not expect this to be an ongoing issue. MB explained that he has written to the relevant director at KPMG explaining the issue identified in the quality assessment and asked for her comments and observations. To date no response has been received.

ACTION: Mark Brooks

It was RESOLVED to NOTE and accept the results and associated actions from the quality assessment conducted by the Counter Fraud Authority.

AC/18/93 Procurement report (agenda item 14)

MB presented the procurement update. Seven major contracts were let with a value of £8.9m including the provision of medical locums. Four major contracts are currently in progress including the provision of taxi services and the provision of out of area beds. £28k CIP (Cost Improvement Plan) savings have been identified to date with a further £21k cost avoidance in savings. It was confirmed 52 Service Line Agreements (SLAs) have currently been signed, with 12 in negotiation, and 14 at the sign off stage.

MB reported that the procurement function had achieved procurement standards level 1 on Friday 12 October which was a very pleasing achievement.

It was RESOLVED to NOTE the update.

AC/18/94 SystmOne implementation risks and milestones (agenda item 15)

Salma Yasmeen presented the update and confirmed training has commenced and that data migration testing was going well. SY stated there were risks around the quality of data, and that the team were working with TPP who were being very responsive. In terms of risk (SY) confirmed these all still require attention and focus. A summary report went to EMT recently which brought the risk status to Amber. SY stated that a big issue had been the ability to retain staff. In part this was due to staff being offered permanent positions elsewhere, particularly in the city of Leeds. SY stated the Trust has recruited someone from Bradford District Care Trust who played a role in their recent go live.

The major issue to be resolved at the moment relates to cut over plans. At time of speaking the Trust has been in dialogue for 3 weeks with TPP re this issue with the discussions raised to director level. The length of cutover offered was originally 14 days, but potentially can be reduced to 10. This will mean no updates or new service user information can be added to the clinical record system for that amount of time. SY confirmed paper systems would therefore need to be used during the length of the cut-over. There are then potentially significant resource implications to transfer the paper records on to SystmOne.

SY also stated that TPP have suggested our go-live may need to be delayed a week due to their readiness. It is understood another implementation in London is potentially being delayed.

In terms of go-live LC asked if the issues identified manifest themselves in delays to the project and is there any particular benefit or disadvantage to going live before or after the year-end. PH noted that whilst minor in the scheme of things if there are any issues within the quality account there is less time to correct closer to the year-end. MB stated that from a financial

perspective there are likely to be implications if the go-live is delayed. He also recognised the cost of getting the implementation right will be much lower than the cost of getting it wrong.

SY added there has been very strong clinical engagement during this phase. Clinical Design Group has a number of important deadlines to meet in the coming weeks. They meet regularly, pushing pace, ensuring this is a fundamental priority.

RC stated it would be helpful to see the go/no go checklist decision making processes and where we are with timescales.

It was RESOLVED to RECEIVE the report and NOTE the information.

AC/18/95 Treasury Management update (agenda item 16)

RA confirmed that all funds remain within the Governance Banking Service (GBS) unless invested with the National Loan Fund. There are currently no funds invested. Unless external investment rates exceed 3.5% plus GBS rate this will continue to be the case.

Forecast interest receivable is currently £55k (April to September 2018). The total received for 2017/18 was £65k.

It was RESOLVED to RECEIVE the update.

AC/18/96 Internal audit progress report (agenda item 17)

Leanne Hawkes (LH) presented the progress report. There were three reviews to report from the 2017/18 plan:

- Pharmacy procurement – which provided limited assurance. The issues in this report largely relate to the set up of approval levels in Agresso and have been corrected for. LC asked if this could relate to other procurements. MB agreed it could, but RA stressed that it was only likely to be for approvals requiring senior authorisation and staff are being reminded to check for these issues.
- Head of Internal Audit Opinion (Stage 1)
- Cyber Security Governance – which provided significant assurance

(LH) advised that the report relating to stage 1 which focussed on the Trust's Board Assurance Framework (BAF) was included within the papers and that the Board questionnaire to support stage 2 was now agreed and has been circulated recently. MB reminded all directors to complete the survey.

Recommendation Tracker

LH reported on the continuing work to develop the on line audit recommendation tracking tool, confirming the Trust's current rate of implementation of 77% which is an improvement since the last meeting. She identified that to enable her to issue a favourable Head of Internal Audit Opinion requires 75% of actions need to be appropriately completed.

RC asked for clarification on the definition of what is described as in progress and what is described as outstanding. A question was also raised about completion dates and whether progress was measured against the original or revised completion date. LH stated it is the revised review date, but will identify if the system can report against the original completion date. Any change in measurement would need to be from April 2019 and MB stated this should be taken through EMT first.

LH reported a discussion had been held with the Director of Finance & Resources around the review planned on CIPs/Transformation. The Audit Committee were requested to consider the scope of this review which was explained and to look at the NHSI checklist relating to plans and consider how CIPs are reported within the organisation at all levels. LC agreed this seemed a sensible approach.

AC/18/97 Counter fraud progress report (agenda item 18)

Steve Moss (SM) Audit Yorkshire presented an update on progress against the work plan, summarising key findings from work undertaken for the last reporting period.

The Counter fraud Authority (CFA) had issued a number of alerts during September 2018 in relation to mandate fraud. SM confirmed guidance had been circulated and that the counter fraud team were scheduled to deliver a presentation to the creditor payments team detailing how to prevent this type of fraud.

(SM) discussed the possibility of a joint piece of work with Internal Audit around fraud prevention guidance.

(SM) reported the counter fraud team were currently undertaking a joint investigation into a Trust employee's credentials and that they were currently liaising with West Yorkshire Police. SM stated that the Audit Committee would be appraised further following receipt of further information.

It was RESOLVED to NOTE the report.

AC/18/98 External audit update (agenda item 19)

PH presented the update stating it was time to start audit planning again; confirming the format of the report would be very similar to last year.

- Given the reduced income for the Trust, the materiality level also reduces. It will be £4.27m, compared to last year's £4.45m. Audit Committee agreed to this change
- Given the fact the Trust operates in a largely block contract environment there is very limited income risk. As such, focus will move away from income and instead cover:
    1. Risk around provision recognition.
    2. Asset valuations as has been the case previously
    3. Management override controls as has been the case previously

PH asked if AC members agreed with these and LC confirmed they did.

No specific risks identified with the value for money opinion at this stage. As a part of this review, the implementation of SystmOne, CIP delivery and responses to CQC actions will all be considered.

Guidance on the quality report has not yet been issued, but PH stressed it was never too early to engage with governors to confirm which measure they would like to be included. EJ to be asked to raise this with the governors.

LC thanked PH for his very comprehensive update. LC raised the question of when any benchmarking feedback will be available. PH agreed to feedback at the next meeting.

ACTION: Paul Hewitson/Emma Jones

It was RESOLVED to NOTE the update.

AC/18/99 Losses and special payments (agenda item 20)

RA reported that the Trust has made payments of £3,983 since the last report to Audit Committee. This included 3 payments relating to cases of assault of staff by service users totaling £3,080.

It was RESOLVED to NOTE the update.

AC18/100 Any other business (agenda item 21)

No other business was raised.

AC/18/101 Consideration of any changes to the organisational risk register relevant to the remit of the Audit Committee (agenda item 22)

No changes to the organisational risk register were requested over those discussed under agenda item 5.

AC/18/102 Items to report to Trust Board (agenda item 23)

The following items were agreed as:

- Review of risks where target exceeds risk appetite, specifically risk 1212
- The information provided in triangulation report and how it has supported risk identification.
- Approval of Charitable funds annual report
- Progress on GDPR compliance
- Asset valuation options, Counter Fraud quality assessment
- External audit key risk areas

AC/18/103 Work programme (agenda item 24)

There were no further changes to work programme.

It was RESOLVED to NOTE the work programme.

AC/18/104 Date of next meeting (agenda item 25)

The next meeting of the Committee will be held on Tuesday 8 January 2018 at 14.00 in Meeting Room 1, Fieldhead, Wakefield.

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	✘							

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.	